

An Independent Licensee of the Blue Cross and Blue Shield Association

## Super Blue Plus 2000<sup>1</sup> WVHTC – Option 2B (Non-Grandfathered) \$250 Deductible

Group Effective Date	December 1, 2019		
Benefit Period (used for Deductible and Coinsurance limits)	January 1 through December 31 (Calendar Year) <sup>2</sup>		
<b>Deductible</b> (Network and Non-Network Deductibles do not cross apply.)	NETWORK		NON-NETWORK
Note: All Services are subject to the Deductible unless otherwise specified.	STANDARD	BLUE DISTINCTION CENTERS <sup>3</sup>	
Individual	\$250	\$0	\$500
Family (may be met collectively)	\$500	\$0	\$1,000
Carry-Over Deductible Period	None		
Coinsurance Limit: (Network and Non-Network Coinsurance dollars do not cross apply.)	NETWORK		NON-NETWORK
	STANDARD	BLUE DISTINCTION CENTERS <sup>3</sup>	
Individual	\$1,250	\$0	\$2,500
Family (may be met collectively)	\$2,500	\$0	\$5,000
<b>Total Maximum Out-of-Pocket</b> <sup>4</sup> (Includes Deductible, Copays, and Coinsurance per Benefit Period, Network only)	NETWORK		NON-NETWORK
Individual	\$6,6	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 I	HIGHLIGHTS		
	NETW	ORK	NON-NETWORK
<b>Primary Care Medical Office Visit / Office Consultation</b> - Applies to Charges for Visit only. Does not apply to other Services received during Visit.	BDTC <sup>5</sup> \$20 per Office Visit, 100% thereafter, No Deductible	Non-BDTC \$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
<b>Urgent Care Copay</b> 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, 80% thereafter, No Deductible
Virtual Visit Originating Site	80%		60%
Telemedicine <sup>6</sup>	\$10 per Visit, 100% thereafter, No Deductible		Not Covered

PRESCRIPTION DRUGS <sup>7</sup>		
Prescription Drug Deductible	NETWORK	NON-NETWORK
Individual	None	No Benefits
Family	None	No Benefits
Prescription Drugs are provided through a Preferred Retail Pharmacy	Member pays 30% or \$20 Minimum	
<b>Network</b> – If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your	Coinsurance, whichever is greater. No  Deductible for Generic/Brand	
Coinsurance, unless the physician writes "brand necessary" (DAW) on the	Maximum out of pocket \$75	
prescription, or if no generic equivalent exists. <b>Maximum 34 day Supply.</b>	Specialty Drugs: Member pays 30%	No Benefits
Note: Prescription Deductibles, Copayments and/or Coinsurance amounts	Coinsurance. No Deductible	
apply toward the Total Maximum Out-of-Pocket.	Maximum out of pocket \$100	
Additional Preventive Prescription Benefits Guidelines as determined by certain Governmental Agencies. You may access this information at	100%, No Deductible	No Benefits
www.healthcare.gov. You may also contact Member Services		
Mail Order Drugs - If you choose Brand over Generic, you will pay the	Generic/Brand: Member pays 30% or \$20	
difference between the Brand and Generic Allowance, in addition to your	Minimum Coinsurance, whichever is greater.  No Deductible.	
Coinsurance, unless the physician writes "brand necessary" (DAW) on the	Maximum out of pocket \$100	No Benefits
prescription, or if no generic equivalent exists. Maximum 90 day supply.	Specialty Drugs: Member pays 30%	No belients
Note: Prescription Deductibles, Copayments and/or Coinsurance amounts	Coinsurance, No Deductible	
apply toward the Total Maximum Out-of-Pocket	Maximum out of pocket \$200	
PREVENTIVE (	CARE SERVICES <sup>8</sup>	
T KEVENIIVE C	NETWORK	NON-NETWORK
5 41.6	NEIWORK	INUIN-INE I WURK
Routine Adult	1000/ No Dadicatible	COO/ often dedetible
Physical exams Adult immunizations	100%, No Deductible 100%, No Deductible	60% after deductible 60% after deductible
Colorectal cancer screening		60% after deductible
	100%, No Deductible	
Routine gynecological exams, including a Pap Test	100%, No Deductible Routine: 100%, No Deductible	60% after deductible
	Routine. 100%, No Deductible	
Mammograms, annual routine and medically necessary	Medically Necessary: 80% after 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
-	·	0070 ditor deddollore
	RUM DISORDER <sup>9</sup>	
Services for diagnosis and treatment of Autism Spectrum Disorder.	000/	000/
(See Section V for additional information.) Covered Services will be paid according to the benefit category (e.g. speech therapy, office visit).	80%	60%
	N SERVICES	
In-Hospital Medical Visit	80%	600/
Surgery, Assistant to Surgery, Anesthesia	80%	60%
Second Surgical Opinion Consultants (Outpatient)	100%, No Deductible	60% 100%, No Deductible
Maternity Care - Dependent daughters are covered.	80%	60%
Newborn Care including circumcision.	80%	
	OU /0	60% 60% for other than
Occupational Therapy (Rehabilitative and Habilitative)  Limit: 30 visits per benefit period for other than chronic pain	80% for other than chronic pain	chronic pain
<b>Limit:</b> 30 visits per event for chronic pain <sup>11</sup> Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	Primary Care Office Visit Cost-sharing will apply for chronic pain	Primary Care Office Visit Cost-sharing will apply for
Physical Therapy (Rehabilitative and Habilitative) Limit: 30 visits per benefit period for other than chronic pain	80% for other than chronic pain	chronic pain 60% for other than chronic pain
Limit: 30 visits per event for chronic pain <sup>11</sup>		
Limitations are for Physician & Outpatient Facility Rehabilitative and Habilitative, combined.	Primary Care Office Visit Cost-sharing will apply for chronic pain	Primary Care Office Visit Cost-sharing will apply for chronic pain
Spinal Manipulations	80% for other than chronic pain	60% for other than chronic pain
Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain <sup>11</sup> Limitations are for Network and Non-Network	Primary Care Office Visit Cost-sharing will apply for chronic pain	Primary Care Office Visit Cost-sharing will apply for chronic pain
Respiratory Therapy	80%	60%
	1 3370	0070

Limitators are for Physical Therapy (Rehabilitative and Habilitative) Physical Therapy (Rehabilitative and Habilitative) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Cost-sharing will apply for	PHYSICIAN SER	VICES (Continued)		
Dialysis   90%   6		,		NON-NETWORK
Chemotherapy		80	%	60%
Radiation Therapy (Rehabilitative and Habilitative) when necessary due to a nedical condition.  Speech Therapy (Rehabilitative and Habilitative) when necessary due to a nedical condition.  Temporomandibular Joint Dysfunction / Craniomandibular Disorders.  Boths. 60%.  BULE DISTRICT SERVICES  Unlimited Days Semi-Private Room and Board (Bariatris Surgery: Cardiac Care; Complex and Faze Cancer Care; Know and High Replacement, Spine Surgery and Transplants received at approved center deductible and coinsurance limits)  BLUE DISTRICTION CENTERS* 100%.  BOTH CENTER		80	%	60%
Infusion Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition.  Temporomandibular Joint Dysfunction / Craniomandibular Disorders 80% 60% 60% 60% 60% 60% 60% 60% 60% 60% 6	Chemotherapy	80	%	60%
Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical candidation. The procomandibular Join Dystruction / Craniomandibular Disorders. 80% 60% 60% 60% 60% 60% 60% 60% 60% 60% 6	Radiation Therapy	80	%	60%
Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical candidative of the programment of the programm	Infusion Therapy	80	%	
a medical condenon. Temporomandibular Joint Dysfunction / Craniomandibular Disorders Diagnostic, X-ray, Lab and Testing Altery Testing and Treatment INPATIENT HOSPITAL / FACILITY SERVICES Unlimited Days Semi-Private Room and Board (Barlattic Surgery: Cardiac Care; Complex and Rare Cancer 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 finitis) Ancillaries, Drugs, Therapy Services, X-ray and Lab Cooperal Nursing Care Surgicial Services Surgicial Services Surgicial Services OUTPATIENT HOSPITAL / FACILITY SERVICES  Finhing Center Care / Maternity Services - Dependent daughters are covered.  OUTPATIENT HOSPITAL / FACILITY SERVICES  OUTPATIENT HOSPITAL / FACILITY SERVICES  Pre-Admission Testing OCCupational Therapy (Rehabilitative and Habilitative) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per ovent for chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per ovent for chronic pain Limit: 30 visits per levent figure of the services  Privary Care Office Visit Cost-sharing will apply for chronic pain Limit: 30 visits per levent figure of the third chronic pain Limit: 30 visits per levent figure of the third chronic pain Limit: 30 visits per levent figure of the third chronic pain Limit: 30 visits per levent figure of the third chronic pain Limit: 30 visits per levent figure of the third chronic pain Limit: 30 visits per levent figure of the third chronic pain Limit: 30 visits per levent figure of the third chronic pain Limit: 30 visits per levent figure of the third chronic pain Limit:	Speech Therapy (Rehabilitative and Habilitative) when necessary due to	90	0/.	
Diagnostic, X-ray, Lab and Teating  Allergy Teating and Treatment  NPATIENT HOSPITAL / FACILITY SERVICES  Unlimited Days Semi-Private Room and Board (Basards Surgery) Cardiac Care; Complex and Rano Care; Rose and Hypery Cardiac Care; Complex and Rano Care; Rose and Hypery Cardiac Care; Complex and Rano Care; Rose and Hypery Cardiac Care; Complex and Rano Care; Rose and Hypery Cardiac Care; Complex and Rano Care; Rose and Hypery Cardiac Care; Complex and Rano Care; Rose and Hypery Cardiac Care; Complex and Rano Care; Rose and Hypery Cardiac Care; Complex and Rano Care; Rose and Hypery Cardiac Care; Complex and Rano Care; Rose and Hypery Cardiac Ro		00	70	60%
INPATIENT HOSPITAL / FACILITY SERVICES	•	80	%	60%
Name		80	%	60%
Unlimited Days Semi-Private Room and Board (Barlatric Surgery; Cardiac Care; Complex and Race Caneer Care; Knee and High Replacement; Spine Surgery and Transplants received at approved Blub Distinction Center will be subject to the Blub Distinction Center deductible and coinsurance limits)  80% 80% 60% 60% 60% 60% 60% 60% 60% 60% 60% 6	Allergy Testing and Treatment	80	%	60%
Cardiac Care' Complex and Rare Cancer Care; Knee and Hip Replacements. Spine Surgery and Transplants roceived at approved Blue Distinction Centers will be subject to the Blue Distinction Center deductible and coinsurance limits)  Ancillaries, Drugs, Therapy Services, X-ray and Lab  80%  80%  80%  80%  80%  80%  80%  80	INPATIENT HOSPITA	L / FACILITY SERVICE	S	
Cardiac Care' Complex and Rare Cancer Care; Knee and Hip Replacements. Spine Surgery and Transplants roceived at approved Blue Distinction Centers will be subject to the Blue Distinction Center deductible and coinsurance limits)  Ancillaries, Drugs, Therapy Services, X-ray and Lab  80%  80%  80%  80%  80%  80%  80%  80	Unlimited Days Semi-Private Room and Board (Bariatric Surgery;		DLUE	
Replacement, spine subject to the Blue Distinction Center deductible and consurrance limits: Ancillaries, Privags, Therapy Services, X-ray and Lab Roman Nursing Care Nursing Care Roman Nursing Care Roman Nursing Care Roman Nursing Care Roman Nursing Care Nursing Care Roman Nursing Care Nursing Nursing Care Nursing Care Nursing Nursing Nursing Care Nursing Nursing Nursing Care Office Visit Cost-sharing will apply for chronic pain Chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Chronic pain Roman Nursing Primary Care Office Visit Cost-sharing will apply for chronic pain Roman Nursing Primary Care Office Visit Cost-sharing will apply for chronic pain Roman Nursing Primary Care Office Visit Cost-sharing will apply for chronic pain Roman Nursing Primary Care Office Visit Cost-sharing will apply for chronic pain Roman	Cardiac Care; Complex and Rare Cancer Care; Knee and Hip	STANDARD	_	
Ancillaries, Drugs, Therapy Services, X-ray and Lab Ancillaries, Drugs, Therapy Services, X-ray and Lab Ancillaries, Drugs, Therapy Services, X-ray and Lab Surgical Services Surgical Services Birthing Carte Care / Maternity Services - Dependent daughters are covered.  OUTPATIENT HOSPITAL / FACILITY SERVICES  Pre-Admission Testing Bignostic, X-ray, Lab and Testing Book 60% Cocupational Therapy (Rehabilitative and Habilitative) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain 'I Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative, combined.  Primary Care Office Visit Cost-sharing will apply for chronic pain 'I Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative, combined.  Primary Care Office Visit Cost-sharing will apply for chronic pain 'I Limitations are for Physician & Outpatient Facility, Network and Habilitative, combined.  Primary Care Office Visit Cost-sharing will apply for chronic pain 'I Limitations are for Physician & Outpatient Facility Rehabilitative and Habilitative, combined.  Primary Care Office Visit Cost-sharing will apply for chronic pain 'Primary Care Office Visit Cost-sharing will apply for chronic pain 'Primary Care Office Visit Cost-sharing will apply for Chronic pain 'Primary Care Office Visit Cost-sharing will apply for Chronic pain 'Primary Care Office Visit Cost-sharing will apply for Chronic pain 'Primary Care Office Visit Cost-sharing will apply for Chronic pain 'Primary Care Office Visit Cost-sharing will apply for Chronic pain 'Primary Care Office Visit Cost-sharing will apply for Chronic pain 'Primary Care Office Visit Cost-sharing will apply for Chronic pain 'Primary Care Office Visit Cost-sharing will apply for Chronic pain 'Primary Care Office Visit Cost-sharing will apply for Chronic pain 'Primary Care Of		_		60%
Ancillaries, Drugs, Therapy Services, X-ray and Lab  General Mursing Care  Surgical Services  Birthing Center Care / Maternity Services - Dependent daughters are covered.  OUTPATIENT HOSPITAL / FACILITY SERVICES  Pre-Admission Testing  Book Birthing Center Care / Maternity Services - Dependent daughters are covered.  OUTPATIENT HOSPITAL / FACILITY SERVICES  Pre-Admission Testing Book Book Book Book Book Book Book Boo	Blue Distinction Centers will be subject to the Blue Distinction	0076		
Services   S0%		90	0/	000/
Surgical Services Birthing Center Care / Maternity Services - Dependent daughters are covered.  OUTPATIENT HOSPITAL / FACILITY SERVICES  Pre-Admission Testing Bignostic, X-ray, Lab and Testing Bosys 60% 60% 60% 60% 60% 60% 60% 60% 60% 60%				
Birthing Center Care / Maternity Services - Dependent daughters are covered.  OUTPATIENT HOSPITAL / FACILITY SERVICES  Pre-Admission Testing 80% 60% 60% 60% 60% 60% 60% 60% 60% 60% 6				
OUTPATIENT HOSPITAL / FACILITY SERVICES  Pre-Admission Testing Diagnostic, X-ray, Lab and Testing Surgery, Operating Room Occupational Therapy (Rehabilitative and Habilitative) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain' Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain' Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain' Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care		80	70	60%
Pre-Admission Testing   80%   60%   60%		80	%	60%
Pre-Admission Testing   80%   60%		AL / EACH ITY CEDVIC	150	
Diagnostic, X-ray, Lab and Testing				
Surgery, Operating Room Occupational Therapy (Rehabilitative and Habilitative) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain' Primary Care Office Visit Cost-sharing will apply for chronic pain apply				
Occupational Therapy (Rehabilitative and Habilitative) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit stopper control chronic pain' Limitations are for Physician & Outpatient Facility, Network and Non- Network, Rehabilitative and Habilitative, combined.  Physical Therapy (Rehabilitative and Habilitative) Limit: 30 visits per event for chronic pain' Limitations are for Physician & Outpatient Facility Rehabilitative and Habilitative, combined.  Respiratory Therapy Respirat	Diagnostic, X-ray, Lab and Testing	80	%	60%
Cocupational Integrapy (renabilitative and reabilitative)   Elimit: 30 visits per benefit period for other than chronic pain'   Elimit: 30 visits per event for chronic pain'   Primary Care Office Visit Cost-sharing will apply for chronic pain of chronic pain of the primary (Rehabilitative and Habilitative)   Elimit: 30 visits per event for chronic pain'   Elimitiations are for Physician & Outpatient Facility Rehabilitative and Habilitative, combined.   Primary Care Office Visit Cost-sharing will apply for chronic pain of chronic pain'   Primary Care Office Visit Cost-sharing will apply for chronic pain of chronic pain'   Primary Care Office Visit Cost-sharing will apply for chronic pain of chronic pain'   Primary Care Office Visit Cost-sharing will apply for chronic pain of chronic pain of chronic pain of chronic pain'   Primary Care Office Visit Cost-sharing will apply for chronic pain of chron	Surgery, Operating Room	80	%	60%
Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.  Physical Therapy (Rehabilitative and Habilitative) Limit: 30 visits per event for chronic pain Limit: 30 visits per event for chronic pain' Respiratory Therapy  80% 60% 60% 60% 60% 60% 60% 60% 60% 60% 6	Limit: 30 visits per benefit period for other than chronic pain	80% for other than chronic pain		
Physical Therapy (Rehabilitative and Habilitative) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per benefit period for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Primar	Limitations are for Physician & Outpatient Facility, Network and Non-			Primary Care Office Visit Cost-sharing will apply for
Limitations are for Physician & Outpatient Facility Rehabilitative and Habilitative, combined.  Respiratory Therapy  80%  60%  Cardiac Rehabilitation Therapy  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.  BEHAVIORAL HEALTH SERVICES  Outpatient Mental Health Services  80%  60%  Inpatient Mental Health Services  80%  60%  Inpatient Mental Health Care Services  80%  60%  Inpatient Substance Abuse Care Services  80%  60%  10%  EMERGENCY CARE SERVICES  Emergency Accident Care and for Emergency Medical Care provided in the ER. ER copay does not apply to Deductible or Coinsurance limits.  Emergency Ambulance  NON-EMERGENCY CARE SERVICES  Non-Network Lability coverage up to \$100,00.00 maximum per Occurrence "  Non-Network Lability coverage up to \$100,00.00 maximum per Occurrence "  Non-Emergency Medical Care provided in the ER.  \$150 copayment per visit, 80% thereafter, subject to deductible  Non-Network Lability coverage up to \$100,00.00 maximum per Occurrence "  Non-Emergency Medical Care provided in the ER.  \$150 copayment per visit, 80% thereafter, subject to deductible  Non-Network Lability coverage up to \$100,00.00 maximum per Occurrence "  Non-Emergency Medical Care provided in the ER.  \$150 copayment per visit, 80% thereafter, subject to deductible  \$150 copayment per visit, 80% thereafter, subject to deductible of ded	Limit: 30 visits per benefit period for other than chronic pain	Primary Care Office Visit Cost-sharing will		60% for other than
Respiratory Therapy Cardiac Rehabilitation Therapy 80% 60% Dialysis 80% 60% Chemotherapy 80% 60% Radiation Therapy 80% 60% 80% 60% 80% 60% 80% 60% 80% 80% 60% 80% 80% 60% 80% 80% 80% 80% 80% 80% 80% 80% 80% 8	Limitations are for Physician & Outpatient Facility Rehabilitative and			Primary Care Office Visit Cost-sharing will apply for chronic pain
Cardiac Rehabilitation Therapy B0% Bolalysis B0%	Respiratory Therapy	80%		
Bilaysis   80%   60%				
Radiation Therapy	• • • • • • • • • • • • • • • • • • • •			
Radiation Therapy Infusion Therapy Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition.  BEHAVIORAL HEALTH SERVICES  Outpatient Mental Health Services Support Mental Health Services Support Mental Health Care Services Support Medical Care provided in the ER- ER copay does not apply to Deductible or Coinsurance limits.  Support Medical Care provided in the ER Support Medical Care provided in the ER- ER copay does not apply to Deductible or Coinsurance limits.  Non-Emergency Ambulance  Non-Emergency Medical Care provided in the ER Support Medical Care provided in the ER- Support Medical Care Provi	-			
Infusion Therapy Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition.  BEHAVIORAL HEALTH SERVICES  Outpatient Mental Health Services 80% 60% Inpatient Substance Abuse Services 80% 60% Inpatient Substance Abuse Care Services 80% 60% 80% 60%  Inpatient Substance Abuse Care Services 80% 60% 60% 60% 60% 60% 60% 60% 60% 60% 6				
Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition.   80%   60%				
BEHAVIORAL HEALTH SERVICES  Outpatient Mental Health Services 80% 60%  Inpatient Substance Abuse Services 80% 60%  Inpatient Mental Health Care Services 80% 60%  Inpatient Substance Abuse Care Services 80% 60%  Inpatient Substance Abuse Care Services 80% 60%  EMERGENCY CARE SERVICES  Emergency Accident Care and /or Emergency Medical Care provided in the ER- ER copay does not apply to Deductible or Coinsurance limits.  Emergency Ambulance  Inow, No Deductible  Inow, No Deductible  Non-Network Liability coverage up to \$100,000.00 maximum per Occurrence 10 \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, \$150 copayment per	• •	00	70	60%
Outpatient Mental Health Services 80% 60% Inpatient Substance Abuse Services 80% 60% Inpatient Mental Health Care Services 80% 60% Inpatient Substance Abuse Care Services 80% 60%  EMERGENCY CARE SERVICES  Emergency Accident Care and /or Emergency Medical Care provided in the ER- ER copay does not apply to Deductible or Coinsurance limits.  Emergency Ambulance  100%, No Deductible  100%, No Deductible  Non-Network Liability coverage up to \$150 copayment per visit, 80% thereafter, subject to deductible  Non-Network Liability coverage up to \$100,000.00 maximum per Occurrence 10 \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to ded		80	%	60%
Dutpatient Substance Abuse Services   80%   60%     Inpatient Mental Health Care Services   80%   60%     Inpatient Substance Abuse Care Services   80%   60%     Impatient Substance Abuse Care Services   80%   60%     EMERGENCY CARE SERVICES	BEHAVIORAL H	EALTH SERVICES		
Dutpatient Substance Abuse Services   80%   60%     Inpatient Mental Health Care Services   80%   60%     Inpatient Substance Abuse Care Services   80%   60%     Impatient Substance Abuse Care Services   80%   60%     EMERGENCY CARE SERVICES	Outpatient Mental Health Services	80	%	60%
Inpatient Mental Health Care Services  Inpatient Substance Abuse Care Services  EMERGENCY CARE SERVICES  Emergency Accident Care and /or Emergency Medical Care provided in the ER- ER copay does not apply to Deductible or Coinsurance limits.  Emergency Ambulance  100%, No Deductible  100%, No Deductible  Non-Network Liability coverage up to \$100,000.00 maximum per Occurrence 10 \$100,000.00 maximum per Occurrence 10 \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to \$100,000.00 maximum per Occurrence 10 \$100,000.00 maximum per Occurrence 10 \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 8	•			
Inpatient Substance Abuse Care Services  EMERGENCY CARE SERVICES  Emergency Accident Care and /or Emergency Medical Care provided in the ER- ER copay does not apply to Deductible or Coinsurance limits.  Emergency Ambulance  Emergency Ambulance  100%, No Deductible  100%, No Deductible  Non-Network Liability coverage up to \$100,000.00 maximum per Occurrence 10 \$100,000.00	•			
Emergency Accident Care and /or Emergency Medical Care provided in the ER- ER copay does not apply to Deductible or Coinsurance limits.  Emergency Ambulance  Emergency Ambulance  100%, No Deductible  100%, No Deductible  100%, No Deductible  Non-Network Liability coverage up to \$100,000.00 maximum per Occurrence 10 \$100,000.00 maximum				
Emergency Accident Care and /or Emergency Medical Care provided in the ER- ER copay does not apply to Deductible or Coinsurance limits.  Emergency Ambulance  Emergency Ambulance  100%, No Deductible  100%, No Deductible  100%, No Deductible  Non-Network Liability coverage up to \$100,000.00 maximum per Occurrence 10 \$100,000.00 maximum per Occurrence 10 \$100 copayment per visit, 80% thereafter, subject to deductible	·		/0	00%
Emergency Accident Care and for Emergency Medical Care provided in the ER- ER copay does not apply to Deductible or Coinsurance limits.  Emergency Ambulance  The integration of the ER- ER copay does not apply to Deductible or Coinsurance limits.  Emergency Ambulance  100%, No Deductible  100%, No Deductible  Non-Network Liability coverage up to \$100,000.00 maximum per Occurrence 10 \$100,000.00 maximum per Occ	EMERGENCY	CARE SERVICES		Ι φισο
Non-Network Liability coverage up to \$100%, No Deductible  NON-EMERGENCY CARE SERVICES  Non-Emergency Medical Care provided in the ER  \$150 copayment per visit, 80% thereafter, subject to deductible  \$150 copayment per visit, 60% thereafter, subject to deductible				80% thereafter, subject to
Non-Emergency Medical Care provided in the ER \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible	Emergency Ambulance	100%, No Deductible		Non-Network Liability coverage up to \$100,000.00 maximum
Non-Emergency Medical Care provided in the ER \$150 copayment per visit, 80% thereafter, subject to deductible \$150 copayment per visit, 60% thereafter, subject to deductible	NON-EMERGENO	Y CARE SERVICES		
		\$150 copayment per visit,		\$150 copayment per visit, 60% thereafter, subject to
	Non-Emergency Ambulance Services	00	0/2	

OTHER COVERED SERVICES			
Private Duty Nursing - Maximum 35 visits per calendar year Note: Maximums are Network and Non-Network combined.	80%		60%
Skilled Nursing Facility	80%		60%
Durable Medical Equipment and Oxygen at home	80%		60%
Orthotic Devices and Prosthetic Appliances	80%		60%
Home Health Care - Maximum 100 Visits  Note: Maximums are Network and Non-Network combined.	8	30%	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)	STANDARD 80%	BLUE DISTINCTION CENTERS <sup>3</sup>	60%
Includes transportation, meals and lodging.		100%	
Bone Marrow Procedures (Transplants received at approved Blue Distinction Centers will be subject to the Blue Distinction Center deductible and coinsurance limits)	STANDARD 80%	BLUE DISTINCTION CENTERS <sup>3</sup>	60%
<ul> <li>Includes transportation, meals and lodging.</li> </ul>		100%	

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) 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.
- (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 the soft mandatory generic provision, 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 WV Preventive Schedule (Women's Health Preventive Schedule may apply).
- (9) Coverage for eligible members to age 18. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (10) 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 emergency ambulance services that are in excess of the amount that Highmark WV pays.
- (11) 30 VISIT MAXIMUM PER EVENT FOR COMBINED PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPINAL MANIPULATIONS