HIGHMARK. West Virginia

An Independent Licensee of the Blue Cross and Blue Shield Association

Super Blue Plus 2000[1]
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)[2]		
Deductible (Network and Non-Network Deductibles do not cross apply.) **Note: All Services are subject to the Deductible unless otherwise specified.**	**NETWORK**		**NON-NETWORK**
	STANDARD	**BLUE DISTINCTION CENTERS[3]**	
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[3]**	
Individual	$1,250	$0	$2,500
Family (may be met collectively)	$2,500	$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] $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
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
Virtual Visit Originating Site	80%		60%
Telemedicine[6]	$10 per Visit, 100% thereafter, No Deductible		Not Covered

PRESCRIPTION DRUGS[7]		
Prescription Drug Deductible Individual Family	**NETWORK** None None	**NON-NETWORK** No Benefits 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 34 day Supply.** **Note**: Prescription Deductibles, Copayments and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket.	Member pays 30% or $20 Minimum Coinsurance, whichever is greater. No Deductible for Generic/Brand Maximum out of pocket $75 Specialty Drugs: Member pays 30% Coinsurance, No Deductible Maximum out of pocket $100	No Benefits
Additional Preventive Prescription Benefits 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.** **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. Maximum out of pocket $100 Specialty Drugs: Member pays 30% Coinsurance, No Deductible Maximum out of pocket $200	No Benefits
PREVENTIVE CARE SERVICES[8]		
	NETWORK	**NON-NETWORK**
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 and medically necessary	Routine: 100%, No Deductible 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
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) **Limit**: 30 visits per benefit period for other than chronic pain **Limit:** 30 visits per event for chronic pain[11] Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	80% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain	60% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain
Physical Therapy (Rehabilitative and Habilitative) **Limit**: 30 visits per benefit period for other than chronic pain **Limit:** 30 visits per event for chronic pain[11] Limitations are for Physician & Outpatient Facility Rehabilitative and Habilitative, combined.	80% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain	60% for other than chronic pain 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[11] Limitations are for Network and Non-Network	80% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain	60% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain
Respiratory Therapy	80%	60%

PHYSICIAN SERVICES (Continued)			
	NETWORK		**NON-NETWORK**
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.	80%		60%
Temporomandibular Joint Dysfunction / Craniomandibular Disorders	80%		60%
Diagnostic, X-ray, Lab and Testing	80%		60%
Allergy Testing and Treatment	80%		60%
INPATIENT HOSPITAL / FACILITY SERVICES			
Unlimited Days Semi-Private Room and Board (Bariatric 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 limits)	**STANDARD** 80%	**BLUE DISTINCTION CENTERS[3]** 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%
Surgery, Operating Room	80%		60%
Occupational Therapy (Rehabilitative and Habilitative) **Limit**: 30 visits per benefit period for other than chronic pain **Limit:** 30 visits per event for chronic pain[11] Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	80% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain		60% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain
Physical Therapy (Rehabilitative and Habilitative) **Limit**: 30 visits per benefit period for other than chronic pain **Limit:** 30 visits per event for chronic pain[11] Limitations are for Physician & Outpatient Facility Rehabilitative and Habilitative, combined.	80% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain		60% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain
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.	80%		60%
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 Accident Care and /or Emergency Medical Care provided in the ER- ER copay does not apply to Deductible or Coinsurance limits.	$150 copayment per visit, 80% thereafter, subject to deductible		$150 copayment per visit, 80% thereafter, subject to deductible
Emergency Ambulance	100%, No Deductible		100%, No Deductible Non-Network Liability coverage up to $100,000.00 maximum per Occurrence[10]
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
Non-Emergency Ambulance Services	80%		60%

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.	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)** • Includes transportation, meals and lodging.	**STANDARD** 80%	**BLUE DISTINCTION CENTERS[3]** 100%	60%
Bone Marrow Procedures **(Transplants received at approved Blue Distinction Centers will be subject to the Blue Distinction Center deductible and coinsurance limits)** • Includes transportation, meals and lodging.	**STANDARD** 80%	**BLUE DISTINCTION CENTERS[3]** 100%	60%

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