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, 2023		
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
	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 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 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 Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply	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 Cost-sharing for Prescription Insulin Drugs 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 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. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	$15 copay per Visit, 100% thereafter, No Deductible Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	$20 copay per Visit, 80% thereafter, No Deductible
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. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	$15 copay per Visit, 100% thereafter, No Deductible Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	$20 copay per Visit, 80% thereafter, No Deductible
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	$15 copay per Visit, 100% thereafter, No Deductible	$20 copay per Visit, 80% thereafter, No Deductible
Respiratory Therapy	80%	60%
Cardiac Rehabilitation Therapy	80%	60%
Dialysis	80%	60%

PHYSICIAN SERVICES (Continued)			
	NETWORK		**NON-NETWORK**
Chemotherapy	80%		60%
Radiation Therapy	80%		60%
Infusion Therapy	80%		60%
Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	$15 copay per Visit, 100% thereafter, No Deductible	$20 copay per Visit, 80% thereafter, No Deductible 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 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% Copayment, if any, does not apply to Diagnostic Services prescribed for the treatment of Mental Health and Substance Use Disorder	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. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	80% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	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. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	80% for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	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. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	80% Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	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 Room Services	$150 per visit, 100% thereafter, No Deductible		
Ambulance **Emergency (ground, water, air)**	100%, No Deductible		

Ambulance **Non-Emergency (ground, water) (10)**	80%	60%
Ambulance **Non-Emergency (air)**	80%	

OTHER COVERED SERVICES			
	NETWORK		NON-NETWORK
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) Telemedicine services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark approved telemedicine vendor. Additional services provided by a Highmark approved 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 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) 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 WV 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