HIGHMARK WEST VIRGINIA
An Independent Licensee of the Blue Cross and Blue Shield Association

Super Blue Plus 2010[1]
University Physicians & Surgeons, Inc.
dba Marshall Health
SUMMARY OF BENEFITS

Effective Date	July 1, 2023		
Benefit Period (used for Deductible and Coinsurances limits and certain benefit frequencies.)	Contract Year[2]		
Note: All Services are subject to the Deductible unless otherwise specified.			
Deductible (Enhanced and Standard cross apply. Non-Network does not cross apply)	**ENHANCED**	**STANDARD**	**NON-NETWORK**
Individual	$300	$1,000	$1,500
Family (may be met collectively)	$600	$2,000	$3,000
Carry-Over Deductible Period	NONE		
Coinsurance Limit: (Enhanced/Standard and Non-Network Coinsurance do cross apply. Does not include Deductible)	**ENHANCED**	**STANDARD**	**NON-NETWORK**
Individual	$2,500	$3,000	$5,000
Family (may be met collectively)	$5,000	$6,000	$10,000
Total Maximum Out–of-Pocket[6] (Includes Deductible, Copays, and Coinsurance per Benefit Period, Enhanced and Standard only)	**ENHANCED**	**STANDARD**	**NON-NETWORK**
Individual	$4,500		Not Applicable
Family (may be met collectively)	$9,000		Not Applicable
Non-Network Liability	UNLIMITED		
Lifetime Maximum Benefit for all Covered Services	UNLIMITED		
BENEFIT HIGHLIGHTS			
	ENHANCED	**STANDARD**	**NON-NETWORK**
Primary Care Medical Office Visit / Office Consultation (Includes Primary Care Virtual Visits) 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.	$0 Co-Pay per Office Visit, 100% thereafter, No Deductible	$30 Co-Pay per Office Visit, 100% thereafter, No Deductible	60%
Specialist Care Medical Office Visit / Office Consultation (Includes Specialist Virtual Visits) 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.	$20 Co-Pay per Office Visit, 100% thereafter, No Deductible	$50 Co-Pay per Office Visit, 100% thereafter, No Deductible	60%
Telemedicine Service (Only through Well360 Virtual Health)[4]	$10 per Visit, 100% thereafter, No Deductible		No Benefits
Urgent Care Center Visits 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.	$0 Co-Pay per Office Visit, 100% thereafter, No Deductible	$75 Co-Pay per Office Visit, 100% thereafter, No Deductible	60%
Virtual Visit Originating Site	100%	80%	60%

PRESCRIPTION DRUGS[7]			
Prescription Drug Deductible	**ENHANCED**	**STANDARD**	**NON-NETWORK**
Individual Family	$0 $0	$50 $100	No Benefits No Benefits
Prescription Drugs: 1-34 Day Supply If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowances, in addition to the Co-Pay or Coinsurance, unless the Physician writes 'Brand Necessary' (DAW) on the prescription, or if no generic equivalent exists. **Note**: Prescription Deductibles, Copayments and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket	**1-34 Day Supply** Member Pays: $0 Co-Pay – Generic $20 Co-Pay – Formulary 25% Non-Formulary Brand 35% up to $200 maximum – Specialty Medication	**1-34 Day Supply** Member Pays: $5 Co-Pay – Generic $20 Co-Pay – Formulary 25% Non-Formulary Brand 35% up to $200 maximum – Specialty Medication	No Benefits
Prescription Drugs: 35-90 Day Supply If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowances, in addition to the Co-Pay or Coinsurance, unless the Physician writes 'Brand Necessary' (DAW) on the prescription, or if no generic equivalent exists. **Note**: Prescription Deductibles, Copayments and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket	**35-90-Day Supply** Member Pays: $0 Co-Pay – Generic $50 Co-Pay Formulary 25% Co-Pay Non-Formulary Brand 35% up to $200 maximum – Specialty Medication	**35-90-Day Supply** Member Pays: $12 Co-Pay – Generic $50 Co-Pay Formulary 25% Co-Pay Non-Formulary Brand 35% up to $200 maximum – Specialty Medication	No Benefits
Mail Order - Maximum 90 day Supply If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowances, in addition to the Co-Pay or Coinsurance, unless the Physician writes 'Brand Necessary' (DAW) on the prescription, or if no generic equivalent exists. **Note:** Prescription Deductibles, Copayments and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket	N/A	90 Day Supply Member Pays: $12 Co-Pay – Generic $50 Co-Pay – Formulary 25% Non-Formulary Brand 35% up to $200 maximum – Specialty Medication	No Benefits
Additional Preventive Prescription Benefits[5] (Retail or Mail Order). 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

PREVENTIVE CARE SERVICES[5, 9]			
Routine Adult			
Physical exams	100%, No Deductible		60%
Adult immunizations	100%, No Deductible		60%
Colorectal cancer screening	100%, No Deductible		60%
Routine gynecological exams, including a Pap Test	100%, No Deductible		60%
Mammograms, annual routine and medically necessary	Routine: 100%, No Deductible		60%
	Medically Necessary: 100% after deductible	Medically Necessary: 80% after deductible	
Diagnostic services and procedures	100%, No Deductible		60%
Routine Pediatric			
Physical exams	100%, No Deductible		60%
Pediatric immunizations	100%, No Deductible		60%
Diagnostic services and procedures	100%, No Deductible		60%

AUTISM SPECTRUM DISORDER[3, 9]			
Services for diagnosis and treatment of Autism Spectrum Disorder (See Section V for additional information). Note: Covered Services will be paid according to the benefit category (e.g. Speech Therapy, Office Visit, etc.)	90%	80%	60%

PHYSICIAN SERVICES[9]			
	ENHANCED	**STANDARD**	**NON-NETWORK**
In-Hospital Medical Visit	90%	80%	60%
Skilled Nursing Facility Medical	90%	80%	60%
Surgery, Assistant to Surgery, Anesthesia	90%	80%	60%
Second Surgical Opinion Consultations (Outpatient)	$100 Co-Pay per visit, 90% thereafter		
Maternity Care - Dependent daughters are covered.	100%	80%	60%
Newborn Care including circumcision.	100%	80%	60%
Occupational Therapy (Rehabilitative and Habilitative) **- Maximum 30 visits per Benefit Period.** Limitations are for Physician & Outpatient Facility, Enhanced, Standard and Non Network, Rehabilitative and Habilitative, combined.	80%		60%
Physical Therapy (Rehabilitative and Habilitative) **- Maximum 30 visits per Benefit Period.** Limitations are for Physician & Outpatient Facility, Enhanced, Standard and Non Network, Rehabilitative and Habilitative, combined.	80%		60%
Spinal Manipulations (Rehabilitative and Habilitative) **– Maximum 30 visits per Benefit Period.** Limitations are for Enhanced, Standard and Non Network, Rehabilitative and Habilitative, combined.	80%		60%
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%
Temporomandibular Joint Dysfunction / Craniomandibular Disorders	100%	80%	60%
Diagnostic, X-ray, Lab and Testing	100%	80%	60%
Allergy Testing and Treatment	100%	80%	60%
INPATIENT HOSPITAL / FACILITY SERVICES[10]			
Unlimited Days Semi-Private Room and Board	$100 Co-Pay per admission 90% thereafter	$100 Co-Pay per admission 80% thereafter	$100 Co-Pay per admission 60% thereafter
Ancillaries, Drugs, Therapy Services, X-ray and Lab	$100 Co-Pay per admission 90% thereafter	$100 Co-Pay per admission 80% thereafter	$100 Co-Pay per admission 60% thereafter
General Nursing Care	$100 Co-Pay per admission 90% thereafter	$100 Co-Pay per admission 80% thereafter	$100 Co-Pay per admission 60% thereafter
Surgical Services	$100 Co-Pay per admission 90% thereafter	$100 Co-Pay per admission 80% thereafter	$100 Co-Pay per admission 60% thereafter
Birthing Center Care / Maternity Services - Dependent daughters are covered.	$100 Co-Pay per admission 100% thereafter	$100 Co-Pay per admission 80% thereafter	$100 Co-Pay per admission 60% thereafter

OUTPATIENT HOSPITAL / FACILITY SERVICES[9]			
	ENHANCED	**STANDARD**	**NON-NETWORK**
Pre-Admission Testing	100%	80%	60%
Diagnostic, X-ray, Lab and Testing	100%	80%	60%
Surgery, Operating Room	100%	80%	60%
Occupational Therapy (Rehabilitative and Habilitative) **- Maximum 30 visits per Benefit Period.** Limitations are for Physician & Outpatient Facility, Enhanced, Standard and Non Network, Rehabilitative and Habilitative, combined.	80%		$100 Co-Pay per visit, 60% thereafter
Physical Therapy (Rehabilitative and Habilitative) **- Maximum 30 visits per Benefit Period.** Limitations are for Physician & Outpatient Facility, Enhanced, Standard and Non Network, Rehabilitative and Habilitative, combined.	80%		$100 Co-Pay per visit, 60% thereafter
Respiratory Therapy	$100 Co-Pay per visit, 80% thereafter		60%
Cardiac Rehabilitation Therapy	$100 Co-Pay per visit, 80% thereafter		60%
Dialysis	$100 Co-Pay per visit, 80% thereafter		60%
Chemotherapy	$100 Co-Pay per visit, 80% thereafter		60%
Radiation Therapy	$100 Co-Pay per visit, 80% thereafter		60%
Infusion Therapy	$100 Co-Pay per visit, 80% thereafter		60%
Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition.	$100 Co-Pay per visit, 80% thereafter		$100 Co-Pay per visit, 60% thereafter

BEHAVIORAL HEALTH SERVICES[9]			
Outpatient Mental Health Services	100%	80%	60%
Outpatient Substance Use Disorder	100%	80%	60%
Inpatient Mental Health Care Services	$100 Co-Pay per admission 100% thereafter	$100 Co-Pay per admission 80% thereafter	$100 Co-Pay per admission 60% thereafter
Inpatient Substance Use Disorder	$100 Co-Pay per admission 100% thereafter	$100 Co-Pay per admission 80% thereafter	$100 Co-Pay per admission 60% thereafter

EMERGENCY CARE SERVICES			
	ENHANCED	**STANDARD**	**NON-NETWORK**
Emergency Accident Care and /or Emergency Medical Care provided in the ER[10]	$150 Co-Pay per visit, 80% after Enhanced Deductible Co-Pay waived if admitted		
Emergency Ambulance (ground, water, air)	90%, No Deductible		

NON-EMERGENCY CARE SERVICES			
Non-Emergency Medical Care provided in the ER	$200 Co-Pay per visit, 80% after Enhanced Deductible		
Non-Emergency Ambulance Services (ground, water)[8]	80%	80%	60%
Non-Emergency Ambulance Services (air)	80%, after Enhanced Deductible		
OTHER COVERED SERVICES[9]			
Private Duty Nursing – **Maximum 35 visits per Benefit Period** Note: Maximums are Enhanced, Standard 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 – Maximum100 Visits per Benefit Period Note: Maximums are Enhanced, Standard and Non Network combined.	80%		60%
Hospice Care	100%		60%
Diabetes Education and Control	100%	80%	60%
HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES			
Human Organ Transplant • Includes transportation, meals and lodging	90%	80%	60%
Bone Marrow Procedures • Includes transportation, meals and lodging	90%	80%	60%

Eligible Dependent Age Limitation	Coverage stops at the end of the month of the 26th birthday for an adult Dependent who qualifies as 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] 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. Please note that certain outpatient procedures also require prior authorization. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that your services are 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 Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.

[3] 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.

[4] 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.

[5] Services are limited to those listed on the Highmark WV Preventive Schedule (Women's Health Preventive Schedule may apply).

[6] 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.

[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. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. 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. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment.

[8]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.

[9]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.

[10]Benefits for care services rendered by an out-of-network provider will be paid at the highest network level of benefits. 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 highest network level of benefits. 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.

HIGHMARK. West Virginia

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you speak English, language assistance services, free of charge, are available to you. Call 1-877-959-2562.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-877-959-2562.

如果您说中文，可向您提供免费语言协助服务。
請致電 1-877-959-2562.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-877-959-2562.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-877-959-2562.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-877-959-2562 .

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-877-959-2562.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다.
1-877-959-2562 로 전화.

日本語が母国語の方は言語アシスタンス・ サービスを無料でご利用いただけます。 1-877-959-2562 を呼び出します。

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-877-959-2562.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-877-959-2562.

หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย
โทร 1-877-959-2562.

यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। 1-877-959-2562 मा फोन गर्नुहोस्।

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان
با تماس با شماره 1-877-959-2562 .

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-877-959-2562.

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔
1-877-959-2562 پر کال کریں ۔

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-877-959-2562.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-877-959-2562.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-877-959-2562.

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-877-959-2562.

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