**Super Blue Plus 20101**

**University Physicians & Surgeons, Inc.**

**dba Marshall Health**

**SUMMARY OF BENEFITS**

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| **Effective Date** | July 1, 2024 |
| **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$5,000 | $3,000$6,000 | $5,000 |
| Family (may be met collectively) | $10,000 |
| **Total Maximum Out–of-Pocket6** (Includes Deductible, Copays, and Coinsurance per Benefit Period, Enhanced and Standard only) | **ENHANCED** | **STANDARD** | **NON-NETWORK** |
| Individual | $5,000$10,000 | Not Applicable |
| Family (may be met collectively) | 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. | $25 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. | $25 Co-Pay per Office Visit, 100% thereafter, No Deductible | $75 Co-Pay per Office Visit, 100% thereafter, No Deductible | 60% |
| 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** | 100% | 80% | 60% |

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| **PRESCRIPTION DRUGS7** |
| **Prescription Drug Deductible** | **ENHANCED** | **STANDARD** | **NON-NETWORK** |
| Individual | $0$0 | $50$100 | No Benefits |
| Family | 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, including when 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: | **1-34 Day Supply** Member Pays:  | No Benefits |
| $0 Co-Pay – Generic  | $5 Co-Pay – Generic  | No Benefits |
| $25 Co-Pay – Formulary Brand | 10% Coinsurance – Formulary Brand | No Benefits |
| 25% Coinsurance - Non-Formulary Brand | 25% Coinsurance - Non-Formulary Brand | No Benefits |
| 35%Coinsurance up to $200 maximum – Specialty Medication | 35% Coinsurance up to $200 maximum – Specialty Medication (Only applicable when not available at Marshall Pharmacy) | 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, including when 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: | **35-90-Day Supply** Member Pays: | No Benefits |
| $0 Co-Pay – Generic  | $12 Co-Pay – Generic  | No Benefits |
| $62.50 Co-Pay -Formulary Brand | 10% Coinsurance – Formulary Brand | No Benefits |
| 25% Coinsurance -Non-Formulary Brand | 25% Coinsurance - Non-Formulary Brand | No Benefits |
| 35% Coinsurance up to $200 maximum – Specialty Medication | 35% Coinsurance up to $200 maximum – Specialty Medication (Only applicable when not available at Marshall Pharmacy) | 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, including when 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: | No Benefits |
| $12 Co-Pay – Generic | No Benefits |
| $50 Co-Pay – Formulary Brand  | No Benefits |
| 25% Coinsurance - Non-Formulary Brand | No Benefits |
| 35% Coinsurance up to $200 maximum – Specialty Medication (Only applicable when not available at Marshall Pharmacy) | No Benefits |
| **Additional Preventive Prescription Benefits5** (Retail or Mail Order).Guidelines as determined by certain Governmental Agencies*.* You may access this information at [www.healthcare.gov](http://www.healthcare.gov). You may also contact Member Services. | 100%, No Deductible | No Benefits |

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| **PREVENTIVE CARE SERVICES5, 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**  | 100%, No Deductible | 60%  |
|  **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%  |

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| **AUTISM SPECTRUM DISORDER3, 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% |

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| **PHYSICIAN SERVICES9** |
|  | **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. Limit does notapply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder | 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. Limit does notapply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder | 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 Allergy Testing** | 100% | 80% | 60% |
| **Allergy Treatment, Extractions, and Injections** | 100% | 80% | 60% |
| **INPATIENT HOSPITAL / FACILITY SERVICES10** |
| **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 |

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| **OUTPATIENT HOSPITAL / FACILITY SERVICES9** |
|  | **ENHANCED** | **STANDARD** | **NON-NETWORK** |
| **Pre-Admission Testing** | 100% | 80% | 60% |
| **Diagnostic, X-ray, Lab, and Allergy Testing** | 100% | 80% | 60% |
| **Medically Necessary Mammogram** | 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. Limit does notapply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder |  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. Limit does notapply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder |  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 SERVICES9** |
| **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 |

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| **EMERGENCY CARE SERVICES** |
| ‍ | **ENHANCED** | **STANDARD** | **NON-NETWORK** |
| **Emergency Accident Care and/or Emergency Medical Care provided** ‍**in the ER10** | $150 Co-Pay per visit, 80% after Enhanced DeductibleCo-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 SERVICES9** |
| **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% |
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| **Bone Marrow Procedures**• Includes transportation, meals and lodging  | 90% | 80% | 60% |
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| **Eligible Dependent Age Limitation** | Coverage stops at the end of the month of the 26th birthday for an adult Dependent who qualifies as an Eligible Dependent. ‍ |
| **Prior Authorization Requirement** | Certain services may require prior authorization. A current listing is published at www.myhighmark.com. You may also contact Member Services. Their phone number is on the back of your ID Card. |

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.

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| 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 designated telemedicine vendor. Additional services provided by a Highmark designated Telemedicine vendor are paid according to the benefit category that they fall under (e.g.PCP is eligible under the PCP office visit benefit, behavioral health is eligible under outpatient mental health.

5 Services are limited to those listed on the Highmark 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 SensibleRx Complete, 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. 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.

8Unless otherwise provided for benefits for emergency ambulance services rendered by a non-network provider will be subject to the same cost-sharing amount, if any, that is applicable to network services. The member will be responsible for any amounts billed by the non-network provider for non-emergency ground and water ambulance services that are in excess of the amount that Highmark pays.

9Covered 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.

10Benefits 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.

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