HIGHMARK West Virginia

An Independent Licensee of the Blue Cross and Blue Shield Association

Jefferson County Commission
SuperBlue Plus 2010

SUMMARY OF BENEFITS[6]

Effective Date	July 1, 2018	
Benefit Period (used for Deductible and Coinsurances limits; and certain benefit frequencies)	Contract Year (July through June)[1]	
Deductible (Network and Non-Network Deductibles do not cross apply)	**NETWORK**	**NON-NETWORK**
Individual	$3,000	$6,000
Family (may be met collectively)	$6,000	$12,000
Carry-Over Deductible Period	None	
Coinsurance Limit (Network and Non-Network Coinsurance dollars do not cross apply)	**NETWORK**	**NON-NETWORK**
Individual	$1,000	$3,000
Family (may be met collectively)	$2,000	$6,000
Total Maximum Out–of-Pocket[2] (Includes Deductible, Copays, and Coinsurance per Benefit Period, Network only.):	**NETWORK**	**NON-NETWORK**
Individual	$7,350	Not Applicable
Family (may be met collectively)	$14,700	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.	$25 per Office Visit, 100% thereafter, No Deductible	$25 per Office Visit, 80% thereafter, No Deductible
Specialist Care Medical Office Visit / Office Consultation - Specialist - (Includes Specialist Virtual Visit). 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 Center Visit Applies to Charges for Visit only. Does not apply to other services received during Visit.	$50 per Office Visit, 100% thereafter, No Deductible	$50 per Office Visit, 80% thereafter, No Deductible
Virtual Visit Originating Site	100%	80%
Telemedicine Service[3]	$10 per Visit, 100% thereafter, No Deductible	Not Covered

PRESCRIPTION DRUGS[7]

Prescription Drug Deductible Individual Family	 None None	 No Benefits No Benefits
Prescription Drugs are provided through a 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	$10 Generic / $20 Formulary Brand / $40 Non-Formulary Brand	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	$25 Generic / $50 Formulary Brand / $90 Non-Formulary Brand	NO BENEFITS
Additional Preventive Prescription Benefits[4] (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[4]		
	NETWORK	**NON-NETWORK**
Routine Adult		
Physical exams	100%, No Deductible	80%
Adult immunizations	100%, No Deductible	80%
Colorectal cancer screening	100%, No Deductible	80%
Routine gynecological exams, including a Pap Test	100%, No Deductible	80%
Mammograms, annual routine and medically necessary	Routine: 100%, No Deductible Medically Necessary: 100% after deductible	80%
Diagnostic services and procedures	100%, No Deductible	80%
Routine Pediatric		
Physical exams	100%, No Deductible	80%
Pediatric immunizations	100%, No Deductible	80%
Diagnostic services and procedures	100%, No Deductible	80%
AUTISM SPECTRUM DISORDER[5]		
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.)	100%	80%
PHYSICIAN SERVICES		
In-Hospital Medical Visit	100%	80%
Surgery, Assistant to Surgery, Anesthesia	100%	80%
Second Surgical Opinion, Consultations (Outpatient)	100%, No Deductible	100%, No Deductible
Maternity Care - Dependent daughters are covered.	100%	80%
Newborn Care including circumcision.	100%	80%
Occupational Therapy (Rehabilitative and Habilitative) **- Maximum 30 visits per Benefit Period.** Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	80%	80%
Physical Therapy (Rehabilitative and Habilitative) **- Maximum 30 visits per Benefit Period.** Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	80%	80%
Chiropractic Manipulations (Rehabilitative and Habilitative) **- Maximum 30 visits per Benefit Period.** Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	80%	80%
Respiratory, Hyperbaric and Pulmonary Therapy	100%	80%
Cardiac Rehabilitation Therapy	100%	80%
Dialysis	100%	80%
Chemotherapy	100%	80%
Radiation Therapy	100%	80%
Infusion Therapy	100%	80%
Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition.	100%	80%
Temporomandibular Joint Dysfunction / Craniomandibular Disorders	100%	80%
Diagnostic, X-ray, Lab and Testing	100%	80%
Allergy Testing and Treatment	100%	80%

INPATIENT HOSPITAL / FACILITY SERVICES		
	NETWORK	**NON-NETWORK**
Unlimited Days Semi-Private Room and Board	$100 per admission Co-Pay, 100% thereafter	$100 per admission Co-Pay, 80% thereafter
Ancillaries, Drugs, Therapy Services, X-ray and Lab	100%	80%
General Nursing Care	100%	80%
Surgical Services	100%	80%
Birthing Center Care/Maternity Services - Dependent daughters are covered.	$100 per admission Co-Pay, 100% thereafter	$100 per admission Co-Pay, 80% thereafter
OUTPATIENT HOSPITAL / FACILITY SERVICES		
Pre-Admission Testing	100%	80%
Diagnostic, X-ray, Lab and Testing	100%	80%
Surgery, Operating Room	100%	80%
Occupational Therapy (Rehabilitative and Habilitative) **- Maximum 30 visits per Benefit Period.** Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	80%	80%
Physical Therapy (Rehabilitative and Habilitative) **- Maximum 30 visits per Benefit Period.** Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	80%	80%
Respiratory, Hyperbaric and Pulmonary Therapy	100%	80%
Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition.	100%	80%
Cardiac Rehabilitation Therapy	100%	80%
Dialysis	100%	80%
Chemotherapy	100%	80%
Radiation Therapy	100%	80%
Infusion Therapy	100%	80%
BEHAVIORAL HEALTH SERVICES		
Outpatient Mental Health Services	100%	80%
Outpatient Substance Abuse Services	100%	80%
Inpatient Mental Health Care Services	$100 per admission Co-Pay, 100% thereafter	$100 per admission Co-Pay, 80% thereafter
Inpatient Substance Abuse Care Services	$100 per admission Co-Pay, 100% thereafter	$100 per admission Co-Pay, 80% thereafter
EMERGENCY CARE SERVICES		
Emergency Accident Care and / or Emergency Medical Care provided in the ER	$125 ER Co-Pay, 100% thereafter (Co-pay waived if admitted)	$125 ER Co-Pay, 100% thereafter (Co-pay waived if admitted)
Emergency Ambulance	100%, No Deductible	100%, No Deductible
NON-EMERGENCY CARE SERVICES		
Non-Emergency Medical Care provided in the ER	$125 ER Co-Pay, 100% thereafter	$125 ER Co-Pay, 80% thereafter
Non-Emergency Ambulance Services	100%	80%

OTHER COVERED SERVICES		
	NETWORK	**NON-NETWORK**
Private Duty Nursing - Maximum 35 visits per benefit period Note: Maximum is Network and Non-Network combined.	100%	80%
Skilled Nursing Facility	$100 per admission Co-Pay, 100% thereafter	$100 per admission Co-Pay, 80% thereafter
Durable Medical Equipment and Oxygen at home	100%	80%
Orthotic Devices and Prosthetic Appliances	100%	80%
Home Health Care - Maximum 100 visits per benefit period Note: Maximums are Network and Non-Network combined.	100%	80%
Hospice Care	$100 per admission Co-Pay, 100% thereafter	Inpatient:$100 per admission Co-Pay, 80% thereafter Outpatient: 80%
Diabetes Education & Control	100%	80%
HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES		
Human Organ Transplant • Includes transportation, meals and lodging	100%	Inpatient: $100 per admission Co-Pay, 80% thereafter Outpatient: 80%
Bone Marrow Procedures • Includes transportation, meals and lodging	100%	Inpatient: $100 per admission Co-Pay, 80% thereafter Outpatient: 80%

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) 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.
(2) 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.
(3) 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.
(4) Services are limited to those listed on the Highmark WV Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) 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.
(6) 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.
(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.