HIGHMARK West Virginia

An Independent Licensee of the Blue Cross and Blue Shield Association

SuperBlue Plus 2008 Non-Group

SUMMARY OF BENEFITS[1]

IMPORTANT: PLEASE READ THE SUMMARY OF BENEFITS SECTION. THIS IS PART OF YOUR CERTIFICATE AND SUBJECT TO CHANGE. FOR FURTHER EXPLANATION REFER TO YOUR CERTIFICATE BOOK.

Benefit Period (used for Deductible and Coinsurances limits; and certain benefit frequencies.)	January 1 through December 31 (Calendar Year)				
Note: All services are subject to the Deductible unless otherwise specified. Co-Pays (Fees) do not apply to Deductibles or Coinsurances limits unless otherwise specified.					
Carry-Over Deductible Period	October, November and December				
Deductible (Applies to Network and Non-Network Benefits combined.)	**DEDUCTIBLE OPTIONS**				
Individual Family (may be met collectively)	$500 $1,000	$1,000 $2,000	$1,500 $3,000	$2,500 $5,000	$5,000 $10,000
Network Coinsurance Limit: (Network and Non-Network Coinsurance dollars cross apply.) Individual Family (may be met collectively)	$3,000 $6,000	$3,000 $6,000	$3,000 $6,000	$3,000 $6,000	$3,000 $6,000
Deductible and Network Coinsurance Limit: Individual Family	$3,500 $7,000	$4,000 $8,000	$4,500 $9,000	$5,500 $11,000	$8,000 $16,000
There is an additional Non-Network Coinsurance Limit of $2,500/Individual and $5,000 Family					
Non-Network Liability	**Unlimited**				
Lifetime Maximum Benefit for all Covered Services	**Unlimited**				

BENEFIT HIGHLIGHTS

	NETWORK[2]	**NON-NETWORK[2]**
Medical Office Visit / Office Consultation – (Includes Specialist/Specialist Virtual Visit). Applies to charge for visit only. Does not apply to other services received during visit.	$25 Co-Pay per Office Visit, 100% thereafter, No Deductible	$25 Co-Payper Office Visit, 60% thereafter, No Deductible
Virtual Visit Originating Site	80%	60%
Telemedicine Service[3]	$10 per Visit, No Deductible	
Prescription Drugs are provided through a Preferred Pharmacy Network If you, the member, 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.**	50%, No Deductible	NO BENEFITS
Mail Order Drugs – If you, the member, 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.**	50%, No Deductible	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 using the number on the back of your ID Card.	100%, No Deductible	NO BENEFITS

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PREVENTIVE CARE SERVICES		
	NETWORK[2]	**NON-NETWORK[2]**
Routine Gynecological Exam – up to two per benefit period.	100%, No Deductible	$25 Co-Pay per Office Visit, 60% thereafter, No Deductible
Routine Pap Smear – up to two per benefit period	100%, No Deductible	60%
Routine HPV Testing - one every 3 years age 30 and older	100%, No Deductible	60%
Well Woman Physical Exam – up to two per benefit period	100%, No Deductible	No Benefits
Routine Mammogram - per schedule age 35 and older	100%, No Deductible	60%
Prostate Exam - one per benefit period for males over age 50.	100%, No Deductible	$25 Co-Pay per Office Visit, 60% thereafter, No Deductible
Prostate Specific Antigen (PSA) Test - one per benefit period	100%, No Deductible	60%
Colorectal Cancer Exam - for individual's age 50 and older (one per benefit period) or a person under age 50 with high risk factors (e.g. family history).	100%, No Deductible	$25 Co-Pay per Office Visit, 60% thereafter, No Deductible
Fecal occult blood test - one per benefit period	100%, No Deductible	60%
Flexible Sigmoidoscopy - one every 5 years	100%, No Deductible	60%
Colonoscopy - one every 10 years	100%, No Deductible	60%
Double Contrast Barium Enema - one every 5 years	100%, No Deductible	60%
Routine Physical Exam - one per benefit period	100%, No Deductible	$25 Co-Pay per Office Visit, 60% thereafter, No Deductible
Routine Screening, Immunization and Diagnostic Services[4] (guidelines as determined by certain Governmental Agencies) – You may access this information at www.healthcare.gov. You may also contact Member Services. Their number is located on the back of your ID Card.	100%, No Deductible	No Benefits
Routine Immunization Services: MMR, Pneumococcal Polysaccaride, Influenza, Varicella, Hepatitis A & B Series and Meningococcal vaccinations	100%, No Deductible	60%
Routine Diagnostic Services Lipid panel, complete blood count and blood glucose screening	100%, No Deductible	60%
Routine Diagnostic Services: urinalysis and rubella titer test	80%	60%
Diabetes Education & Control – Copay applies to office visit only. All other services will fall under Medical Benefits.	$25 Co-Pay per Office Visit, 100% thereafter, No Deductible 80% other services, subject to Deductible	$25 Co-Pay per Office Visit, 60% thereafter, No Deductible 60% other services, subject to Deductible
WELL BABY / CHILD CARE SERVICES[4]		
Well Baby Care - Routine office visits, lab tests and immunizations to age 6.	100%, No Deductible	100%, No Deductible
Well Child Care – Routine office visits and immunizations age 6 through 17.	100%, No Deductible	100%, No Deductible
PHYSICIAN SERVICES		
In-Hospital Medical Visit	80%	60%
Surgery, Assistant to Surgery, Anesthesia	80%	60%
Second Surgical Opinion Services (outpatient)	100%, No Deductible	100%, No Deductible
Maternity Care - dependent daughters are covered	80% only when purchasing the maternity rider	60% only when purchasing the maternity rider
Newborn Care including circumcision.	80%	60%
Occupational, Physical Therapy and Chiropractic Manipulations Note: Limitations are Physician and Outpatient Facility services combined (per benefit period). Coinsurance for these services does not apply to your Coinsurance limits.	80% for the first 20 treatments, 50% thereafter	80% for the first 20 treatments, 50% thereafter
Respiratory, Hyperbaric and Pulmonary Therapy	80%	60%
Speech Therapy 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%

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	NETWORK[2]	NON-NETWORK[2]
INPATIENT HOSPITAL / FACILITY SERVICES		
Unlimited Days Semi-Private Room and Board Note: If admission is not Precertified, you pay a $500 Precertification review penalty.	80%	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% only when purchasing the maternity rider	60% only when purchasing the maternity rider
OUTPATIENT HOSPITAL / FACILITY SERVICES		
Pre-Admission Testing	80%	60%
Diagnostic, X-ray, Lab and Testing	80%	60%
Surgery, Operating Room	80%	60%
Radiation and Chemotherapy	80%	60%
Occupational and Physical Therapy Note: Limitations are Physician and Outpatient Facility services combined (per benefit period). Coinsurance for these services does not apply to your Coinsurance limits.	80% for the first 20 treatments, 50% thereafter	80% for the first 20 treatments, 50% thereafter
Respiratory, Hyperbaric and Pulmonary Therapy	80%	60%
Speech Therapy when necessary due to a medical condition.	80%	60%
BEHAVIORAL HEALTH SERVICES		
Inpatient Mental Health Care Services If admission is not precertified you pay a $500 Precertification review penalty.	80%	60%
Inpatient Drug Abuse Services If admission is not precertified you pay a $500 Precertification review penalty.	80%	60%
Inpatient Alcoholism Services If admission is not precertified you pay a $500 Precertification review penalty.	80%	60%
Outpatient Mental Health Services **Note:** Limitations are Physician and Outpatient Facility services combined (per benefit period). Coinsurances do not apply to your Coinsurance Limits.	80% for the first 20 treatments, 50% thereafter	80% for the first 20 treatments, 50% thereafter
Outpatient Drug Abuse Services **Note:** Limitations are Physician and Outpatient Facility services combined (per benefit period). Coinsurances do not apply to your Coinsurance Limits.	80% for the first 20 treatments, 50% thereafter	80% for the first 20 treatments, 50% thereafter
Outpatient Alcoholism Services **Note:** Limitations are Physician and Outpatient Facility services combined (per benefit period). Coinsurances do not apply to your Coinsurance Limits.	80% for the first 20 treatments, 50% thereafter	80% for the first 20 treatments, 50% thereafter
EMERGENCY CARE SERVICES		
Emergency Accident Care and / or Emergency Medical Care provided in the ER	$100 ER Co-Pay, 80% after Deductible (Co-Pay waived if admitted)	$100 ER Co-Pay, 80% after Deductible (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	$100 ER Co-Pay, 80% after Deductible (Co-Pay waived if admitted)	$100 ER Co-Pay, 60% after Deductible (Co-Pay waived if admitted)
Non-Emergency Ambulance Services	80%	60%

OTHER COVERED SERVICES		
	NETWORK[2]	**NON-NETWORK[2]**
Private Duty Nursing - $5,000 Maximum per benefit period Note: Maximum is Network and Non-Network combined.	80%	60%
Skilled Nursing Facility - Note: If admission is not Precertified, you pay a $500 Precertification review penalty.	80%	60%
Durable Medical Equipment and Oxygen at home	80%	60%
Orthotic Devices and Prosthetic Appliances	80%	60%
Home Health Care - Maximum 100 visits per benefit period Note: Maximum is Network and Non-Network combined.	80%	60%
Hospice Care	80%	60%
HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES		
Human Organ Transplant • $150 per day to a maximum of $10,000 for transportation, meals and lodging.	80%	60%
Bone Marrow Procedures • $150 per day to a maximum of $10,000 for transportation, meals and lodging.	80%	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
Precertification Requirement	Penalty for no Precertification is $500 reduction of benefits per Inpatient admission.
Preexisting Condition Limitation **(**For plan years beginning on or after September 23rd, 2010, preexisting condition limitation does not apply to children under 19 years of age.)	Preexisting Condition Waiting Period: "If you were enrolled in another health insurance policy prior to the effective date of your coverage under this Contract, the length of time you were covered under the previous policy will be applied to the Preexisting Condition Waiting Period. If there is a 63 day lapse in coverage, the 365 day waiting period will apply."

[1]ALL SERVICES ARE SUBJECT TO A DETERMINATION OF MEDICAL NECESSITY BY HIGHMARK WV.

[2]PAYMENT IS BASED ON THE PLAN ALLOWANCE. THE PLAN ALLOWANCE WILL GENERALLY BE LESS FOR SERVICES RECEIVED FROM A NON-NETWORK PROVIDER. IN ADDITION, YOU WILL BE RESPONSIBLE FOR THE NON-NETWORK LIABILITY.

[3]SERVICES MUST BE PERFORMED BY A HIGHMARK APPROVED TELEMEDICINE PROVIDER

[4]THE SCHEDULE OF COVERED SERVICES IS BASED UPON RECOMMENDATIONS FROM THE AMERICAN ACADEMY OF PEDIATRICS; THE AMERICAN COLLEGE OF PHYSICIANS; THE U.S. PREVENTIVE SERVICES TASK FORCE; THE INSTITUTE OF MEDICINE, AND THE AMERICAN CANCER SOCIETY AND THE BLUE CROSS BLUE SHIELD ASSOCIATION. THEREFORE, THE FREQUENCY AND ELIGIBILITY OF SERVICES IS SUBJECT TO CHANGE