Super Blue Plus Non Group Qualified High Deductible Health Plan

Benefit Period (used for Deductible and Coinsurance limits)	Contract Year	
Carry-Over Deductible	Does not apply	
Deductible (Applies to Network and Non-Network Benefits combined)	**Individual Contract**	**Family Contract***
Important Note: Deductible applies to Medical, Retail and Mail Order Prescription Drugs.	$3,000	$6,000
Note: All services are subject to the Deductible unless otherwise specified.	* Family (A separate individual deductible will not apply to family contracts. The family deductible may be met by one member or may be met collectively.)	
Network Coinsurance Limit:	$0	$0
Important Note: Retail and Mail Order Prescription Drugs have a separate Coinsurance Limit.	* Family (A separate individual coinsurance limit will not apply to family contracts. The family coinsurance limit may be met by one member or may be met collectively.)	
Non-Network Medical Coinsurance Limit: (In addition to the Deductible and Coinsurance limits)	$2,500	$5,000
Lifetime Maximum Benefit For all Covered Services	Unlimited	

PREFERRED PRESCRIPTION DRUG BENEFITS

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.**	Subject to Deductible, then 50%. Individual Contract Coinsurance Limit $2,500 / Family Contract Coinsurance Limit $5,000. ***Deductible is Retail, Mail Order and Medical services combined. Prescription Coinsurance Limits are Retail and Mail Order combined.***
Additional Benefits with Prescription (Retail or Mail Order) - *Adults: Aspirin, Folic Acid, Children: Iron Supplements and Oral Fluoride (guidelines as determined by certain Governmental Agencies)* - You may access this information at www.healthcare.gov. You may also contact Customer Service. Their number is located on the back of your ID Card.	100%, No Deductible
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.**	Subject to Deductible, then 50%. Individual Contract Coinsurance Limit $2,500 / Family Contract Coinsurance Limit $5,000. ***Deductible is Retail, Mail Order and Medical services combined. Prescription Coinsurance Limits are Retail and Mail Order combined.***

BENEFIT HIGHLIGHTS

	NETWORK	NON-NETWORK
Annual Gynecological Exam - one per contract year	Preventive Care Services These services are paid at 100%, No Deductible	80%
Routine Pap Smear - one per contract year **Routine HPV Testing -** one every 3 years age 30 and older		80%
Routine Mammogram - per schedule age 35 and older		80%
Prostate Exam - one per contract year for males over age 50		80%
Prostate Specific Antigen (PSA) Test - one per contract year		80%
Colorectal Cancer Exam - for individual's age 50 and older or a symptomatic person under age 50. One per contract year.		80%
Fecal occult blood test - one per contract year		80%
Flexible Sigmoidoscopy - one every 5 years		80%
Colonoscopy - one every 10 years		80%
Double Contrast Barium Enema - one every 5 years		80%
Routine Screening, Immunization and Diagnostic Services *(guidelines as determined by certain Governmental Agencies)* - You may access this information at www.healthcare.gov. You may also contact Customer Service. Their number is located on the back of your ID Card.		No Benefits

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WELL BABY / CHILD CARE SERVICES		
	NETWORK	**NON-NETWORK**
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		
	NETWORK	**NON-NETWORK**
Medical Office Visit / Office Consultation	100%	80%
Emergency Accident Care and/or Emergency Medical Care provided in the ER	100%	100%
Non-Emergency Accident Care and/or Non-Emergency Medical Care provided in the ER	100%	80%
Diabetes Education & Control	100%	80%
In-Hospital Medical Visit	100%	80%
Surgery, Assistant to Surgery, Anesthesia	100%	80%
Second Surgical Opinion Services (outpatient)	100%	80%
Maternity Care - dependent daughters are covered	100% only if purchasing the maternity coverage rider	80% only if purchasing the maternity coverage rider
Newborn Care including circumcision.	100% only if purchasing the maternity coverage rider	80% only if purchasing the maternity coverage rider
Occupational, Physical Therapy and Chiropractic (Spinal) Manipulations	100%	80%
Respiratory, Hyperbaric and Pulmonary Therapy	100%	80%
Speech Therapy when necessary due to a medical condition.	100%	80%
Rehabilitation Services	100%	80%
Temporomandibular Joint Dysfunction / Craniomandibular Disorders	100%	80%
Diagnostic, X-ray, Lab and Testing	100%	80%
Allergy Testing and Treatment	100%	80%
Outpatient Mental Health Services	100%	80%
Outpatient Drug Abuse Services	100%	80%
Outpatient Alcoholism Services	100%	80%

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INPATIENT HOSPITAL / FACILITY SERVICES

	NETWORK	NON-NETWORK
Unlimited Days Semi-Private Room and Board Note: If admission is not Precertified, you pay a $500 Precertification review penalty.	100%	80%
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% only if purchasing the maternity coverage rider	80% only if purchasing the maternity coverage rider
Inpatient Mental Health Care Services - If admission is not precertified you pay a $500 Precertification review penalty.	100%	80%
Inpatient Drug Abuse Services - If admission is not precertified you pay a $500 Precertification review penalty.	100%	80%
Inpatient Alcoholism Services - If admission is not precertified you pay a $500 Precertification review penalty.	100%	80%

OUTPATIENT HOSPITAL / FACILITY SERVICES

	NETWORK	NON-NETWORK
Emergency Accident Care and/or Emergency Medical Care provided in the ER	100%	100%
Non-Emergency Accident Care and/or Non-Emergency Medical Care provided in the ER	100%	80%
Pre-Admission Testing	100%	80%
Diagnostic, X-ray, Lab and Testing	100%	80%
Surgery, Operating Room	100%	80%
Radiation and Chemotherapy	100%	80%
Occupational and Physical Therapy	100%	80%
Respiratory, Hyperbaric and Pulmonary Therapy	100%	80%
Speech Therapy when necessary due to a medical condition.	100%	80%
Rehabilitation Services	100%	80%
Outpatient Mental Health Services	100%	80%
Outpatient Drug Abuse Services	100%	80%
Outpatient Alcoholism Services	100%	80%

OTHER COVERED SERVICES

	NETWORK	NON-NETWORK
Private Duty Nursing - $5,000 Maximum per contract year Note: Maximums are Network and Non-Network combined.	100%	80%
Skilled Nursing Facility Note: If admission is not Precertified, you pay a $500 Precertification review penalty.	100%	80%
Durable Medical Equipment and Oxygen at home	100%	80%
Orthotic Devices and Prosthetic Appliances	100%	80%
Home Health Care - Maximum 100 visits Note: Maximums are Network and Non-Network combined.	100%	80%
Emergency Ambulance	100%	100%
Other Ambulance Services	100%	80%
Hospice Care	100%	80%

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HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES		
Human Organ Transplant • $150 per day to a maximum of $10,000 for transportation, meals and lodging	100%	80%
Bone Marrow Procedures • $150 per day to a maximum of $10,000 for transportation, meals and lodging.	100%	80%

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."

ALL SERVICES ARE SUBJECT TO A DETERMINATION OF MEDICAL NECESSITY BY HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA. PAYMENT IS BASED ON THE ACTUAL CHARGES OR PROVIDERS REIMBURSEMENT. IN ADDITION, YOU WILL BE RESPONSIBLE FOR THE NON-NETWORK LIABILITY.