Simply Blue Direct Pay

SUMMARY OF BENEFITS[1]

Effective Date			
Benefit Period (used for Deductible and Coinsurances limits)	January 1 through December 31 (Calendar Year)		
Deductible (Network and Non-Network Deductibles cross apply)	**Network**		**Non- Network**
	Silver Option	***Bronze Option***	
Individual	$1,000	$2,000	$4,000
Family (may be met collectively)	$2,000	$4,000	$8,000
Note: All services are subject to the Deductible unless otherwise specified.			
Carry-Over Deductible Period	October, November and December		
Coinsurance Limit (Network and Non-Network Coinsurance dollars **do not** cross apply)	**Network**		**Non- Network**
Individual	$5,000		$6,000
Family (may be met collectively)	$10,000		$12,000
Maximum Out-of-Pocket	**Network**		**Non- Network**
	Silver Option	***Bronze Option***	
Individual	$6,000	$7,000	$10,000
Family (may be met collectively)	$12,000	$14,000	$20,000
Non-Network Liability	Unlimited		
Lifetime Maximum Benefit for all Covered Services	Unlimited		

BENEFIT HIGHLIGHTS

	NETWORK[2]	**NON-NETWORK[2]**
Primary Care Provider Medical Office Visit / Office Consultation - Applies to Charges for Visit only. Does not apply to other Services received during Visit. Office Visit Fees do not apply to Deductible or Coinsurance limits. Co-Pays do not apply for certain preventive visits. See the Preventive section for this information.	1st visit: $20 per Office Visit, 100% thereafter, No Deductible Subsequent Visits: $35 per Office Visit, 100% thereafter, No Deductible	60%
Specialist Care Medical Office Visit / Office Consultation - Applies to Charges for Visit only. Does not apply to other Services received during Visit. Office Visit Fees do not apply to Deductible or Coinsurance limits. Co-Pays do not apply for certain preventive visits. See the Preventive section for this information.	$50 per Office Visit, 100% thereafter, No Deductible	60%
Urgent Care Center Medical Office Visit / Office Consultation - Applies to Charges for Visit only. Does not apply to other Services received during Visit. Office Visit Fees do not apply to Deductible or Coinsurance limits. Co-Pays do not apply for certain preventive visits. See the Preventive section for this information.	$50 per Office Visit, 100% thereafter, No Deductible	$50 per Office Visit, 60% thereafter
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.**	50% Generic 50% Brand No Deductible	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.**	50% Generic 50% Brand No Deductible	No Benefits
Additional Prescription Benefits [3] (Retail or Mail Order) **-** *Adults: Aspirin, Smoking Cessation, 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 Member Services.	100%, No Deductible	No Benefits

PREVENTIVE CARE SERVICES		
	NETWORK[2]	**NON-NETWORK[2]**
Annual Gynecological Exam - one per Calendar year.	100%, No Deductible	60%, No Deductible
Routine Pap Smear - one per Calendar year	100%, No Deductible	60%, No Deductible
Routine HPV Testing - one every 3 years age 30 and older	100%, No Deductible	60%
Routine Mammogram - per schedule age 35 and older	100%, No Deductible	60%
Prostate Exam - one per Calendar year for males over age 50.	100%, No Deductible	60%
Prostate Specific Antigen (PSA) Test - one per Calendar year	100%, No Deductible	60%
Colorectal Cancer Exam - for individual's age 50 and older or a symptomatic person under age 50. One per Calendar year.	100%, No Deductible	60%
Fecal occult blood test - one per Calendar year	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 Calendar year	100%, No Deductible	No Benefits
Routine Screening, Immunization and Diagnostic Services[3] (*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
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	80%	60%
WELL BABY / CHILD CARE SERVICES[3]		
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 Consultations (Outpatient)	100%, No Deductible	100%, No Deductible
[Maternity Care - Dependent daughters are covered. (Covered only when purchasing the Maternity rider.)]	[80%] [No Benefits]	[60%] [No Benefits]
[Newborn Care including circumcision.]	[80%] [No Benefits]	[60%] [No Benefits]
Physical Therapy- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your Coinsurance limits. **10 visit Maximum per Calendar year.**	$50 per visit, 100% thereafter No Deductible	60%
Occupational Therapy- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your Coinsurance limits. **10 visit Maximum per Calendar year.**	$50 per visit, 100% thereafter No Deductible	60%
Chiropractic Manipulations- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Coinsurance amounts for these Services do not apply to your Coinsurance limits. **10 visit Maximum per Calendar year.**	$50 per visit, 100% thereafter No Deductible	60%
Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network Coinsurance amounts for these Services do not apply to your Coinsurance limits. **10 visit Maximum per Calendar year.**	$50 per visit, 100% thereafter No Deductible	60%
Therapy Services (Cardiac Rehab, Chemotherapy , Radiation Therapy and Dialysis)	80%	60%
Temporomandibular Joint Dysfunction / Craniomandibular Disorders	80%	60%
Respiratory, Hyperbaric and Pulmonary Therapy	80% after Network Deductible	

PHYSICIAN SERVICES (continued)		
	NETWORK[2]	**NON-NETWORK[2]**
Advanced Diagnostic Imaging Services (MRI, CT, PET, etc.) Maximum one Co-Pay per service.	$150 Co-Pay per type of service per day, 80% thereafter, No Deductible	60%
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology) Maximum one Co-Pay per service.	$25 Co-Pay per type of service per day, 80% thereafter, No Deductible	60%
Allergy Testing and Treatment	80%	60%
INPATIENT HOSPITAL / FACILITY SERVICES		
Unlimited Days Semi-Private Room and Board Note: If an admission is not Precertified, you will pay a $500 Precertification review penalty. Per admission Co-Pay does not apply to Deductible or Coinsurance limits.	$500 per admission Co-Pay, 80% thereafter	$500 per admission Co-Pay. 60% thereafter
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. Per admission Co-Pay does not apply to Deductible or Coinsurance limits. (Covered only when purchasing the Maternity rider.)]	[$500 per admission Co-Pay, 80% thereafter] [No Benefits]	[$500 per admission Co-Pay. 60% thereafter] [No Benefits]
OUTPATIENT HOSPITAL / FACILITY SERVICES		
Pre-Admission Testing	80%	60%
Advanced Diagnostic Imaging Services (MRI, CT, PET, etc.) Maximum one Co-Pay per service.	$150 Co-Pay per type of service per day, 80% thereafter, No Deductible	60%
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology) Maximum one Co-Pay per service.	$25 Co-Pay per type of service per day, 80% thereafter, No Deductible	60%
Surgery, Operating Room	80%	60%
Radiation and Chemotherapy	80%	60%
Physical Therapy- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network Coinsurance amounts for these Services do not apply to your Coinsurance limits. **10 visit Maximum per Calendar year.**	$50 per visit, 100% thereafter, No Deductible	60%
Occupational Therapy- Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network Coinsurance amounts for these Services do not apply to your Coinsurance limits. **10 visit Maximum per Calendar year.**	$50 per visit, 100% thereafter, No Deductible	60%
Speech Therapy when necessary due to a medical condition. Note: Limitations are for Physician and Outpatient Facility Services combined (per Calendar year). Network and Non-Network Coinsurance amounts for these Services do not apply to your Coinsurance limits. **10 visit Maximum per Calendar year.**	$50 per visit, 100% thereafter, No Deductible	60%
Therapy Services (Cardiac Rehab, Chemotherapy , Radiation Therapy and Dialysis)	80%	60%
Respiratory, Hyperbaric and Pulmonary Therapy	80% after Network Deductible	
BEHAVIORAL HEALTH SERVICES		
Outpatient Mental Health Services	No Benefits	No Benefits
Outpatient Substance Abuse Services	No Benefits	No Benefits
Inpatient Mental Health Care Services	No Benefits	No Benefits
Inpatient Substance Abuse Care Services	No Benefits	No Benefits

EMERGENCY CARE SERVICES		
	NETWORK[2]	**NON-NETWORK[2]**
Emergency Accident Care and / or Emergency Medical Care provided in the ER ER Co-Pay does not apply to Deductible or Coinsurance limits.	$150 per visit (waived if admitted), 100% thereafter, No Deductible	
Emergency Ambulance	80% after Network Deductible	
NON-EMERGENCY CARE SERVICES		
Non-Emergency Medical Care provided in the ER	$150 per visit (waived if admitted) 80% after deductible	$150 per visit (waived if admitted) 60% after deductible
Non-Emergency Ambulance Services	80% after Network Deductible	
OTHER COVERED SERVICES		
Private Duty Nursing – (240 hours Maximum per Calendar year) Note: Maximums are Network and Non-Network combined.	80% after Network Deductible	
Skilled Nursing Facility- Note: If admission is not Precertified, you pay a $500 Precertification review penalty.	$500 per admission Co-Pay, 80% thereafter	$500 per admission Co-Pay, 60%, Maximum 100 days per Calendar year
Durable Medical Equipment and Oxygen at home	80%	60%
Orthotic Devices and Prosthetic Appliances	80%	60%
Home Infusion Therapy	80% after Network Deductible	
Home Health Care	80%	60%
Hospice Care	Inpatient: $500 per admission Co-Pay, 80% thereafter Outpatient: 80%	Inpatient: $500 per admission Co-Pay, 60% thereafter Outpatient: 60%
HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES		
Human Organ Transplant • $150 per day to a maximum of $10,000 for transportation, meals and lodging	Inpatient: $500 per admission Co-Pay, 80% thereafter Outpatient: 80%	Inpatient: $500 per admission Co-Pay, 60% thereafter Outpatient: 60%
Bone Marrow Procedures • $150 per day to a maximum of $10,000 for transportation, meals and lodging.	Inpatient: $500 per admission Co-Pay, 80% thereafter Outpatient: 80%	Inpatient: $500 per admission Co-Pay, 60% thereafter Outpatient: 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.
Precertification Requirement	Penalty for no Precertification is a $500 reduction of benefits per Inpatient admission.
Preexisting Condition Limitation (Note: 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 group 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 reduce 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]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 AMERICAN CANCER SOCIETY AND THE BLUE CROSS BLUE SHIELD ASSOCIATION. THEREFORE, THE FREQUENCY AND ELIGIBILITY OF SERVICES IS SUBJECT TO CHANGE.