



A HIGHMARK AFFILIATE

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual	\$3,000
Family	\$6,000

Direct Pay

## Qualified High Deductible Health Plan (HDHP) Preferred Provider Organization - PPO

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

Please keep in mind, with this product the Individual Deductible and Individual Out-of-Pocket Maximums only apply for a subscriber with individual coverage. For a subscriber with family coverage, the Family Deductible must be met by one or more members of the family before benefits will be paid. This product is designed for individuals who wish to enroll in a qualified high deductible health plan for use with a Health Savings Account as defined by the Internal Revenue Service. However, it is not a requirement of this product to open a Health Savings Account. The decision is determined by each subscriber of the policy.

Benefit Period (used for Deductible and Coinsurance limits)	Contract Year	
<b>Carry-Over Deductible</b>	Does not apply	
<b>Deductible (Applies to Network and Non-Network Benefits combined)</b> <i>Important Note: Deductible applies to Medical, Retail and Mail Order Prescription Drugs.</i> <b>Note: All services are subject to the Deductible unless otherwise specified.</b>	<b>Individual Contract</b>	<b>Family Contract*</b>
	\$3,000	\$6,000
<b>Coinsurance Limit: (Includes Network and Non-Network)</b> <i>Important Note: Retail and Mail Order Prescription Drugs have a separate Coinsurance Limit.</i>	\$0	\$0
<b>Non-Network Medical Coinsurance Limit: (In addition to the Deductible and Coinsurance limits)</b> <b>Lifetime Maximum Benefit</b> For all Covered Services (in addition to the lifetime maximums for Organ Transplants and Bone Marrow Procedures)	\$2,500	\$5,000
	\$2,000,000 per Covered Person	

### PREFERRED PRESCRIPTION DRUG BENEFITS

<b>Prescription Drugs are provided through a Preferred Pharmacy Network.</b> - 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. <b>Maximum 34 day supply.</b>	Subject to Deductible, then 50%. Individual Contract Coinsurance Limit \$2,500 / Family Contract Coinsurance Limit \$5,000. <b>Deductible is Retail, Mail Order and Medical services combined. Prescription Coinsurance Limits are Retail and Mail Order combined.</b>
<b>Mail Order Drugs</b> - 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. <b>Maximum 90 day supply.</b>	Subject to Deductible, then 50%. Individual Contract Coinsurance Limit \$2,500 / Family Contract Coinsurance Limit \$5,000. <b>Deductible is Retail, Mail Order and Medical services combined. Prescription Coinsurance Limits are Retail and Mail Order combined.</b>

### BENEFIT HIGHLIGHTS

	NETWORK	NON-NETWORK
<b>Annual Gynecological Exam</b> - one per contract year	Preventive Care Services The first \$300 of these services are paid at 100%, then subject to deductible and 100% thereafter	80%
<b>Routine Pap Smear</b> - one per contract year		80%
<b>Routine HPV Testing</b> - one every 3 years age 30 and older		80%
<b>Routine Mammogram</b> - per schedule age 35 and older		80%
<b>Prostate Exam</b> - one per contract year for males over age 50 Prostate Specific Antigen (PSA) Test - one per contract year		80%
<b>Colorectal Cancer Exam</b> - for individual's age 50 and older or a symptomatic person under age 50. One per contract year. Fecal occult blood test - one per contract year Flexible Sigmoidoscopy - one every 5 years Colonoscopy - one every 10 years Double Contrast Barium Enema - one every 5 years		80%
		80%
		80%

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<b>WELL CHILD CARE SERVICES</b>		
	<b>NETWORK</b>	<b>NON-NETWORK</b>
<b>Well Baby Care</b> - routine office visits, lab tests and immunizations to age 6.	100%, No Deductible	100%, No Deductible
<b>Well Child Immunizations</b> and related office visit age 6 through 17.	100%, No Deductible	100%, No Deductible
<b>PHYSICIAN SERVICES</b>		
	<b>NETWORK</b>	<b>NON-NETWORK</b>
<b>Office Visit / Office Consultation</b>	100%	80%
<b>Emergency Accident Care / Emergency Medical Care</b>	100%	80%
<b>Diabetes Education &amp; Control</b> - refresher education limited to \$100 per contract year.	100%	80%
<b>In-Hospital Medical Visit</b>	100%	80%
<b>Surgery, Assistant to Surgery, Anesthesia</b>	100%	80%
<b>Second Surgical Opinion Services</b> (outpatient)	100%	80%
<b>Maternity Care</b> - dependent daughters are NOT covered.	1900%	
<b>Newborn Care</b> including circumcision.	100%	80%
<b>Occupational, Physical Therapy and Chiropractic (Spinal) Manipulations</b>	100%	80%
<b>Respiratory, Hyperbaric and Pulmonary Therapy</b>	100%	80%
<b>Speech Therapy</b> when necessary due to a medical condition.	100%	80%
<b>Rehabilitation Services</b>	100%	80%
<b>Temporomandibular Joint Dysfunction / Craniomandibular Disorders</b>	100%	80%
<b>Diagnostic, X-ray, Lab and Testing</b>	100%	80%
<b>Allergy Testing and Treatment</b>	100%	80%
<b>Outpatient Mental Health Services</b> - Treatment Plan is required prior to the 9th treatment to determine medical necessity. If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary.	100%	80%
<b>Outpatient Drug Abuse Services</b> - Treatment Plan is required prior to the 9th treatment to determine medical necessity. If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary.	100%	80%
<b>Outpatient Alcoholism Services</b> - Treatment Plan is required prior to the 9th treatment to determine medical necessity. If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary.	100%	80%
<b>INPATIENT HOSPITAL / FACILITY SERVICES</b>		
	<b>NETWORK</b>	<b>NON-NETWORK</b>
<b>Unlimited Days Semi-Private Room and Board</b> Note: If admission is not Precertified, you pay a \$500 Precertification review penalty.	100%	80%
<b>Ancillaries, Drugs, Therapy Services, X-ray and Lab</b>	100%	80%
<b>General Nursing Care</b>	100%	80%
<b>Surgical Services</b>	100%	80%
<b>Birth Center Care / Maternity Services</b> - dependent daughters are NOT covered.	Covered only if purchasing the optional maternity rider.	
<b>Inpatient Mental Health Care Services</b> - If admission is not precertified you pay a \$500 Precertification review penalty.	100%	80%
<b>Inpatient Drug Abuse Services</b> - If admission is not precertified you pay a \$500 Precertification review penalty.	100%	80%
<b>Inpatient Alcoholism Services</b> - If admission is not precertified you pay a \$500 Precertification review penalty.	100%	80%

## OUTPATIENT HOSPITAL / FACILITY SERVICES

	NETWORK	NON-NETWORK
<b>Non-Emergency Medical Care</b>	100%	80%
<b>Pre-Admission Testing</b>	100%	80%
<b>Diagnostic, X-ray, Lab and Testing</b>	100%	80%
<b>Surgery, Operating Room</b>	100%	80%
<b>Radiation and Chemotherapy</b>	100%	80%
<b>Occupational and Physical Therapy</b>	100%	80%
<b>Respiratory, Hyperbaric and Pulmonary Therapy</b>	100%	80%
<b>Speech Therapy</b> when necessary due to a medical condition.	100%	80%
<b>Rehabilitation Services</b>	100%	80%
<b>Outpatient Mental Health Services - Treatment Plan is required prior to the 9th treatment to determine medical necessity.</b> If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary.	100%	80%
<b>Outpatient Drug Abuse Services - Treatment Plan is required prior to the 9th treatment to determine medical necessity.</b> If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary.	100%	80%
<b>Outpatient Alcoholism Services - Treatment Plan is required prior to the 9th treatment to determine medical necessity.</b> If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary.	100%	80%

## OTHER COVERED SERVICES

	NETWORK	NON-NETWORK
<b>Private Duty Nursing - \$5,000 Maximum per contract year</b> Note: Maximums are Network and Non-Network combined.	100%	80%
<b>Skilled Nursing Facility - \$10,000 Maximum per contract year.</b> Note: If admission is not Precertified, you pay a \$500 Precertification review penalty. Maximums are Network and Non-Network combined.	100%	80%
<b>Durable Medical Equipment and Oxygen at home</b>	100%	80%
<b>Orthotic Devices and Prosthetic Appliances</b>	100%	80%
<b>Home Health Care - Maximum 100 visits</b> Note: Maximums are Network and Non-Network combined.	100%	80%
<b>Emergency Ambulance</b>	100%	80%
<b>Other Ambulance Services</b>	100%	80%
<b>Hospice Care</b>	100%	80%

## HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES

	NETWORK	NON-NETWORK
<b>Human Organ Transplant</b> <ul style="list-style-type: none"> <li>• \$2,000,000 lifetime maximum per type of transplant</li> <li>• \$25,000 for acquisition, storage and transport of organ</li> <li>• \$150 per day to a maximum of \$10,000 for transportation, meals and lodging.</li> </ul> Note: Benefit is in addition to the lifetime medical maximum.	100%	80%
<b>Bone Marrow Procedures</b> <ul style="list-style-type: none"> <li>• \$2,000,000 lifetime maximum per cause of transplant for all procedures combined</li> <li>• \$150 per day to a maximum of \$10,000 for transportation, meals and lodging.</li> </ul> Note: Benefit is in addition to the lifetime medical maximum.	100%	80%

## OTHER IMPORTANT INFORMATION

Eligible Dependent Age Limitation	Coverage stops the end of the month in which the dependent turns 26, even if a full time student.
Precertification Requirement	Penalty for no Precertification is \$500 reduction of benefits per Inpatient admission.
Preexisting Condition Limitation	Preexisting Condition Waiting Period: "If you were enrolled in another health insurance policy prior to the Hire 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."

## PROVIDER NETWORKS

<b>MOUNTAIN STATE BLUE CROSS BLUE SHIELD NETWORK</b>	Your relationship with your local doctors, hospitals and other providers is an important part of getting well and staying that way. That's why we've credentialed providers to help ensure you receive quality care. Our network includes 95% of the hospitals and 75% of the physicians in West Virginia. To find out if your physician is in our network, you can call 1-800-533-3627.
<b>THE BLUE CARD PPO PROGRAM</b>	The Super Blue Plus High Deductible Health Plan provides The BlueCard PPO Program. This allows members traveling outside the Mountain State service area to receive high level benefits when utilizing the services of more than 385,000 Blue Cross Blue Shield Preferred Providers nationwide.
<b>PHARMACY NETWORK</b>	Prescription drug coverage is offered through our extensive preferred pharmacy network of more than 40,000 pharmacies nationwide.

## WEBSITE ACCESS TO INFORMATION 24/7

As a Mountain State Blue Cross Blue Shield (MSBCBS) member, you will have a wealth of health information at your fingertips. Log onto [www.mybenefitshome.com](http://www.mybenefitshome.com) to find a wide range of tools to help you take greater control of your health. From the Personal Wellness Profile that provides a comprehensive health assessment to online access to 24-hour-a-day health decision support, your MSBCBS member Web site provides in-depth health information. You can also access My Benefits Home by going to [www.msbcbs.com](http://www.msbcbs.com) and clicking on the link.

### [www.mybenefitshome.com](http://www.mybenefitshome.com)

Through My Benefits Home you will have access to physician and pharmacy directories, so you can look up a physician in your plan or locate your nearest pharmacy. You can request an ID card, order a claim form, send a secure message to customer service, check on a claim or sign up to receive e delivery of EOB (Explanation of Benefits) statements - **all online**.

## Opening a Health Savings Account through BlueAccount

BlueAccount is a Healthcare spending account product that increases the consumer's involvement in spending. By using BlueAccount on the MSBCBS website, members can manage both their health plan and their spending account through a single entry point. You can access account balances and history, and choose to either submit requests for account payment electronically from the website on a claim-by-claim basis or have your health plan automatically submit such requests for all claims that have a member liability. Your **BlueAccount HSA** is easy to maintain and track. You simply log onto your MSBCBS member website at [www.mybenefitshome.com](http://www.mybenefitshome.com) and click "**Your Spending**" where you can access all of your account information once you set up your account.

## HOW TO APPLY FOR ASSISTANCE CALL 1-800-385-1985

1. Complete and return the enclosed application in the postage-paid envelope provided. (An incomplete application will delay processing time or could result in your application being returned to you.)
2. Enclose your first month's premium and the \$20 application fee with your application. Make check payable to Mountain State Blue Cross Blue Shield. (You can include one check for both the application fee and the premium.) A CHECK MUST ACCOMPANY THE APPLICATION. WE WILL HOLD THE CHECK UNTIL THE APPLICATION IS APPROVED BY UNDERWRITING.
3. If you have any questions regarding the product, processing of your application or completion of the application please call our office at 1-800-385-1985 and we will assist you!

**Electronic Funds Transfer ~ PAY IT EASY ~** To make premiums easy, we offer a direct payment plan, which authorizes your bank to pay premiums automatically through your checking account. Complete the enclosed brochure and submit with a voided check.

•Rates are based on 5-year age bands. (Ex., If you're 34 years old, your rate will increase the first of the month in which you turn 35.)

•Maternity and Newborn services are not covered under this policy unless purchasing the optional Maternity Rider.

ALL SERVICES ARE SUBJECT TO A DETERMINATION OF MEDICAL NECESSITY BY MOUNTAIN STATE BLUE CROSS BLUE SHIELD. PAYMENT IS BASED ON THE ACTUAL CHARGES, PROFESSIONAL ALLOWANCE OR PROVIDERS REASONABLE CHARGE. IN ADDITION, YOU WILL BE RESPONSIBLE FOR THE NON-NETWORK LIABILITY.