2026 WV SHIP SBP Plan B

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

In-Network Coverage / Super Blue Plus PPO Network Providers
Out of Network Coverage / Non-Participating Providers

Benefit	In Network	Out of Network
General Provisions		
Effective Date	8/11/2026	
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual	$500	$5,000
Plan Pays – payment based on the plan allowance	80% after deductible	50% after deductible
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual	$8,350	not applicable
Office/Clinic/Urgent Care Visits[11]		
Retail Clinic Visits & Virtual Visits	80% after $25 copayment (deductible does not apply)	$70 copayment after deductible, 50% thereafter
Primary Care Provider (PCP) Office Visits & Virtual Visits	80% after $25 copayment (deductible does not apply)	$70 copayment after deductible, 50% thereafter
Specialist Office Visits & Virtual Visits	80% after $25 copayment (deductible does not apply)	$70 copayment after deductible, 50% thereafter
Virtual Visit Originating Site Fee	80% after deductible	50% after deductible
Urgent Care Center Visits	80% after $50 copayment (deductible does not apply)	$50 copayment after deductible, 50% thereafter
	copayment does not apply to services prescribed for the treatment of mental illness or substance use disorder	
Preventive Care [4][11]		
Routine Adult Physical Exams	100% (deductible does not apply)	Not Covered
Adult Immunizations	100% (deductible does not apply)	50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Breast Cancer Screening	100% (deductible does not apply)	50% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)	50% after deductible
Pediatric Immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Pediatric Vision(13) Routine Eye Exam Eyeglasses / Contact Lenses	100% (deductible does not apply)	Not Covered
Pediatric Dental(14) Consultations, Routine Exams, X-rays, Cleanings, Fluoride Treatments, Palliative Treatment (emergency), Sealants and Space Maintainers	100% (deductible does not apply)	Not Covered
Other Pediatric Dental Services	50% (deductible does not apply)	Not Covered
Emergency Services		
Emergency Room Services (12)	$300 copayment then 80% after deductible (copay waived if admitted)	
Ambulance Emergency (ground, water, air)	100% after deductible	
Ambulance Non-Emergency (ground, water) (9)	100% after deductible	100% after deductible
Ambulance Non-Emergency (air)	100% after deductible	
Hospital and Medical / Surgical Expenses (including maternity)[11][12]		
Hospital Inpatient	$300 copayment per admission then 80% after deductible	$300 copayment per admission then 50% after deductible
Hospital Outpatient	80% after deductible	50% after deductible
Outpatient Surgery Facility	80% after deductible	50% after deductible

Benefit	In Network	Out of Network
Surgical Services (Professional)	80% after deductible	50% after deductible
Maternity (non-preventive professional services) including dependent daughters	80% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)	80% after deductible	50% after deductible
Therapy Services[11]		
Physical Therapy [10] (Habilitative and Rehabilitative)	80% after $25 copayment (deductible does not apply)	$70 copayment after deductible, 50% thereafter
	copayment does not apply to services prescribed for the treatment of mental illness or substance use disorder	
	Limit: 20 visits per event for chronic pain Limits are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined Limits do not apply to services prescribed for the treatment of Mental Health or Substance Use Disorder]	
Respiratory Therapy	80% after deductible	50% after deductible
Speech Therapy (Habilitative and Rehabilitative)	80% after $25 copayment (deductible does not apply)	$70 copayment after deductible, 50% thereafter
	copayment does not apply to services prescribed for the treatment of mental illness or substance use disorder	
	Limit: 30 visits per benefit period Limits are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined Limits do not apply to services prescribed for the treatment of Mental Health or Substance Use Disorder	
Occupational Therapy [10] (Habilitative and Rehabilitative)	80% after $25 copayment (deductible does not apply)	$70 copayment after deductible, 50% thereafter
	copayment does not apply to services prescribed for the treatment of mental illness or substance use disorder	
	Limit: 20 visits per event for chronic pain Limits are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined Limits do not apply to services prescribed for the treatment of Mental Health or Substance Use Disorder	
Spinal Manipulations [Chiropractic] [10] (Habilitative and Rehabilitative)	80% after $25 copayment (deductible does not apply)	$70 copayment after deductible, 50% thereafter
	Limit: 20 visits per event for chronic pain Limits are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined Limits do not apply to services prescribed for the treatment of Mental Health or Substance Use Disorder	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	50% after deductible
Mental Health / Substance Abuse[11]		
Inpatient Mental Health Services	$300 copayment per admission then 80% after deductible	$300 copayment per admission then 50% after deductible
Inpatient Detoxification / Rehabilitation	$300 copayment per admission then 80% after deductible	$300 copayment per admission then 50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $25 copayment (deductible does not apply)	$70 copayment after deductible, 50% thereafter
Outpatient Substance [Abuse][Use Disorder] Services[/Detoxification](includes virtual visits)	100% after $25 copayment (deductible does not apply)	$70 copayment after deductible, 50% thereafter
Other Services[11]		
Allergy Extracts and Injections	80% after deductible	50% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	80% after deductible	50% after deductible
Dental Services Related to Accidental Injury	100% after deductible	100% after deductible
Diagnostic Services	copayment does not apply to Diagnostic Services prescribed for the treatment of mental illness or substance use disorder	
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after $25 copayment (deductible does not apply)	$70 copayment after deductible, 50% thereafter
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after $25 copayment (deductible does not apply)	$70 copayment after deductible, 50% thereafter
Mammograms, Medically Necessary	80% after $25 copayment (deductible does not apply)	$70 copayment after deductible, 50% thereafter

Benefit	In Network	Out of Network
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	50% after deductible
	Cost sharing for eligible Diabetic Devices will not exceed $100 for a 30-day supply	
Home Health Care	80% after deductible	50% after deductible
	Limit: 100 per visitst per beneit period	
Hospice	80% after deductible	50% after deductible
	Limit: Respite Care; 30 days maxmum per 30 days	
Infertility Counseling, Testing and Treatment (6)	80% after deductible	50% after deductible
Private Duty Nursing	80% after deductible	50% after deductible
	limit: 35 visits/benefit period	
Skilled Nursing Facility Care	$300 copayment per admission then 80% after deductible	$300 copayment per admission then 50% after deductible
Transplant Services(13)	80% after deductible	50% after deductible
Travel and Lodging- when the facility is greater than 50 miles from the recipients home	80% after deducitble $150 per day limit for lodging and meals $10,000 limit for all travel expenses including ground & air travel and tolls &parking. See Certificate for additoinal information	
Coverage Outside of the United States	Coverage for medical services outside of the United States is the same as coverage for medical services provided inside the United States. In most cases you will need to pay up front and submit a claim for reimbursement. To learn more, visit www.bcbsglobalcore.com. Prescription drugs are not covered when dispensed outside the United States	
Precertification Requirements (7)	Yes	Yes
[Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program[8] SensibleRx Complete Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design Specialty drugs limited to a 34 -day supply for Retail and Mail Order	**Network Retail Drugs (34/90 – day supply)** $15/$30 Generic copayment $40/$80 Formulary Brand copayment $70/$140 Non-Formulary Brand & Generic copayment Cost-sharing for prescription insulin drugs will not exceed $35 for a 30-day supply Cost-sharing for eligible Diabetic Devices will not exceed $100 for a 30-day supply **Specialty drugs (34 -day supply)** Specialty Drugs Plan pays 80% Brand & Generic **Network Maintenance Drugs through Mail Order (90 –day supply)** $30 Generic copayment $120 Formulary Brand copayment $140 Non-Formulary Brand copayment Cost-sharing for prescription insulin drugs will not exceed $35 for a 30-day supply Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply	

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 SCHOOL'S BENEFIT PERIOD IS BASED ON A CONTRACT YEAR. THE CONTRACT YEAR IS A CONSECUTIVE 12-MONTH PERIOD BEGINNING ON YOUR SCHOOL'S EFFECTIVE DATE. CONTACT YOUR SCHOOL 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 LIMITED TO THOSE LISTED ON THE HIGHMARK PREVENTIVE SCHEDULE (WOMEN'S HEALTH PREVENTIVE SCHEDULE MAY APPLY).
4) AFTER INITIAL EVALUATION, APPLIED BEHAVIORAL ANALYSIS WILL BE COVERED AS SPECIFIED ABOVE. ALL OTHER COVERED SERVICES FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS WILL BE COVERED ACCORDING TO THE BENEFIT CATEGORY (E.G SPEECH THERAPY, DIAGNOSTIC SERVICES). TREATMENT OF AUTISM SPECTRUM DISORDERS DOES NOT REDUCE VISIT/DAY LIMITS.
5) TREATMENT INCLUDES COVERAGE FOR THE CORRECTION OF A PHYSICAL OR MEDICAL PROBLEM ASSOCIATED WITH INFERTILITY. INFERTILITY DRUG THERAPY MAY OR MAY NOT BE COVERED DEPENDING ON YOUR GROUP'S PRESCRIPTION DRUG PROGRAM.
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. PLEASE NOTE THAT CERTAIN OUTPATIENT PROCEDURES ALSO REQUIRE PRIOR AUTHORIZATION. BE SURE TO VERIFY THAT YOUR PROVIDER IS CONTACTING MM&P FOR PRECERTIFICATION. IF THIS DOES NOT OCCUR AND IT IS LATER DETERMINED THAT YOUR SERVICES ARE NOT MEDICALLY NECESSARY OR APPROPRIATE, YOU MAY BE RESPONSIBLE FOR PAYMENT OF ANY COSTS NOT COVERED.
7) THE HIGHMARK FORMULARY IS AN EXTENSIVE LIST OF FOOD AND DRUG ADMINISTRATION (FDA) APPROVED 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 SENSIBLERX COMPLETE, WHEN YOU PURCHASE A BRAND DRUG THAT HAS A GENERIC EQUIVALENT, YOU WILL BE RESPONSIBLE FOR THE BRAND DRUG MEMBER COST SHARE INDICATED PLUS THE DIFFERENCE IN COST BETWEEN THE BRAND AND GENERIC DRUGS. 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.

8) UNLESS OTHERWISE PROVIDED FOR BENEFITS FOR EMERGENCY AMBULANCE SERVICES RENDERED BY A NON-NETWORK PROVIDER WILL BE SUBJECT TO THE SAME COST-SHARING AMOUNT, IF ANY, THAT IS APPLICABLE TO NETWORK SERVICES. THE MEMBER WILL BE RESPONSIBLE FOR ANY AMOUNTS BILLED BY THE NON-NETWORK PROVIDER FOR NON-EMERGENCY GROUND AND WATER AMBULANCE SERVICES THAT ARE IN EXCESS OF THE AMOUNT THAT HIGHMARK PAYS.
9) 20 VISIT MAXIMUM PER EVENT FOR COMBINED PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPINAL MANIPULATIONS.
10) COVERED VIRTUAL SERVICES WILL BE PAID ACCORDING TO THE BENEFIT CATEGORY (E.G. PRIMARY CARE PROVIDER OFFICE VISIT, MATERNITY VISIT, ETC.) FOR EXAMPLE VIRTUAL VISITS RELATING TO THE TREATMENT OF MENTAL ILLNESS OR SUBSTANCE USE DISORDER ARE COVERED UNDER YOUR OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFIT AND SUBJECT TO THE COST SHARING AMOUNT IN THIS SCHEDULE OF BENEFITS
11) BENEFITS FOR EMERGENCY CARE SERVICES RENDERED BY AN OUT-OF-NETWORK PROVIDER WILL BE PAID AT THE NETWORK SERVICES LEVEL. BENEFITS FOR HOSPITAL SERVICES OR MEDICAL CARE SERVICES RENDERED BY AN OUT-OF-NETWORK PROVIDER TO A MEMBER REQUIRING AN INPATIENT ADMISSION OR OBSERVATION IMMEDIATELY FOLLOWING RECEIPT OF EMERGENCY CARE SERVICES WILL BE PAID AT THE NETWORK SERVICES LEVEL. THE MEMBER WILL NOT BE RESPONSIBLE FOR ANY AMOUNTS BILLED BY THE OUT-OF-NETWORK PROVIDER THAT ARE IN EXCESS OF THE PLAN ALLOWANCE FOR SUCH SERVICES.
12) COVERED SERVICES WILL BE COVERED ACCORDING TO THE BENEFIT CATEGORY TO WHICH THEY APPLY (E.G. OUTPATIENT SURGERY, HOSPITAL INPATIENT, DIAGNOSTIC SERVICES.
13) COVERAGE FOR PEDIATRIC VISION CARE SERVICES TERMINATES AT THE END OF THE MONTH IN WHICH THE MEMBER REACHES AGE 19.
14) COVERAGE FOR PEDIATRIC DENTAL SERVICES TERMINATES AT THE END OF THE BENEFIT PERIOD IN WHICH THE MEMBER REACHES AGE 19.