2026 Highmark Health Options Duals West Virginia Benefits

Medicare Annual/Open Enrollment Period

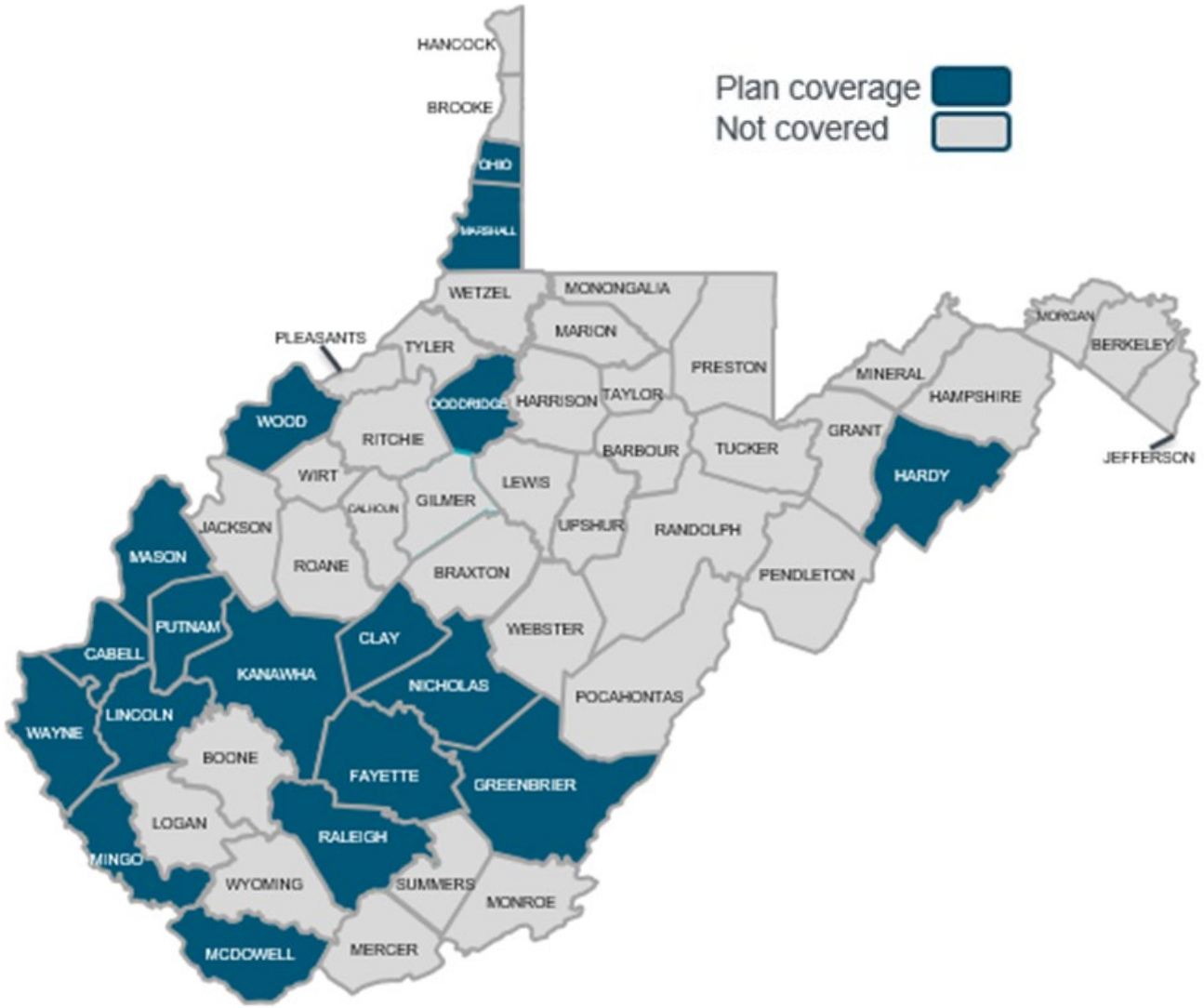
- The Medicare Open Enrollment Period runs from October 15 – December 7
- Annual or open enrollment period is when all people who are dually eligible for both Medicare and Medicaid (D-SNP beneficiaries) can select or change their Medicare health plans and prescription drug coverage for the following year.
- Health insurance organizations can start marketing for the coming year as early as October 1
- Only agents and brokers can sell plans!
- Non-sales agents/brokers can educate on available benefits and plan offering but can not recommend a specific plan or offer personal opinions on which plan is best for a member

Service Area

HIGHMARK

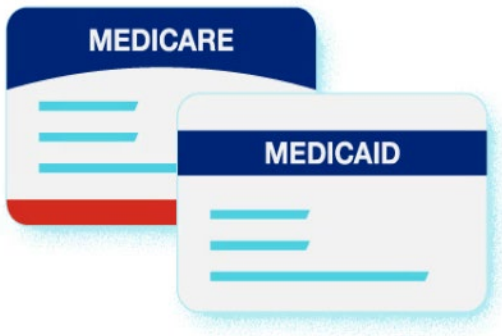
Highmark Health Options Duals (HMO SNP) West Virginia

Covered Counties
Cabell
Clay
Doddridge
Fayette
Greenbrier
Hardy
Kanawha
Lincoln
Marshall
Mason
McDowell
Mingo
Nicholas
Ohio
Putnam
Raleigh
Wayne
Wood



Eligibility Requirements

WV Highmark Health Options Duals Eligibility



Enrollment Eligibility:

- Live in the Service Area
- Entitled to Medicare Part A
- Enrolled in Medicare Part B
- Enrolled in state Medicaid Program with one of the following Medicaid Aid categories
- **Full Benefit Dual Eligible (FBDE) –** Individuals eligible for Medicaid either categorically or through optional coverage groups, such as medically needy or special income levels for institutionalized or home and community-based waivers.
- **Qualified Medicare Beneficiaries Plus (QMB Plus)** – Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, copayments). QMB Plus also have full Medicaid benefits.
- **Specified Low-Income Medicare Beneficiaries Plus (SLMB Plus)** – Helps pay Part B premiums. People with SLMB Plus also have full Medicaid benefits.
- **Qualified Medicare Beneficiary (QMB)** – Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments).
  - QMB beneficiaries do not receive full Medicaid benefits but are still eligible to enroll in the HHO Duals DSNP plan in 2026.

https://www.cms.gov/files/document/2016-medicare-medicaid-enrollee-categories-job-aidpdf

2026 HHO WV D-SNP Benefits Grids

WEST VIRGINIA BENEFITS GRID		HHO DUALS	AUTH REQ'D
BASIC PLAN COST	**Premium**	$0	
	MOOP	$9250	
PRESCRIPTION DRUGS	**Co-pays**	Copays assessed based on member's Low-income subsidy level (LIS) and whether the drug is a generic or brand. Refer to the Pharmacy Benefits section of this document for additional details.	
PHYSICIAN SERVICES	**Doctor Office Visit**	PCP: $0 Specialist/Other Professional: $0 Telehealth covered for PCP and Specialist	
	Lab & Diagnostic Tests (Outpatient Facility)	$0	X
	Chiropractic	$0 for Medicare-covered	X
	Podiatry	$0 for Medicare-covered $0 for routine exams – 6 visits per year	
	Annual Physical Exam	$0	
	Vision Exams	$0 Routine Vision (1 per year) $0 Diabetic Retinal Eye Exam $0 for Medicare-covered vision office visit	
	Hearing Exams	$0 for Medicare-covered $0 for routine exam (1 per year)	
	Other Healthcare Professional (Acupuncture)	$0 Up to 12 visits in 90 days for chronic lower back pain and an additional 8 if improvement is demonstrated.	X
	Opioid Treatment	$0	

WEST VIRGINIA BENEFITS GRID		HHO DUALS	AUTH REQ'D
FACILITY SERVICES	Substance Abuse, Mental Health, & Psychiatric Therapy	$0 for individual or group sessions Telehealth covered for individual mental health, psychiatric and opioid treatment program services	
	Outpatient Hospital Services	$0	X
	Outpatient Diagnostic and Therapeutic Radiology Services	$0	X
	Outpatient Blood	$0	
	Occupational, Physical, & Speech Therapy	$0	X
	Emergency Room	$0	
	Urgent Care	$0	
	Inpatient Hospital (medical and Psych)	$0	X
	Skilled Nursing Facility	$0	X
	Ambulatory Surgical Services (ASC)	$0	X
	Cardiac Rehab	$0	
	Pulmonary Rehab	$0	
	Supervised Exercise Therapy	$0	

WEST VIRGINIA BENEFITS GRID		HHO DUALS	AUTH REQ'D
OTHER PLAN COVERAGE	Dialysis Services	$0	
	Ambulance	$0 for ground and air Authorization required for Non-Emergency Medicare Services	X
	Durable Medical Equipment/Prosthetics	$0	X
	Diabetic Supplies	$0	
	Part B Drugs	$0 for Part B covered Insulin 0% coinsurance for all other Part B Drugs Authorization required for certain Part B drugs	X
	Medicare Covered Dental	$0 Authorization may be required for Medicare covered services	X
	Home Health	$0	X

WEST VIRGINIA BENEFITS GRID		HHO DUALS	AUTH REQ'D
PREVENTIVE SERVICES	**Health Education**	$0 Disease Management Program featuring educational materials, and support from Case Managers.	
	Smoking Cessation	$0 copay for 2 additional counseling visits per attempt in addition to the Medicare-covered benefit of 8 counseling sessions per year.	
	Kidney Disease Education	$0	
	Nurse Line	24/7 toll-free telephonic coaching from a trained clinician.	
	Medicare-covered Preventative Services	$0 Glaucoma screening; Diabetes self-management training; Digital rectal exams; EKG (following Welcome Visit)	

Part D Prescription Benefits

Pharmacy Copays

- Copays for drugs covered under Part D benefits for duals members will be based on a member's Low Income Subsidy Level (LIS), also known as Extra Help **and** the drug type/category.
- LIS Levels are determined by CMS and can be viewed in CVS or CRM/EPlus
- Copays apply until a member hits the $2,100 max out of pocket (MOOP)

LIS Category Code	Generic/Preferred Part D Drug	Part D Brand or Specialty Drug
LIS Level 1	$5.10	$12.65
LIS Level 2	$1.60	$4.90
LIS Level 3	$0.00	$0.00

Medicare Prescription Payment Plan

- Because the HHO Duals Plan will have cost sharing for Part D prescriptions it must give members the option to enroll in the Medicare Prescription Payment Plan (MP3 or MPPP).
- MP3 offers Part D enrollees the option to manage out of pocket prescription drug costs in monthly installments spread throughout the plan year.
- MP3 does not lower the total cost of the drug, rather it spreads the payments over the year.
- MP3 will be administered by CVS on HHO's behalf

HHO WV Duals Supplemental Benefits

FlexCard

OTC & Home/Bathroom Safety Allowance

$50 per month combined allowance

- Balance loaded onto a MasterCard Flex Card issued by Payforward
- Funds do NOT roll over month to month!

Over The Counter (OTC) items are non-prescription health and wellness items such as:

- First Aid Supplies
- Vitamins
- Dental Products
- Pain Medications
- Incontinence
- Products
- Topical Ointments
- Tobacco cessation items

www.myhealthyflex.com
PayForward: 1-833-623-2619

Home & Bathroom Safety Products are those designed to prevent accidents and injuries within the home. Items not covered as DME.

- Toilet seat risers
- Toilet safety arm support
- Tub grab bars
- Tub/Shower anti-slip treads
- Transfer bench
- Reaching aids
- Chrome grab bars
- Bath bench
- Knock down bath seat
- Folding commode
- Bathmat
- Shower Chair

SSBCI Criteria & Benefits

Special Supplemental Benefits for the Chronically Ill (SSBCI)

The HHO Duals Plan in WV will offer SSBCI benefits to those who meet the requirements outlined below. SSBCI benefits are items or services that have a reasonable expectation of improving or maintaining the health or overall function of a chronically ill enrollee.

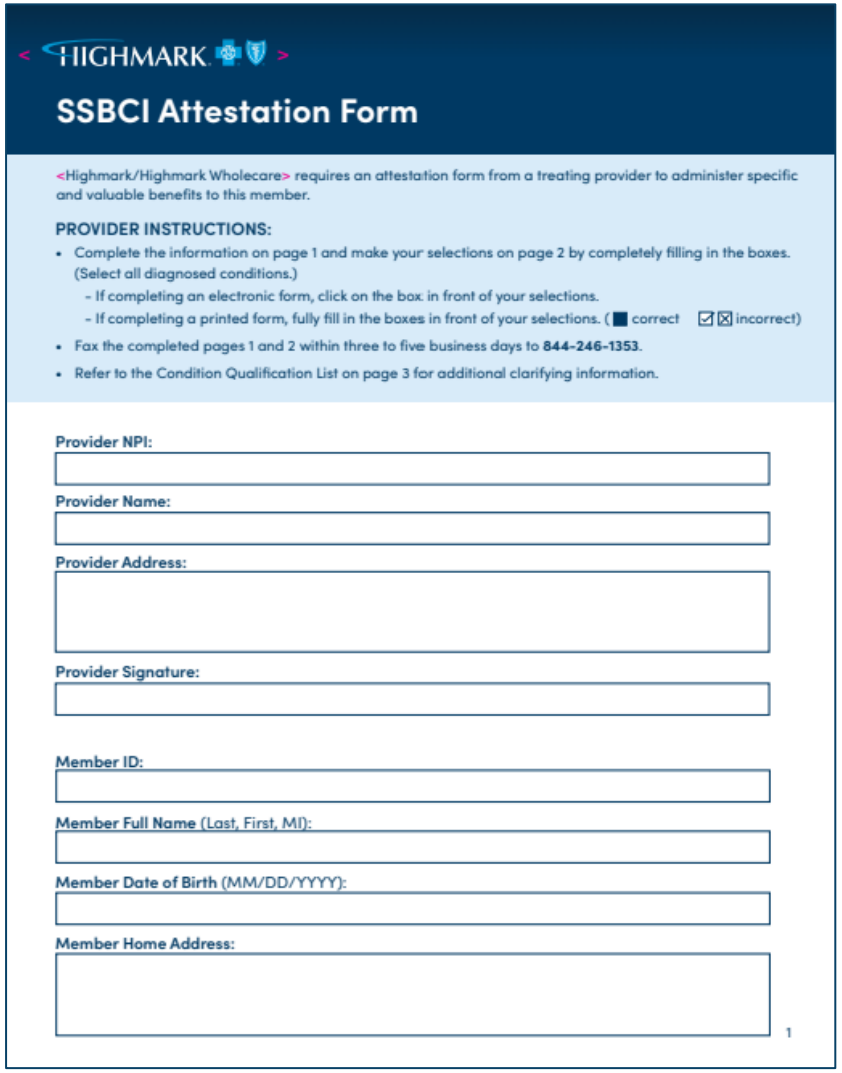
CMS Requirements to qualify for SSBCI Benefits; **(Must meet all three)**

- ❑ Having one or more life threatening/significantly limiting chronic conditions (see next slide for listing of eligible conditions)
- ❑ High risk of hospitalization
- ❑ Require intensive care coordination
- ❑ **Providers must fill out the form and submit to HHOWV**

Highmark D-SNP 2026 SSBCI Conditions

- Chronic alcohol and other drug dependence
- Autoimmune disorders
- Cancer
- Cardiovascular Disorders
- Chronic Heart Failure
- Dementia
- Diabetes Mellitus
- End-stage liver disease
- ESRD
- Severe hematologic disorders
- HIV/AIDS
- Chronic and disabling mental conditions
- Chronic lung disorder
- Neurologic Disorder
- Chronic Kidney Disease
- Overweight/obesity
- Chronic gastrointestinal disease
- Post-organ transplantation
- Immunodeficiency and immunosuppressive disorders
- Conditions associated with cognitive impairment
- Chronic conditions that impair vision, hearing, taste, touch and smell
- Conditions that require therapy services to maintain or retain functioning

Provider Attestation Form



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SSBCI Attestation Form

<Highmark/Highmark Wholecare> requires an attestation form from a treating provider to administer specific and valuable benefits to this member.

PROVIDER INSTRUCTIONS:

- Complete the information on page 1 and make your selections on page 2 by completely filling in the boxes. (Select all diagnosed conditions.)
  - If completing an electronic form, click on the box in front of your selections.
  - If completing a printed form, fully fill in the boxes in front of your selections. (■ correct ☑☒ incorrect)
- Fax the completed pages 1 and 2 within three to five business days to **844-246-1353**.
- Refer to the Condition Qualification List on page 3 for additional clarifying information.

Provider NPI:

Provider Name:

Provider Address:

Provider Signature:

Member ID:

Member Full Name (Last, First, MI):

Member Date of Birth (MM/DD/YYYY):

Member Home Address:

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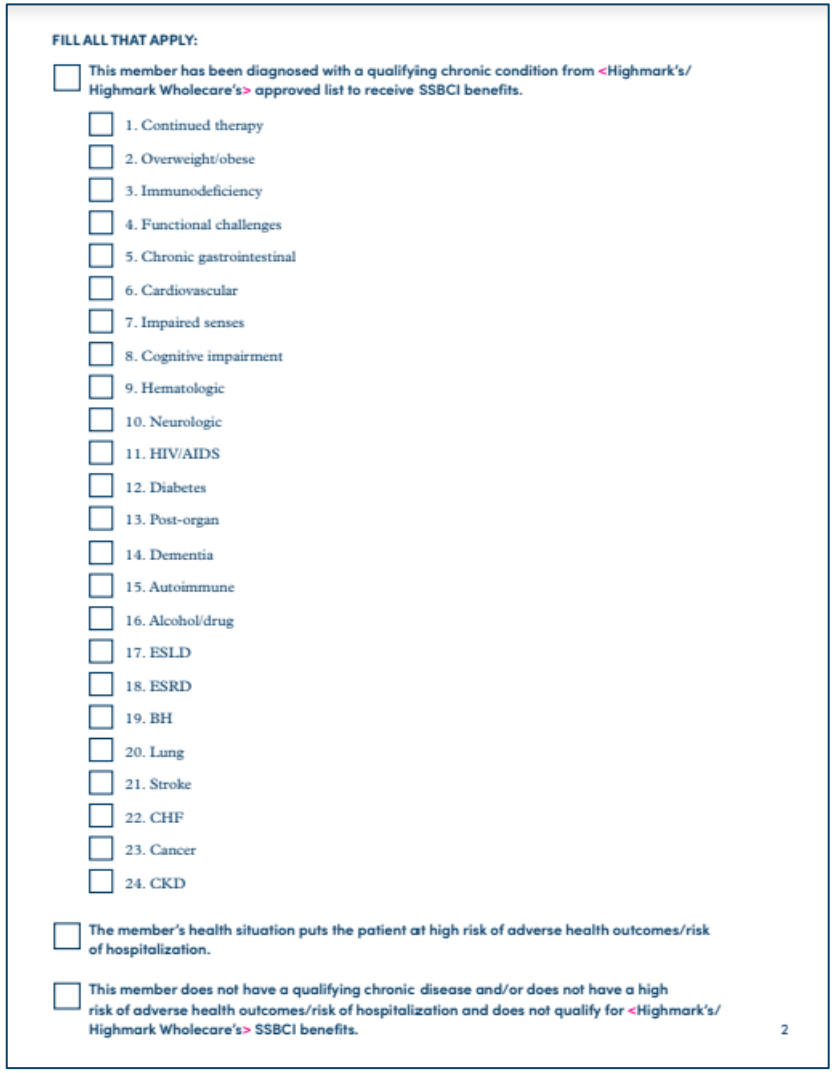

FILL ALL THAT APPLY:

☐ This member has been diagnosed with a qualifying chronic condition from <Highmark's/ Highmark Wholecare's> approved list to receive SSBCI benefits.

- ☐ 1. Continued therapy
- ☐ 2. Overweight/obese
- ☐ 3. Immunodeficiency
- ☐ 4. Functional challenges
- ☐ 5. Chronic gastrointestinal
- ☐ 6. Cardiovascular
- ☐ 7. Impaired senses
- ☐ 8. Cognitive impairment
- ☐ 9. Hematologic
- ☐ 10. Neurologic
- ☐ 11. HIV/AIDS
- ☐ 12. Diabetes
- ☐ 13. Post-organ
- ☐ 14. Dementia
- ☐ 15. Autoimmune
- ☐ 16. Alcohol/drug
- ☐ 17. ESLD
- ☐ 18. ESRD
- ☐ 19. BH
- ☐ 20. Lung
- ☐ 21. Stroke
- ☐ 22. CHF
- ☐ 23. Cancer
- ☐ 24. CKD

☐ The member's health situation puts the patient at high risk of adverse health outcomes/risk of hospitalization.

☐ This member does not have a qualifying chronic disease and/or does not have a high risk of adverse health outcomes/risk of hospitalization and does not qualify for <Highmark's/ Highmark Wholecare's> SSBCI benefits.

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Highmark D-SNP 2026 SSBCI Condition Qualification List

1. Conditions that require continued therapy services for individuals to maintain or retain functioning
2. Overweight, obesity, and metabolic syndrome
3. Immunodeficiency and immunosuppressive disorders
4. Conditions with functional challenges
5. Chronic gastrointestinal disease
6. Cardiovascular disorders limited to: Cardiac arrhythmias, coronary artery disease, elevated lipid profile, peripheral vascular disease, hypertension, and chronic venous thromboembolic disorder
7. Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
8. Conditions associated with cognitive impairment
9. Severe hematologic disorders limited to: Aplastic anemia; hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease (excluding sickle-cell trait), and chronic venous thromboembolic disorder
10. Neurologic disorders limited to: Amyotrophic lateral sclerosis (ALS), epilepsy, extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia) Huntington's disease, multiple sclerosis, Parkinson's disease, polyneuropathy, spinal stenosis, and stroke-related neurologic deficit
11. HIV/AIDS
12. Diabetes mellitus
13. Post-organ transplantation
14. Dementia
15. Autoimmune disorders limited to: Polyarteritis nodosa, polymyalgia rheumatica, polymyositis, rheumatoid arthritis, and systemic lupus erythematosus
16. Chronic alcohol and other drug dependence
17. End-stage liver disease
18. End-stage renal disease
19. Chronic and disabling mental health conditions limited to: Bipolar disorders, major depressive disorders, paranoid disorder, schizophrenia, and schizoaffective disorder
20. Chronic lung disorders limited to: Asthma, chronic bronchitis, chronic obstructive pulmonary disease, emphysema, pulmonary fibrosis, and pulmonary hypertension
21. Stroke
22. Chronic heart failure
23. Cancer, excluding pre-cancer conditions or in-situ status
24. Chronic kidney disease

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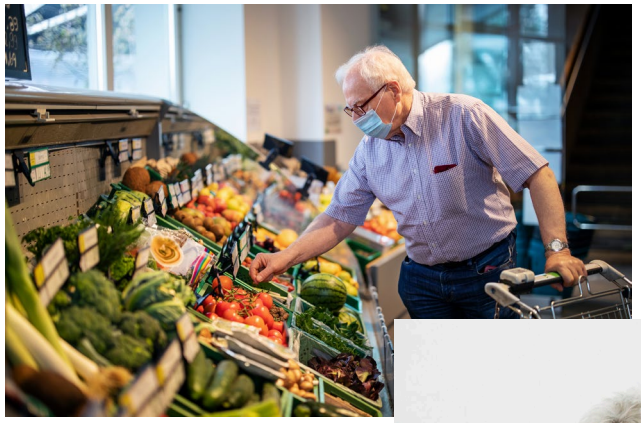
SSBCI Allowance



- $185 per month combined allowance for healthy groceries, utility payments, pay-at-the-pump
  - For a total combined allowance of $235 per month when combined with OTC and Home/Bathroom Safety allowance
- Funds loaded onto the same FlexCard as the OTC and Home/Bathroom Safety allowance
- Funds do not rollover from month to month*

Dental, Vision, Hearing & More

HHO Duals Dental Benefits

- $2,500 Comprehensive allowance (combined with preventive)

Comprehensive Dental Services

- Unlimited white or silver fillings
- Simple tooth extractions
- Crowns limited to 2 per year (1 crown in 5 years per tooth)
- 2 Endodontics Services per year
- Scaling and root planing with each quad every year
- Full mouth debridement 1 per year

Dentures

- 1 per arch every year, including full denture, partial denture or immediate denture and denture repairs (included in comprehensive max)

HHO Duals Vision Benefits

- 1 annual routine eye exam
- $200 allowance towards eyeglass frames or contacts
  - 1 pair of lenses and frames or contact lenses each year
  - Covered lenses include Single vision, lined bifocals, lined trifocals, or lenticulars
  - Lens upgrades are NOT covered
- Benefit administered by VSP

HHO Duals Hearing Benefits

- 1 Routine Hearing Exam per year
- 1 TruHearing brand hearing aid per ear every 3 years
- Hearing Aid package includes:
  - 1 year of follow-up visits for fittings & adjustments
  - 80 batteries per aid for non-rechargeable models
  - 60 day trial period
  - 3-year manufacturer repair, loss and damage warranty
- Members should contact TruHearing for assistance: 1-844-763-4240

Additional Benefits

Transportation

24 one-way trips to health-related locations such as doctor offices, medical appointments, fitness centers, pharmacies provided by American Logistics

Types of Rides

- Rideshare(Uber)
  - Door to Door
  - Wheelchair

SilverSneakers

- A no-cost fitness program administered by Tivity Health
- Over 22,000 gyms, studios and community centers
- Access to classes like tai chi, yoga, walking groups and more at local parks and rec centers
- Virtual classes and on demand work out videos

Post Discharge Meals

- Up to 14 meals (2 per day for 7 days) after a member has been discharged from an inpatient hospital, rehab facility or skilled nursing facility.
- Provided by Moms Meals
- Coordinated through HHOWV Care Coordination or Case Management Teams

Personal Emergency Response Service

- Members can receive one PERS unit per lifetime
- Administered by Lifeline
- Coordinated through Case Management

Model of Care

As a Special Needs Plan, Health Options Duals is required by CMS to administer a Model of Care (MOC) Plan. In accordance with CMS guidelines., Highmark Health Options' SNP MOC Plan is the basis of design for our care management policies, procedures, and operational systems that will enable our Medicare Advantage Organization to provide coordinated care for special needs individuals.

Annual review of the MOC is required by all providers.
These documents will be available on our website soon.

Case Management

Highmark Health Options understands that many factors impact the ability and desire for members to focus on their health. Case Managers intervene with members who have complex medical or social issues.

- **Member Outreach Form** - Providers can refer members for additional education regarding adhering to their treatment plan, keeping scheduled appointments, understanding their benefits, and resources.

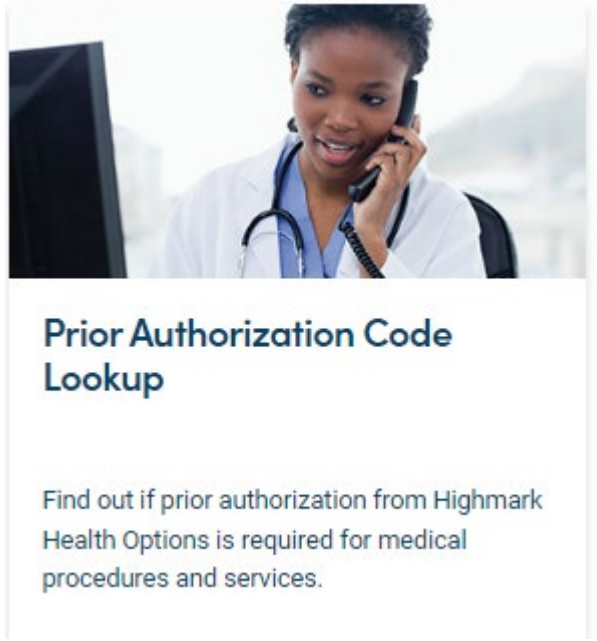
- Medicare Case Management functions to meet all the needs of the member through our Model of Care requirements: HRA completion, Change in Health Status, Transitions of Care, Individualized Care Plans.

GuidingCare - Prior Authorization Portal via NaviNet®

Participating providers must submit authorizations electronically through GuidingCare, via NaviNet®.

The GuidingCare user guide can be found under the Forms and Reference Material page of our website: https://hho.fyi/wv-GuidingCare.

Providers can utilize the Code Authorization Lookup Tool on the provider page of our website to determine if a code requires prior authorization.



Claims and Billing

Claims Submission

Electronic claims are accepted through any clearinghouse with payer ID 88831.

Claims can be submitted with or without the Alpha character prefix appearing on the member's ID card.

For submission of professional or institutional electronic claims for Highmark Health Options West Virginia, please refer to the following grid:

CPID	PAYER NAME	PAYER ID	Claim Type
2298	Highmark Health Options Duals West Virginia (HHO WV)	88831	Professional
2912	Highmark Health Options Duals West Virginia (HHO WV)	88831	Institutional

Mailing address for paper claims submission:

- Attention: Claims Processing Department
  Highmark Health Options WV
  PO Box 21871
  Eagan, MN 55121

Timely Filing Guidelines for Claims Submission

- Providers must submit a complete, original CMS-1500 or UB-04 claims form within 365 days from the date of service.
- Electronic claims submission is the preferred method to receive claims, but claims can be submitted on paper.
- Corrected claims or requests for review must be received within 365 days from the date of service. Claims submitted after these deadlines will be denied for untimely filing.

Payment Disputes

Our company will review any claim that a practitioner feels was denied or paid incorrectly.

- These are requests that are not regarding medical necessity but rather are administrative in nature such as but not limited to, disputes regarding the amount paid, denials regarding lack of modifiers, or coordination of benefit (COB) issues.
- Please include all the appropriate documentation, (i.e. the actual claim information, reason for the denial dispute and applicable documentation).

Payment disputes can be submitted two ways:

- Via the NaviNet® portal under Enhanced Provider Features then select Submit Appeals and Claims Disputes.
- Via fax to 1-833-623-2571.

Complaints, Grievances, and Appeals

Provider Appeals

Any provider may file a provider appeal to request the review of any post-service denial. This process is intended to afford providers with the opportunity to address issues regarding payment only. Appeals for services that have not yet been provided must follow the Member Grievance or Complaint Process. The Provider Appeal Process must be initiated by the provider through a written request. A first level appeal must be submitted in writing within 60 calendar days from the date on the notice of adverse benefit determination **(authorization denial).** In this instance there is a denied authorization however services have already been provided. 180 calendar days from the date of the post-service claim denial, or as governed per contract. **When an authorization has been denied, provider must adhere to the sixty (60) calendar-day time frame, the one hundred and eighty (180) calendar days once the claim has denied does not apply.**

Failure to follow the prior authorization process may result in the administrative denial of your claim, regardless of medical necessity.

It is the responsibility of the provider to submit a request for a retrospective authorization when outside of their control and provide justification as to why an authorization was not requested within the timeframe.

Provider Appeals

Provider Appeal Requests can be submitted through our provider portal or fax:

NaviNet	https://connect.NaviNet.net
Fax	833-623-2571

- Select Highmark Health Options West Virginia from the NaviNet home page.
- Choose Enhanced Provider Features.
- Select “Submit Appeals and claims Disputes”.
- Please include all **clinical and pertinent** documentation to support your request. Documents can be uploaded through the portal. You must include medical records, copy of denied claims, reason for the appeal, etc.
- Additional information regarding the provider appeal process can be found in our provider manual, which is available on our website: Highmark Health Options Duals Medicare D-SNP Provider Manual

Member Complaints, Grievances and Appeals

- A patient or provider may contact a Member Advocate or Grievance Coordinator at any time for help or any questions about the appeals and grievances process.
- Patients have a right to appoint a representative to act on their behalf.
- If a provider is acting on behalf of a patient, Highmark Health Options West Virginia requires the patient's consent in writing prior to reviewing a request for an appeal or grievance.
- Grievances must be filed within 60 days of the date of the incident.
- An appeal must be filed within 60 calendar days from the Notice of Adverse Benefit Determination letter. A decision letter will be mailed within 30 calendar days from the date the appeal was filed.
- If the normal timeframe to review an appeal could seriously jeopardize the patient's life, health, or ability to attain, maintain or regain maximum function, providers may ask for an expedited appeal either verbally or in writing. Decisions are sent within 72 hours from the day the request is filed.

D-SNP Training Materials

Resources

Provider Resource Center

Highmark Health Options Duals Medicare D-SNP Provider Manual

Culturally Competent Care

THANK YOU!

For questions about Contracting with Highmark Health Options, connect with Provider Contracting at 304-424-0365 or HHOWVContracting@highmark.com

For questions about working with Highmark Health Options, contact Provider Relations at HHOWVPR@highmarkhealth.org

Call Provider Services with administrative questions at 1-833-957-0020, Monday – Friday, 8 a.m. to 5 p.m.

NaviNet® is a separate company that provides an internet-based application for providers to streamline data exchanges between their offices and Highmark Health Options such as, routine eligibility, benefits and claims status inquiries.

HealthHelp is a separate company that offers education and guidance from specialists in sleep, cardiology, and radiation oncology for Highmark Health Options.

United Concordia Dental is a separate company that administers dental benefit(s) for Highmark Health Options.

VSP Vision is a separate company that administers the vision benefit(s) for Highmark Wholecare.

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