The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-624-6961. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthplan.org or call 1-800-624-6961 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 Single/$2,000 Family	If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services, office visits, urgent and emergency care and prescriptions	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,850 Single/$13,700 Family	If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover and supplemental riders	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthplan.org or call 1-800-624-6961	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/ visit	Not covered	Deductible waived
	Specialist visit	$40 copay/ visit	Not covered	Deductible waived. Preauthorization required
	Preventive care/screening/ immunization	$0 copay/visit	Not covered	Deductible waived. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Preauthorization required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthplan.org	Generic drugs	$10 copay/ each retail $20.00 copay/ each home delivery	Not covered	Deductible waived. Covers up to a 31-day supply retail, 90-day supply home delivery
	Preferred brand drugs	Retail Not Covered Home Delivery Not Covered	Not covered	Deductible waived. Covers up to a 31-day supply retain, 90-day supply home delivery, member responsible for cost difference between generic and preferred brand
	Non-preferred brand drugs	Retail Not Covered Home Delivery Not Covered	Not covered	Deductible waived. Covers up to a 31-day supply retail, 90-day supply home delivery, member responsible for cost difference between generic and non-preferred brand
	Specialty drugs	30% coinsurance or $300 copay whichever is less. Generic only	Not covered	Deductible waived. Covers up to a 30-day supply retail or home delivery. Preauthorization required
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/ visit +30%	Not covered	Preauthorization required
	Physician/surgeon fees	$100 copay/ visit+30%	Not covered	Preauthorization required
If you need immediate medical attention	Emergency room care	$250 copay/ visit	$250 copay/ visit	Deductible waived. True emergency services only
	Emergency medical transportation	$75 copay/ transport	$75 copay/ transport	Non-emergency transports preauthorization required
	Urgent care	$50 copay/ visit	$50 copay/ visit	Deductible waived

* For more information about limitations and exceptions, see your Benefits Office for a copy of the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay +30%	Not covered	Preauthorization required unless emergent admission
	Physician/surgeon fees	$100copay+30%	Not covered	Preauthorization required unless emergent admission
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/ visit	Not covered	Deductible waived office visit only, other care may include tests and services described elsewhere in the SBC (i.e. diagnostic testing)
	Inpatient services	$100 copay +30%	Not covered	Preauthorization required unless emergent admission
If you are pregnant	Office visits	$40 copay/ visit	Not covered	Deductible waived office visit only, maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound or preventive services)
	Childbirth/delivery professional services	$100 copay +30%	Not covered	None
	Childbirth/delivery facility services	$100 copay +30%	Not covered	None
If you need help recovering or have other special health needs	Home health care	$0 copay	Not covered	Preauthorization required, limited to 100 visits per contract year
	Rehabilitation services	$0; 30% Days 31+	Not covered	Preauthorization required
	Habilitation services	$40 copay/ visit per therapy type	Not covered	Preauthorization required
	Skilled nursing care	$35 copay/ day	Not covered	Preauthorization required, limited to 90 days per contract year
	Durable medical equipment	30% coinsurance	Not covered	Equipment greater than $500 preauthorization required
	Hospice services	$0 copay	Not covered	Preauthorization required
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None, unless supplemental rider purchased
	Children's glasses	Not covered	Not covered	None, unless supplemental rider purchased
	Children's dental check-up	Not covered	Not covered	None, unless supplemental rider purchased

* For more information about limitations and exceptions, see your Benefits Office for a copy of the plan or policy document.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
●Acupuncture	●Infertility treatment	●Routine eye care
●Cosmetic surgery	●Long-term caret	●Routine foot care
●Dental care	●Non-emergency care when traveling outside the U.S.	●Weight loss programs
●Hearing aids		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
●Bariatric surgery	●Private-duty nursing
●Chiropractic care	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are: West Virginia Offices of the Insurance Commissioner, Consumer Services Division, 1-888-879-9842 or www.wvinsurance.gov or the Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Health Plan Appeals Coordinator at 1-800-624-6961 or TTY 711.

Does this plan provide Minimum Essential Coverage?

Yes. If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards?

Yes. If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-847-7902.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-847-7902.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-847-7902.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-847-7902.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see your Benefits Office for a copy of the plan or policy document.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ **The plan's overall deductible**	$1,000
■ **Specialist *[cost sharing]***	$40
■ **Hospital (facility) *[cost sharing]***	$100
■ **Other *[cost sharing]***	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000.00
Copayments	$180.00
Coinsurance	$3,440.00
What isn't covered	
Limits or exclusions	$10.00
The total Peg would pay is	$4,630.00

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	$1,000
■ **Specialist *[cost sharing]***	$40
■ **Hospital (facility) *[cost sharing]***	$100
■ **Other *[cost sharing]***	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000.00
Copayments	$540.00
Coinsurance	$490.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	$2,030.00

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	$1,000
■ **Specialist *[cost sharing]***	$40
■ **Hospital (facility) *[cost sharing]***	$100
■ **Other *[cost sharing]***	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	1,000.00
Copayments	$450.00
Coinsurance	$70.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	$1,520.00

The plan would be responsible for the other costs of these EXAMPLE covered services.