



## **PEIA**

### **Schedule of Benefits**

**July 1, 2019 to June 30, 2020**

**Plans A, B (HMO) & C (POS)**

**The Health Plan**  
1110 Main Street  
Wheeling WV 26003  
1.888.847.7902  
TDD: 711  
[healthplan.org](http://healthplan.org)





Benefit Description	Plan A	Plan B	Plan C (POS)
Annual Deductible	\$600/\$1,200 Goes towards OOP Max	\$1,000/\$2,000 Goes towards OOP Max	IN: \$1,200/\$2,400 OUT: \$2,400/\$4,800 Goes towards OOP Max
Annual Out-of-Pocket Maximum *Includes Rx copays	Single: \$6,850 Two person: \$13,700 Family: \$13,700 *Includes Rx copays	Single: \$ 6,850 Two person: \$13,700 Family: \$13,700 *Includes Rx copays	<u>IN</u> Single: \$6,850 Two person: \$13,700 Family: \$13,700 <u>OUT</u> Single: \$10,000 Two person: \$20,000 Family: \$20,000 *Includes Rx copays
<b>Physician Services</b>			
Adult Routine Physical Examinations <i>(including prostate and gynecological, with PAP smear)</i>	Covered in full per healthcare reform	Covered in full per healthcare reform	IN: Covered in full per healthcare reform OUT: 40% co-insurance after deductible
Diagnostic X-ray, Lab and Testing	20% co-insurance after deductible	30% co-insurance after deductible	IN: 30% co-insurance after deductible OUT: 50% co-insurance after deductible
Mammograms	Routine covered in full per healthcare reform	Routine covered in full per healthcare reform	IN: Routine covered in full per healthcare reform OUT: 40% co-insurance after deductible

Physician Inpatient Visits	\$100 copay + 15% co-insurance after deductible	\$100 copay +30% co-insurance after deductible	IN: \$100 copay +30% co-insurance after deductible OUT: 50% co-insurance after deductible
Physician Office Visits – Primary Care	\$10 copay/visit deductible waived	\$10 copay/visit deductible waived	IN: \$10 copay/visit deductible waived OUT: 40% co-insurance after deductible
Physician Office Visits – Specialty Care	\$40 copay/visit deductible waived	\$40 copay/visit deductible waived	IN: \$40 copay/visit deductible waived OUT: 40% co-insurance after deductible
Prenatal Care	\$40 copay initial visit only deductible waived	\$40 copay initial visit only deductible waived	IN: \$40 copay initial visit only deductible waived OUT: 40% co-insurance after deductible
Second Surgical Opinions	\$40 copay/visit deductible waived	\$40 copay/visit deductible waived	IN: \$40 copay/ visit deductible waived OUT: 40% co-insurance after deductible
Voluntary Sterilization	Men 30% co-insurance after deductible Women covered in full per healthcare reform	Men 30% co-insurance after deductible Women covered in full per healthcare reform	IN: Male 30% co-insurance after deductible OUT: Male 40% co-insurance after deductible IN: Female covered in full per healthcare reform OUT: 40% co-insurance after deductible

Well-Child Exams	Covered in full per healthcare reform	Covered in full per healthcare reform	IN: Covered in full per healthcare reform OUT: 40% co-insurance after deductible
Well-Child Immunizations (birth through 16)	Covered in full per healthcare reform	Covered in full per healthcare reform	In: Covered in full per healthcare reform OUT: 40% co-insurance after deductible
<b>Inpatient Services</b>			
Semi-private Room; Ancillary; Therapy Services, X-ray, Lab, Surgical Services, and General Nursing Care	\$100 copay + 15% co-insurance after deductible	\$100 copay + 30% co-insurance after deductible	IN: \$100 copay + 30% co-insurance after deductible OUT: 50% co-insurance after deductible
Inpatient Occupational, Physical, or Speech Therapy	\$100 copay + 15% co-insurance after deductible	\$100 + 30% co-insurance after deductible	IN: \$100 + 30% co-insurance after deductible OUT: 50% co-insurance after deductible
Maternity Care (delivery)	\$100 copay + 15% co-insurance after deductible	\$100 copay + 30% co-insurance after deductible	IN: \$100 copay + 30% co-insurance after deductible OUT: 50% co-insurance after deductible
Rehabilitation	\$0 days 1-30 20% copay days 31+ after deductible	\$0 days 1-30 30% copay days 31+ after deductible	IN: \$0 days 1-30 30% co-insurance days 31+ after deductible OUT: 50% co-insurance after deductible

Skilled Nursing	\$35 copay/day after deductible	\$35 copay/day after deductible	IN: \$35 copay/day after deductible OUT: 40% co-insurance after deductible
<b>Hospital Outpatient Services</b>			
Ambulatory/ Outpatient Surgery	\$100 copay + 15% co-insurance after deductible	\$100 copay + 30% co-insurance after deductible	IN: \$100 copay + 30% co-insurance after deductible OUT: 50% co-insurance after deductible
Pre-admission Testing, Diagnostic X-ray and Lab	20% co-insurance after deductible	30% co-insurance after deductible	IN: 30% co-insurance after deductible OUT: 50% co-insurance after deductible
<b>Mental Health &amp; Chemical Dependency Benefits</b>			
Outpatient Chemical Dependency	\$10 copay/visit deductible waived	\$10 copay/visit deductible waived	IN: \$10 copay/visit deductible waived OUT: 40% co-insurance after deductible
Outpatient Mental Health	\$10 copay/visit deductible waived	\$10 copay/visit deductible waived	IN: \$10 copay/visit deductible waived OUT: 40% co-insurance after deductible
Inpatient Chemical Dependency (including partial hospitalization)	\$100 copay + 15% co-insurance/ admission after deductible	\$100 copay + 30% co-insurance/ admission after deductible	IN: \$100 copay + 30% co-insurance after deductible OUT: 50% co-insurance after deductible

Inpatient Detoxification	\$100 copay + 15% co-insurance/ admission after deductible	\$100 copay + 30% co-insurance/ admission after deductible	IN: \$100 copay + 30% co-insurance after deductible OUT: 50% co-insurance after deductible
Inpatient Mental Health <i>(including partial hospitalization)</i>	\$100 copay + 15% co-insurance/ admission after deductible	\$100 copay + 30% co-insurance/ admission after deductible	IN: \$100 copay + 30% co-insurance after deductible OUT: 50% co-insurance after deductible
<b>Outpatient Therapies</b>			
Acupuncture	Not covered	Not covered	Not covered
Chiropractic	\$40 copay/visit deductible waived	\$40 copay/visit deductible waived	IN: \$40 copay/visit deductible waived OUT: 40% co-insurance after deductible

Occupational Therapy	<p>Visit 1-20: \$40 copay/visit after deductible</p> <p>21+ visits: 50% copay/visit after deductible</p>	<p>Visit 1-20: \$40 copay/visit after deductible</p> <p>21+ visits: 50% copay/visit after deductible</p>	<p>IN: Visits 1-20: \$40 copay/visit after deductible</p> <p>21+ visits: 50% copay/visit after deductible</p> <p>OUT 40% co-insurance/visit after deductible</p>
Physical Therapy	<p>Visit 1-20: \$40 copay/visit after deductible</p> <p>21+ visits: 50% copay/visit</p> <p>After deductible</p>	<p>Visit 1-20: \$40 copay/visit after deductible</p> <p>21+ visits: 50% copay/visit</p> <p>After deductible</p>	<p>IN: Visits 1-20: \$40 copay/visit after deductible</p> <p>21+ visits: 50% copay visit after deductible</p> <p>OUT 40% co-insurance/visit after deductible</p>
Speech Therapy	<p>Visit 1-20: \$40 copay/visit after deductible</p> <p>21+ visits: 50% co-insurance/visit after deductible</p>	<p>Visits 1-20: \$40 copay/visit after deductible</p> <p>21+ visits: 50% co-insurance/visit after deductible</p>	<p>IN Visits 1-20: \$40 copay/visit after deductible</p> <p>21+ visits: 50% co-insurance after deductible</p> <p>OUT 40% co-insurance/visit after deductible</p>
All Other Medical Services			
Allergy Testing and Treatment	\$40 copay/visit after deductible	\$40 copay/visit after deductible	<p>IN: \$40 copay/visit after deductible</p> <p>OUT: 40% co-insurance/visit after deductible</p>



Cardiac Rehabilitation	\$10 copay/visit after deductible	\$10 copay/visit after deductible	IN: \$10 copay/visit after deductible OUT: 40% co-insurance/visit after deductible
Dental Services – Accident Related	\$100 copay + 15% after deductible	\$100 copay + 30% after deductible	IN: \$100 copay +30% after deductible OUT: 50% co-insurance after deductible
Dental Services - Other	Not covered	Not covered	Not covered
Diabetic Supplies	\$0 copay deductible waived	\$0 copay deductible waived	IN: \$0 copay deductible waived OUT: 40% co-insurance after deductible
Dialysis	20% co-insurance/visit after deductible	20% co-insurance/visit after deductible	IN: 20% co-insurance/visit after deductible OUT: 40% co-insurance/visit after deductible
Durable Medical Equipment (DME)	30% copay after deductible	30% copay after deductible	IN: 30% co-insurance after deductible OUT: 50% co-insurance after deductible
Emergency Ambulance <i>(medically necessary)</i>	\$75 copay/transport after deductible	\$75 copay/transport after deductible	IN: \$75 copay/transport after deductible OUT: \$75 copay/transport after deductible

Emergency Room Treatment <i>(non-emergency)</i>	Not covered	Not covered	Not covered
Emergency Services <i>(including supplies)</i>	\$250 copay/visit waived if admitted Deductible waived	\$250 copay/visit waived if admitted Deductible waived	<u>IN &amp; OUT</u> \$250 copay/visit waived if admitted Deductible waived
Growth Hormone	Rx benefit: 30% or \$300 whichever is less per specialty drug	Rx benefit: 30% or \$300 whichever is less per specialty drug Generic only	<u>IN &amp; OUT</u> Rx benefit 30% or \$300 whichever is less per specialty drug Generic only
Hearing Exam	\$40 copay/visit deductible waived	\$40 copay/visit deductible waived	IN: \$40 copay/visit deductible waived OUT: 40% co-insurance/visit after deductible
Home Health Services	\$0 copay after deductible	\$0 copay after deductible	IN: \$0 copay after deductible OUT: 40% co-insurance after deductible
Home Health Supplies	\$0 copay after deductible	\$0 copay after deductible	IN: \$0 copay after deductible OUT: 40% co-insurance after deductible

Hospice	\$0 copay after deductible	\$0 copay after deductible	IN: \$0 copay after deductible OUT: 40% co-insurance after deductible
Infertility Services	30% copay/visit/injection Limitations apply after deductible	30% copay/visit/injection Limitations apply after deductible	IN: 30% copay/visit/injection Limitations apply after deductible OUT: 40% co-insurance/visit/injection Limitations apply after deductible
Medical Supplies	30% co-insurance Certain limits may apply after deductible	30% co-insurance Certain limits may apply after deductible	IN: 30% co-insurance Certain limits apply after deductible OUT: 50% co-insurance Certain limits apply after deductible
Podiatry	\$40 copay/visit deductible waived	\$40 copay/visit deductible waived	IN: \$40 copay/visit deductible waived OUT: 40% co-insurance/visit after deductible
Prosthetics	30% co-insurance after deductible	30% co-insurance after deductible	IN: 30% co-insurance after deductible OUT: 50% co-insurance after deductible
Pulmonary Rehabilitation	\$10 copay/visit after deductible	\$10 copay/visit after deductible	IN: \$10 copay after deductible OUT: 40% co-insurance after deductible

Radiation and Chemotherapy	20% co-insurance after deductible	20% co-insurance after deductible	IN: 20% co-insurance after deductible OUT: 40% co-insurance after deductible
TMJ	Not covered	Not covered	Not covered
Transplants <i>(non-experimental)</i>	\$100 copay + 15% co-insurance after deductible	\$100 copay + 30% co-insurance after Deductible	IN: \$100 copay + 30% co-insurance after deductible OUT: 50% co-insurance after deductible
Urgent Care	\$50 copay/incident deductible waived	\$50 copay/incident deductible waived	<u>IN &amp; OUT</u> \$50 copay/incident deductible waived
Vision Services	Not covered	Not covered	Not covered

## Prescription Drug Benefits

Deductible	None	None	None
Generic Copayment	\$10 copay	\$10 copay	\$10 copay
Formulary Brand	50% copay if generic is NOT available	Not covered	Not covered
Non-Formulary Brand	Not covered	Not covered	Not covered
Maintenance Medication Discount Program Details	90-day supply mail order \$20 or 50% copay	90-day supply generic ONLY \$20 copay	90-day supply generic ONLY \$20 copay
Annual Benefit Maximum <i>(per member/year)</i>	None Out-of-pocket maximum is combined with medical	None Out-of-pocket maximum is combined with medical	None Out-of-pocket maximum is combined with medical
Other Details	Specialty drugs – 30% or \$300 whichever is less per specialty drug	Specialty drugs – 30% or \$300 whichever is less per GENERIC specialty drug	Specialty drugs – 30% or \$300 whichever is less per GENERIC specialty drug
Family Planning	Contraceptive injections, IUD, diaphragms and sterilizations (women) covered in full under medical benefit  Oral contraceptives – covered in full under Rx benefit per healthcare reform	Contraceptive injections, IUD, diaphragms and sterilizations (women) covered in full under medical benefit  Oral contraceptives – covered in full under Rx benefit per healthcare reform	Contraceptive injections, IUD, diaphragms and sterilizations (women) covered in full under medical benefit  Oral contraceptives – covered in full under Rx benefit per healthcare reform
Hearing Aids	Not covered	Not covered	Not covered
Lifetime maximum	Unlimited	Unlimited	Unlimited

*When services are limited to a maximum number of days, treatments, visits, etc., each visit, treatment, etc. must be medically necessary and appropriate to be covered.*