**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, [insert contact information]. 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 1.800.622.6961 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network:<br>$4,000 Individual / $8,000 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 care. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **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?** | $7,900 individual / $15,800 family | The out-of-pocket limit is the most you could pay in a year for covered services. 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, penalties, supplemental riders, and health care this plan doesn't cover. | 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 for a list of network providers. | 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 and 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. |

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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 | 40% coinsurance | Not covered | Deductible waived |
| | Specialist visit | 40% coinsurance | Not covered | Deductible waived. Preauthorization required. |
| | Preventive care/screening/ immunization | No charge | Not covered | Deductible waived. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan pays. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 40% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance | Not covered | Preauthorization is 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 | 40% coinsurance/each retail & home delivery | Not covered | Covers up to a 31-day supply retail, 90-day supply home delivery. |
| | Preferred brand drugs | 40% coinsurance/each retail & home delivery | Not covered | 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 | 40% coinsurance/each retail & home delivery | Not covered | Covers up to a 31-day supply retain, 90-day supply home delivery, member responsible for cost difference between generic and non-preferred brand. |
| | Specialty drugs | 50% coinsurance | Not covered | 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) | 40% coinsurance | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | 40% coinsurance | Not covered | Preauthorization is required. |
| **If you need immediate medical attention** | Emergency room care | 40% coinsurance | 40% coinsurance | True emergency services only. |
| | Emergency medical transport | 40% coinsurance | 40% coinsurance | Non-emergency transports, preauth required. |
| | Urgent care | 40% coinsurance | 40% coinsurance | Deductible waived. |

| 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) | 40% coinsurance/ admission | Not covered | Preauthorization is required unless emergent admission. |
| | Physician/surgeon fees | 40% coinsurance | Not covered | Preauthorization is required unless emergent admission. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 40% coinsurance/visit | Not covered | Deductible waived office visit only, other care may include tests and services described elsewhere in SBC. (i.e. Diagnostic Testing) |
| | Inpatient services | 40% coinsurance | Not covered | Preauthorization is required unless emergent admission. |
| **If you are pregnant** | Office visits | 40% coinsurance/visit | Not covered | Deductible waived office visit only, maternity care may include tests and services described elsewhere in SBC (i.e. Ultrasound or preventative services.) |
| | Childbirth/delivery professional services | 40% coinsurance | Not covered | None |
| | Childbirth/delivery facility services | 40% coinsurance | Not covered | None |
| **If you need help recovering or have other special health needs** | Home health care | 40% coinsurance | Not covered | Preauth required 100 visits/contract year |
| | Rehabilitation services | 40% coinsurance | Not covered | Preauthorization is required. |
| | Habilitation services | 40% coinsurance | Not covered | |
| | Skilled nursing care | 40% coinsurance | Not covered | Preauth required 90 visits/contract year |
| | Durable medical equipment | 40% coinsurance | Not covered | Equipment greater than $500 preauthorization required. |
| | Hospice services | 40% coinsurance | Not covered | Preauthorization is required. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not covered | Coverage limited to one exam/year |
| | Children's glasses | No charge | Not covered | Coverage limited to one pair of glasses/year |
| | Children's dental check-up | No charge | Not covered | 1 exam/ 6 months |

- 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
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric Surgery
- Chiropractic Care
- Private Duty Nursing

**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 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 1.855.577.7123.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.855.577.7123.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1.855.577.7123
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1.855.577.7123.

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

## 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 | $4000 |
| Specialist copayment | 40% |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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 | $4,000 |
| Copayments | $0 |
| Coinsurance | $3,520 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$7,520** |

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

| | |
|---|---|
| The plan's overall deductible | $4000 |
| Specialist copayment | 40% |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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* | $4,000 |
| Copayments | $0 |
| Coinsurance | $1,360 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$5,360** |

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

| | |
|---|---|
| The plan's overall deductible | $4000 |
| Specialist copayment | 40% |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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* | $1,900 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,900** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1.800.624.6961
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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