



Schedule of Benefits

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



July 1, 2026 to
June 30, 2027



1110 Main Street, Wheeling, WV 26003

1.888.847.7902 | 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	<u>IN</u> : \$1,200/\$2,400 <u>OUT</u> : \$2,400/\$4,800 Goes towards OOP Max
Annual Out-of-Pocket Maximum <i>*Includes Rx copays</i>	Single: \$6,850 Two person: \$13,700 Family: \$13,700 <i>*Includes Rx copays</i>	Single: \$ 6,850 Two person: \$13,700 Family: \$13,700 <i>*Includes Rx copays</i>	<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 <i>*Includes Rx copays</i>

Physician Services

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	<u>IN</u> : Covered in full per healthcare reform <u>OUT</u> : 40% co-insurance after deductible
Diagnostic X-ray, Lab and Testing	20% co-insurance after deductible	30% co-insurance after deductible	<u>IN</u> : 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible
Mammograms	Routine covered in full per healthcare reform	Routine covered in full per healthcare reform	<u>IN</u> : Routine covered in full per healthcare reform <u>OUT</u> : 40% co-insurance after deductible
Physician Inpatient Visits	15% co-insurance after deductible	30% co-insurance after deductible	<u>IN</u> : 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible
Physician Office Visits – Primary Care	\$10 copay/visit deductible waived	\$10 copay/visit deductible waived	<u>IN</u> : \$10 copay/visit deductible waived <u>OUT</u> : 40% co-insurance after deductible
Physician Office Visits – Specialty Care	\$40 copay/visit deductible waived	\$40 copay/visit deductible waived	<u>IN</u> : \$40 copay/visit deductible waived <u>OUT</u> : 40% co-insurance after deductible



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Prenatal Care	\$40 copay initial visit only deductible waived	\$40 copay initial visit only deductible waived	<u>IN</u> : \$40 copay initial visit only deductible waived <u>OUT</u> : 40% co-insurance after deductible
Second Surgical Opinions	\$40 copay/visit deductible waived	\$40 copay/visit deductible waived	<u>IN</u> : \$40 copay/ visit deductible waived <u>OUT</u> : 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	<u>IN</u> : Male 30% co-insurance after deductible <u>OUT</u> : Male 40% co-insurance after deductible <u>IN</u> : Female covered in full per healthcare reform <u>OUT</u> : 40% co-insurance after deductible
Well-Child Exams	Covered in full per healthcare reform	Covered in full per healthcare reform	<u>IN</u> : Covered in full per healthcare reform <u>OUT</u> : 40% co-insurance after deductible
Well-Child Immunizations (birth through 16)	Covered in full per healthcare reform	Covered in full per healthcare reform	<u>IN</u> : Covered in full per healthcare reform <u>OUT</u> : 40% co-insurance after deductible
Inpatient Services			
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	<u>IN</u> : \$100 copay + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible
Inpatient Occupational, Physical, or Speech Therapy	\$100 copay + 15% co-insurance after deductible	\$100 copay + 30% co-insurance after deductible	<u>IN</u> : \$100 + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible



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Maternity Care (delivery)	\$100 copay + 15% co-insurance after deductible	\$100 copay + 30% co-insurance after deductible	<u>IN</u> : \$100 copay + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible
Rehabilitation	Visit 1-30: \$0 copay/visit after deductible 31+ visits: 20% visit after deductible	Visit 1-30: \$0 copay/visit after deductible 31+ visits: 30% visit after deductible	<u>IN</u> : Visit 1-30: \$0 Copay/visit after deductible 31+ visits: 30% coinsurance <u>OUT</u> : 50% after deductible
Skilled Nursing	\$35 copay/day after deductible	\$35 copay/day after deductible	<u>IN</u> : \$35 copay/day after deductible <u>OUT</u> : 40% co-insurance after deductible
Hospital Outpatient Services			
Ambulatory/Outpatient Surgery	\$100 copay + 15% co-insurance after deductible	\$100 copay + 30% co-insurance after deductible	<u>IN</u> : \$100 copay + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible
Pre-admission Testing, Diagnostic X-ray and Lab	20% co-insurance after deductible	30% co-insurance after deductible	<u>IN</u> : 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible
Mental Health & Chemical Dependency Benefits			
Outpatient Chemical Dependency	\$10 copay/visit deductible waived	\$10 copay/visit deductible waived	<u>IN</u> : \$10 copay/visit deductible waived <u>OUT</u> : 40% co-insurance after deductible
Outpatient Mental Health	\$10 copay/visit deductible waived	\$10 copay/visit deductible waived	<u>IN</u> : \$10 copay/visit deductible waived <u>OUT</u> : 40% co-insurance after deductible



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Inpatient Chemical Dependency <i>(including partial hospitalization)</i>	\$100 copay + 15% co-insurance/ admission after deductible	\$100 copay + 30% co-insurance/ admission after deductible	<u>IN</u> : \$100 copay + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible
Inpatient Detoxification	\$100 copay + 15% co-insurance/admission after deductible	\$100 copay + 30% co-insurance/admission after deductible	<u>IN</u> : \$100 copay + 30% co-insurance after deductible <u>OUT</u> : 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	<u>IN</u> : \$100 copay + 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible
Outpatient Therapies			
Acupuncture	Not covered	Not covered	Not covered
Chiropractic	\$10 copay/visit deductible waived	\$10 copay/visit deductible waived	<u>IN</u> : \$10 copay/visit deductible waived <u>OUT</u> : 40% co-insurance after deductible
Occupational Therapy	Visit 1-20: \$10 copay/visit	Visit 1-20: \$10 copay/visit	<u>IN</u> : Visits 1-20: \$10 copay/visit <u>OUT</u> : 40% co-insurance/visit after deductible
Physical Therapy	Visit 1-20: \$10 copay/visit	Visit 1-20: \$10 copay/visit	<u>IN</u> : Visits 1-20: \$10 copay/visit <u>OUT</u> : 40% co-insurance/visit after deductible
Speech Therapy	Visit 1-20: \$10 copay/visit	Visits 1-20: \$10 copay/visit	<u>IN</u> : Visits 1-20: \$10 copay/ visit <u>OUT</u> : 40% co-insurance/ visit after deductible



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All Other Medical Services			
Allergy Testing and Treatment	\$40 copay/visit after deductible	\$40 copay/visit after deductible	<u>IN</u> : \$40 copay/visit after deductible <u>OUT</u> : 40% co-insurance/visit after deductible
Cardiac Rehabilitation	\$10 copay/visit after deductible	\$10 copay/visit after deductible	<u>IN</u> : \$10 copay/visit after deductible <u>OUT</u> : 40% co-insurance/visit after deductible
Dental Services – Accident Related	\$100 copay + 15% after deductible	\$100 copay + 30% after deductible	<u>IN</u> : \$100 copay +30% after deductible <u>OUT</u> : 50% co-insurance after deductible
Dental Services – Other	Not covered	Not covered	Not covered
Diabetic Supplies	\$0 copay deductible waived	\$0 copay deductible waived	<u>IN</u> : \$0 copay deductible waived <u>OUT</u> : 40% co-insurance after deductible
Dialysis	20% co-insurance/visit after deductible	20% co-insurance/visit after deductible	<u>IN</u> : 20% co-insurance/visit after deductible <u>OUT</u> : 40% co-insurance/visit after deductible
Durable Medical Equipment (DME)	30% copay after deductible	30% copay after deductible	<u>IN</u> : 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible
Emergency Ambulance (medically necessary)	\$75 copay/Transport after deductible	\$75 copay/Transport after deductible	<u>IN</u> : \$75 copay/transport after deductible <u>OUT</u> : \$75 copay/transport after deductible
Emergency Room Treatment (non-emergency)	Not covered	Not covered	Not covered
Emergency Services (including supplies)	\$250 copay/visit waived if admitted Deductible waived	\$250 copay/visit waived if admitted Deductible waived	<u>IN & OUT</u> : \$250 copay/visit waived if admitted Deductible waived



Benefit Description	Plan A	Plan B	Plan C (POS)
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</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	<u>IN</u> : \$40 copay/visit deductible waived <u>OUT</u> : 40% co-insurance/visit after deductible
Home Health Services	\$0 copay after deductible	\$0 copay after deductible	<u>IN</u> : \$0 copay after deductible <u>OUT</u> : 40% co-insurance after deductible
Home Health Supplies	\$0 copay after deductible	\$0 copay after deductible	<u>IN</u> : \$0 copay after deductible <u>OUT</u> : 40% co-insurance after deductible
Hospice	\$0 copay after deductible	\$0 copay after deductible	<u>IN</u> : \$0 copay after deductible <u>OUT</u> : 40% co-insurance after deductible
Infertility Services	Basic Health Care Limitations apply after deductible	Basic Health Care Limitations apply after deductible	<u>IN</u> : Basic Health Care Limitations apply after deductible <u>OUT</u> : Basic Health Care Limitations apply after deductible
Medical Supplies	30% co-insurance Certain limits may apply after deductible	30% co-insurance Certain limits may apply after deductible	<u>IN</u> : 30% co-insurance Certain limits apply after deductible <u>OUT</u> : 50% co-insurance Certain limits apply after deductible
Podiatry	\$40 copay/visit deductible waived	\$40 copay/visit deductible waived	<u>IN</u> : \$40 copay/visit deductible waived <u>OUT</u> : 40% co-insurance/visit after deductible



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Prosthetics	30% co-insurance after deductible	30% co-insurance after deductible	<u>IN</u> : 30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible
Pulmonary Rehabilitation	\$10 copay/visit after deductible	\$10 copay/visit after deductible	<u>IN</u> : \$10 copay after deductible <u>OUT</u> : 40% co-insurance after deductible
Radiation and Chemotherapy	20% co-insurance after deductible	20% co-insurance after deductible	<u>IN</u> : 20% co-insurance after deductible <u>OUT</u> : 40% co-insurance after deductible
TMJ	40% co-insurance/visit after deductible	40% co-insurance/visit after deductible	<u>IN</u> : 40% After deductible <u>OUT</u> : 50% After deductible
Transplants (non-experimental)	\$100 copay + 15% co-insurance after deductible	\$100 copay + 30% co-insurance after deductible	<u>IN</u> : \$100 copay +30% co-insurance after deductible <u>OUT</u> : 50% co-insurance after deductible
Urgent Care	\$50 copay/incident deductible waived	\$50 copay/incident deductible waived	<u>IN & 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 generic or 50% brand formulary if no generic	90-day supply generic ONLY \$20 copay	90-day supply generic ONLY \$20 copay
Annual Benefit Maximum (per member/year)	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.

