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Schedule of Benefits

July 1, 2025 to June 30, 2026

WEST VIRGINIA PEIA PUBLIC EMPLOYEES INSURANCE AGENCY

OUR ROOTS RUN DEEP · THE HEALTH PLAN

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

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	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*	IN: Single: $6,850 Two person: $13,700 Family: $13,700 OUT: Single: $10,000 Two person: $20,000 Family: $20,000 **Includes Rx copays*
Physician Services			
Adult Routine Physical Examinations *(including prostate and gynecological, with PAP smear)*	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	15% co-insurance after deductible	30% co-insurance after deductible	IN: 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

Benefit Description	Plan A	Plan B	Plan C (POS)
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
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	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 copay + 30% co-insurance after deductible	IN: $100 + 30% co-insurance after deductible OUT: 50% co-insurance after deductible

Benefit Description	Plan A	Plan B	Plan C (POS)
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	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	IN: Visit 1-30: $0 Copay/visit after deductible 31+ visits: 30% coinsurance OUT: 50% 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
Hospital Outpatient Services			
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
Mental Health & Chemical Dependency Benefits			
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

Benefit Description	Plan A	Plan B	Plan C (POS)
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 *(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
Outpatient Therapies			
Acupuncture	Not covered	Not covered	Not covered
Chiropractic	$10 copay/visit deductible waived	$10 copay/visit deductible waived	IN: $10 copay/visit deductible waived OUT: 40% co-insurance after deductible
Occupational Therapy	Visit 1-20: $10 copay/visit	Visit 1-20: $10 copay/visit	IN: Visits 1-20: $10 copay/visit OUT: 40% co-insurance/visit after deductible
Physical Therapy	Visit 1-20: $10 copay/visit	Visit 1-20: $10 copay/visit	IN: Visits 1-20: $10 copay/visit OUT: 40% co-insurance/visit after deductible
Speech Therapy	Visit 1-20: $10 copay/visit	Visits 1-20: $10 copay/visit	IN: Visits 1-20: $10 copay/ visit OUT: 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	IN: $40 copay/visit after deductible OUT: 40% co-insurance/ visit after deductible
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 *(medically necessary)*	$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 *(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	IN & OUT: $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	IN: 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	Basic Health Care Limitations apply after deductible	Basic Health Care Limitations apply after deductible	IN: Basic Health Care Limitations apply after deductible OUT: 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	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

Benefit Description	Plan A	Plan B	Plan C (POS)
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	40% co-insurance/visit after deductible	40% co-insurance/visit after deductible	IN: 40% After deductible OUT: 50% After deductible
Transplants *(non-experimental)*	$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	IN & OUT: $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.