




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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-624-6961 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$4,000 individual / \$8,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$8,550 individual / \$17,100 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> on certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.healthplan.org">www.healthplan.org</a> or call 1-800-624-6961 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	40% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Specialist</a> visit	40% <a href="#">coinsurance</a>	Not covered	None, <a href="#">Preauthorization</a> is required.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	Deductible does not apply. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.healthplan.org">www.healthplan.org</a> .	Generic drugs	40% <a href="#">coinsurance</a> (retail & mail order)	Not covered	Covers up to a 31-day supply (retail); 90 day supply (mail order)
	Preferred brand drugs	40% <a href="#">coinsurance</a> (retail & mail order)	Not covered	Covers up to a 31-day supply (retail); 90 day supply (mail order). Member is responsible for cost difference between generic and preferred brand.
	Non-preferred brand drugs	40% <a href="#">coinsurance</a> (retail & mail order)	Not covered	Covers up to a 31-day supply (retail); 90 day supply (mail order). Member is responsible for cost difference between generic and non-preferred brand.
	<a href="#">Specialty drugs</a>	50% <a href="#">coinsurance</a>	Not covered	Covers up to a 30-day supply (retail or home delivery). <a href="#">Preauthorization</a> is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	True emergency services only.
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Non-emergency transports, <a href="#">preauthorization</a> is required.
	<a href="#">Urgent care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.

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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a> /admission	Not covered	<a href="#">Preauthorization</a> is required unless emergent admission.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required unless emergent admission.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	40% <a href="#">coinsurance</a>	Not covered	Other care may include tests and services described elsewhere in SBC (i.e. Diagnostic Testing)
	Inpatient services	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required unless emergent admission.
<b>If you are pregnant</b>	Office visits	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	Not covered	None
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	Not covered	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	Not covered	100 visits/year. <a href="#">Preauthorization</a> is required.
	<a href="#">Rehabilitation services</a>	40% <a href="#">coinsurance</a>	Not covered	20 visits/year. Includes physical, speech, and occupational therapy. <a href="#">Preauthorization</a> is required.
	<a href="#">Habilitation services</a>	40% <a href="#">coinsurance</a>	Not covered	20 visits/year. Includes physical, speech, and occupational therapy. <a href="#">Preauthorization</a> is required.
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	Not covered	90 visits/contract year. <a href="#">Preauthorization</a> is required.
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required for equipment greater than \$500.
	<a href="#">Hospice services</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required.
<b>If your child needs dental or eye care</b>	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 the [plan](#) or policy document at [www.healthplan.org](http://www.healthplan.org)

## 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](http://www.wvinsurance.gov) or The Department of Health and Human Services at 1877-267-2323 x61565 or [www.ccio.cms.gov](http://www.ccio.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](http://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](#). For more information about your rights, this notice, or assistance, contact: The Health Plan Appeals Coordinator at 1-800-624-6961 or TTY 711. Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#).

### Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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 1-855-577-7123.

[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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,000
■ <a href="#">Specialist copayment</a>	40%
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$4,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$3,520
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,520</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,000
■ <a href="#">Specialist copayment</a>	40%
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a> *	\$4,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,360
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$5,360</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,000
■ <a href="#">Specialist copayment</a>	40%
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a> *	\$1,900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.