

 **This is only a summary and is not a guarantee of payment. Benefits will be based on eligibility and plan limitations at the time services are rendered.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling 304-348-8015.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$300 person/ \$600 family Doesn't apply to preventive care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other <u>deductibles</u> for specific services?	No	
Is there an <u>out-of-pocket limit</u> on my expenses?	\$1,500 person/ \$3,000 family	The out-of-pocket limit is the most you could pay during a coverage period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, chiropractic care, physical therapy, occupational therapy and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.
Does this plan use a <u>network of providers</u> ?	Yes, the primary network is SelectNet Plus, call (800)647-0873. The secondary network outside of WV is PHCS, call (800)678-7427 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-624-8605 or visit us at www.HealthSmart.com

If you aren't clear about any of the underlined terms used in this form, see the Glossary.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **SelectNet Plus providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider’s</u> office or clinic	Primary care visit to treat an injury or illness	20% after the deductible is met.	40% after the deductible is met.	
	Specialist visit	20% after the deductible is met.	40% after the deductible is met.	
	Other practitioner office visit	20% after the deductible is met.	40% after the deductible is met.	
	Preventive care/screening/immunization	100%	Not Covered	Refer to Summary Plan Description for frequency limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20%- CAMC/ 25%-Network, after the deductible is met.	40% after the deductible is met.	
	Imaging (CT/PET scans, MRIs)	20%- CAMC/ 25%-Network, after the deductible is met.	40% after the deductible is met.	

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.LDIRx.com .	Generic drugs	\$5 plus 20% of balance	\$5 plus 20% of balance	\$50 individual/\$100 family deductible applies.
	Preferred brand drugs	\$20 plus 20% of balance; If generics are available: \$35 plus 20% of balance	\$20 plus 20% of balance; If generics are available: \$35 plus 20% of balance	\$50 individual/\$100 family deductible applies.
	Non-preferred brand drugs	\$35 plus 20% of balance	\$35 plus 20% of balance	\$50 individual/\$100 family deductible applies.
	Specialty drugs	\$100 Maximum Copay	\$100 Maximum Copay	\$50 individual/\$100 family deductible applies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after the deductible is met.	40% after the deductible is met.	
	Physician/surgeon fees	20% after the deductible is met.	40% after the deductible is met.	
If you need immediate medical attention	Emergency room services	100% after a \$50 copay for true medical emergencies. 80% after a \$50 copay for non-medical emergencies subject to the deductible.	100% after a \$50 copay. 60% after a \$50 copay for non-medical emergencies subject to the deductible.	Copay waived if admitted directly from the Emergency Room.
	Emergency medical transportation	100% no Deductible (Emergency) / 80%, after deductible (non-emergency)	100% no Deductible (Emergency) / 60%, after deductible (non-emergency)	
	Urgent care	100% after a \$25 copay.	40% after the deductible is met.	

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20%- CAMC/ 25%-Network, after the deductible is met.	40% after the deductible is met.	All admissions are subject to Precertification procedures
	Physician/surgeon fee	20% after the deductible is met.	40% after the deductible is met.	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% after the deductible is met.	40% after the deductible is met.	
	Mental/Behavioral health inpatient services	20% after the deductible is met.	40% after the deductible is met.	All admissions are subject to Precertification procedures
	Substance use disorder outpatient services	20% after the deductible is met.	40% after the deductible is met.	
	Substance use disorder inpatient services	20% after the deductible is met.	40% after the deductible is met.	All admissions are subject to Precertification procedures
If you are pregnant	Prenatal and postnatal care	20% after the deductible is met.	40% after the deductible is met.	
	Delivery and all inpatient services	20% after the deductible is met.	40% after the deductible is met.	All admissions are subject to Precertification procedures

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20%- CAMC/ 25%-Network, after the deductible is met.	40% after the deductible is met.	Limited to 120 days per calendar year.
	Rehabilitation services	20%- CAMC/ 25%-Network, after the deductible is met.	40% after the deductible is met.	All admissions are subject to Precertification procedures
	Habilitation services	20%- CAMC/ 25%-Network, after the deductible is met.	40% after the deductible is met.	All admissions are subject to Precertification procedures
	Skilled nursing care	20%- CAMC/ 25%-Network, after the deductible is met.	40% after the deductible is met.	Limited to 100 days per calendar year.
	Durable medical equipment	20% after the deductible is met.	40% after the deductible is met.	Durable medical equipment purchases and/or rentals of \$1000 or more requires Precertification; Maintenance – routine periodic servicing such as testing, cleaning, regulating, and checking of the equipment is not covered.
	Hospice service	20% after the deductible is met.	40% after the deductible is met.	Preauthorization required
If your child needs dental or eye care	Eye exam	Refer to Vision Coverage	Refer to Vision Coverage	
	Glasses	Refer to Vision Coverage	Refer to Vision Coverage	
	Dental check-up	Refer to Dental Coverage	Refer to Dental Coverage	

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Care and treatment that is deemed not Medically Necessary
- Expenses in excess of the Usual, Customary and Reasonable Charges
- Services rendered after termination of participation in the Plan
- Any related expenses for a procedure not covered by the Plan
- Charges and services related to a newborn who is not a participating Dependent
- Hearing aids, implants, routine hearing testing or services necessary due to degenerative hearing loss not specifically caused by sickness, congenital defect or trauma
- For any prescriptions covered under the drug card program
- Maternity services for eligible dependents other than the spouse or the employee
- Services incurred for an injury or illness sustained during the commission or attempted commission of any criminal or illegal act.
- Exercise equipment including bicycles, weights, ergometers, or other equipment not generally considered Durable Medical Equipment
- Sterilization expenses for dependent Children
- Biofeedback, acupuncture, or hypnotherapy
- Services due to intentional self-inflicted injuries unless due to a medical condition (either physical or mental) or domestic violence
- Cosmetic Surgery
- Services rendered which are eligible for payment or coverage by any other plan that does not provide coordination of benefits.
- Sexual conversion Surgery, sexual dysfunctions, or other services related to gender reassignment or disturbance of gender identification
- Sterilization reversals;
- Medical care claims filed more than one (1) years from the date of service

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Oral Surgery of Impacted Teeth
- Orthotics that are rigid or semi-rigid supportive devices that limit or stop the motion of a weak or diseased body part
- Medically Necessary Care and treatment
- Allergy testing, injections and vials/medication
- Diabetes Education and Services
- Initial pair of contacts or glasses following cataract surgery
- Prosthetics
- Dean Ornish Program
- Chiropractic Medical Care (subject to plan limitation)

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Your Rights to Continue Coverage:

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that certain *Participants* as specified below may elect to continue participation as a temporary extension of medical coverage (hereinafter "continuation coverage") upon payment of a monthly premium by the *Participant* in certain instances where participation in the *Plan* would otherwise be terminated. It is the responsibility of an *Employee*, a participating *Spouse* or *Dependent* (hereinafter referred to as a "qualified beneficiary") to notify the Human Resources Department in writing of any of the following events within sixty (60) days of the event:

1. Divorce or legal separation from the *Employee* or Retired Employee;
2. Parents' divorce or legal separation;
3. The dependent *Child* ceases to be a *Dependent* as defined;
4. A second qualifying event that occurs while on COBRA;
5. Notice that a qualified beneficiary is entitled to a disability extension; or
6. Notice that a qualified beneficiary is no longer disabled as determined by the Social Security Administration.

Failure to notify the Human Resources Department as required will result in the forfeiture of the qualified beneficiary's (as applicable) rights to continuation coverage.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: HealthSmart Benefit Solutions at 800-624-8605.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-624-8605.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5740
- Patient pays \$ 1800

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$650
Copays	\$50
Coinsurance	\$1100
Limits or exclusions	\$0
Total	\$1800

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3950
- Patient pays \$ 1450

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$350
Copays	\$100
Coinsurance	\$1000
Limits or exclusions	\$
Total	\$1450

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.