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, contact the Plan Sponsor at 1-304-344-8331. 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.dol.gov/ebsa/healthreform or call the Plan Sponsor at 1-304-344-8331 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Non-Medicare Eligible Participant: Salary $0 - $10,000 $400 participant/$800 family Salary $10,000 - $20,000 $600 participant/$1,200 family Salary $20,000 - $30,000 $800 participant/$1,600 family Salary $30,000 + $1,000 participant/$2,000 family Medicare Eligible Participant: $250/participant	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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 and primary care services are covered before you meet your deductible.	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?	Yes – Non-Medicare Eligible Participant: In Network Salary $0 - $10,000 $2,250 participant/$4,500 family Salary $10,000 - $20,000 $2,450 participant/$4,900 family Salary $20,000 - $30,000 $2,650 participant/$5,300 family Salary $30,000 + $2,850 participant/$5,700 family Out-of-Network Salary $0 - $10,000 $4,500 participant/$9,000 family Salary $10,000 - $20,000 $4,700 participant/$9,400 family Salary $20,000 - $30,000 $4,900 participant/$9,800 family Salary $30,000 + $5,100 participant/$10,200 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. Cost sharing (includes, deductible, coinsurance and copayment) under the plan for Essential Health Benefits provided in network shall not exceed $7,350 for self-only coverage, or $14,700 for other than self-only coverage. No – Medicare Eligible Participant. Not applicable because there is

	No – Medicare Eligible Participant.	no out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, 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.4mosthealth.com or call 1-888-258-6477, or www.nppn.com or call 1-800-557-1656 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?	No.	You can see the specialist you choose without a referral.

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)	Medicare Supplement	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/ visit; deductible does not apply	50% coinsurance	No charge	None
	Specialist visit	$15 copay/ visit; deductible does not apply	50% coinsurance	No charge	
	Preventive care/screening/ immunization	No charge	No charge	No charge	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 will pay for. Out-of-Network limit $100/calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	No charge	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	No charge	

* For more information about limitations and exceptions, see your plan document. Contact the Plan Sponsor at 1-304-344-8331 to request a copy.

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)	Medicare Supplement	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	Maintenance Drugs: $35 copay (mail order)	Non-maintenance: 25% copay after deductible (retail) Maintenance drugs when available through mail order: 50% copay after deductible	*50% copay	Non-maintenance drugs are not available through mail order. *Medicare Supplement reimbursement benefit at 50% of the Medicare Part D "Donut Hole" expense of $3,750 to $5,000 up to a maximum of $625 per calendar year.
	Preferred brand drugs				
	Non-preferred brand drugs				
	Specialty drugs				
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	No charge	Includes surgery in the physician's office.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	No charge	
If you need immediate medical attention	Emergency room care	$50 copay	$50 copay	No charge	Emergency care provided in a physician's office $15 copay. If non-emergency, 30% coinsurance.
	Emergency medical transportation	30% coinsurance	30% coinsurance	No charge	
	Urgent care	$15 copay	$15 copay	No charge	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	$200 copay/admission + 50% coinsurance	No charge	Preauthorization is required. If you don't get preauthorization, benefits will be reduced by $500 and by 50% for any days and charges that are determined not medically necessary.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	No charge	Second surgical opinion no charge.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay	50% coinsurance	No charge	Office charge only.
	Inpatient services	30% coinsurance	$200 copay/admission + 50% coinsurance	No charge	None
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	No charge	Initial visit to determine pregnancy in network $15 copay. Limited to employee or their dependent spouse.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	No charge	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	No charge	
If you need help	Home health care	30% coinsurance	50% coinsurance	No charge	Limited to 40 visits/calendar year.

* For more information about limitations and exceptions, see your plan document. Contact the Plan Sponsor at 1-304-344-8331 to request a copy.

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)	Medicare Supplement	
recovering or have other special health needs	Rehabilitation services	30% coinsurance	50% coinsurance	No charge	None
	Habilitation services	Not covered	Not covered	No charge	None
	Skilled nursing care	30% coinsurance	50% coinsurance	No charge	None
	Durable medical equipment	30% coinsurance	50% coinsurance	No charge	None
	Hospice services	30% coinsurance	50% coinsurance	No charge	Limited to a maximum period of 6 months. Limited to 3 bereavement counseling sessions per occurrence.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	Dental is an Excepted Benefit under the health plan. For dental benefits, see Summary of Dental Benefits in your Plan 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
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Experimental or investigational treatment
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eyecare (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.)

- Charges related to Autism
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- 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 is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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

* For more information about limitations and exceptions, see your plan document. Contact the Plan Sponsor at 1-304-344-8331 to request a copy.

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 Plan Sponsor at 1-304-344-8331. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 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 1-304-344-8331.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-304-344-8331.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-304-344-8331.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-304-344-8331.

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	$600
Specialist copayment	$15
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$0
Coinsurance	$1,850
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,510

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

The plan's overall deductible	$600
Specialist copayment	$15
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$7,389

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$605
Coinsurance	$728
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,988

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

The plan's overall deductible	$600
Specialist copayment	$15
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$1,926

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$45
Coinsurance	$490
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,135

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