# 2027 SUMMARY OF BENEFITS

## January 1, 2027 – December 31, 2027

The Health Plan SecureChoice Optimum (PPO)
H8604-014-2

A Medicare Advantage Plan with Prescription Drugs

Our service area includes the following counties in **West Virginia:**

Barbour, Berkeley, Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, Wyoming.

This document is available in other formats such as braille, large print and audio CD. For additional information on available formats, call us at **1.877.847.7915 (TTY: 711)**.

## INTRODUCTION

The benefit information provided in this booklet is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, access our Evidence of Coverage online at healthplan.org/medicare. Or call us to request a copy.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get a copy by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

The Health Plan SecureChoice Optimum (PPO) is a PPO plan with a Medicare contract. Enrollment in The Health Plan SecureChoice – Optimum (PPO) depends on contract renewal.

## ELIGIBILITY

To join The Health Plan SecureChoice Optimum (PPO) you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

## WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN I USE?

This is a Preferred Provider Organization (PPO) plan. This means that even though we have a network of doctors, hospitals, pharmacies and other providers, you may use providers that are not in our network. However, if you use providers outside of our network, your costs may be higher. No referral is needed, but some services do require prior authorization from the plan.

Out-of-network/non-contracted providers are under no obligation to treat SecureChoice Optimum (PPO) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information,including the cost-sharing that applies to out-of-network services.

You can see current provider lists on our website at findadoc.healthplan.org. Or call us and we will send you a copy.

## HOW TO REACH US

If you are a member, call toll-free: 1.877.847.7907 (TTY: 711)

If you are not a member, call toll-free: 1.877.847.7915 (TTY: 711)

Hours of operation:

- October 1 to March 31, 8:00 a.m. to 8:00 p.m. Eastern, 7 days a week.
- April 1 to September 30, 8:00 a.m. to 8:00 p.m. Eastern, Monday through Friday.

Or visit our website: healthplan.org/medicare.




# Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1.877.847.7915 (TTY: 711)**.

**Understanding the Benefits**

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit healthplan.org/medicare or call **1.877.847.7915 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

**Understanding Important Rules**

- ☐ **Effect on Current Coverage**. Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ In addition to your monthly plan premium (if applicable), you must continue to pay your Medicare Part B premium if not otherwise paid by a third party like the state. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2028.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

| Premium, Deductible, and Maximum Out-of-Pocket Limit | |
|---|---|
| **Monthly Plan Premium** | $0<br>You must continue to pay your Medicare Part B premium. |
| **Annual Medical Deductible** | This plan does not have a medical deductible. |
| **Maximum Out-of-Pocket Responsibility (Does not include prescription drugs)** | $7,000 for Medicare-covered services that you receive from providers in our plan.<br>$9,550 for Medicare-covered services that you receive from providers both in and out of our plan.<br>Like all Medicare Advantage plans, this plan protects you by limiting your annual out-of-pocket costs for care. The amounts you pay for copays and coinsurance for Medicare covered Part A and Part B services count towards the maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount, you will not have to pay any additional out-of-pocket costs for Medicare covered Part A and B services for the rest of the year. |

| Medical Benefits | THE HEALTH PLAN SECURECHOICE OPTIMUM (PPO) H8604-014-2<br>What You Pay On This Plan | |
|---|---|---|
| **Inpatient Hospital Coverage***<br>**(Per admission or stay)** | In-Network:<br>Days 1-6: $395 copay per day<br>Days 7-90: $0 copay<br>Days 91 and beyond: $0 copay | Out-of-Network:<br>30% co-insurance per stay |
| | Our plan covers an unlimited number of days for an inpatient hospital stay. | |
| **Outpatient Hospital Coverage*** | In-Network:<br>$500 copay for outpatient surgeries.<br>$0 copay for diagnostic colonoscopies.<br>$500 copay for observation visits | Out-of-Network:<br>30% co-insurance |
| **Ambulatory Surgical Center*** | In-Network:<br>$500 copay | Out-of-Network:<br>30% co-insurance |
| **Doctor Visit: Primary Care Provider** | In-Network:<br>$0 copay | Out-of-Network:<br>$25 copay |
| **Doctor Visit: Specialist** | In-Network:<br>$45 copay<br>No referral needed. However, organizational authorization may be required for tertiary specialists. | Out-of-Network:<br>$60 copay |

| Medical Benefits | THE HEALTH PLAN SECURECHOICE OPTIMUM (PPO) H8604-014-2<br>What You Pay On This Plan | |
|---|---|---|
| **Preventive Care (Medicare-covered zero cost sharing preventive services)** | Medicare–covered zero cost sharing preventive services<br>$0 copay for the following:<br>• Abdominal aortic aneurysm screenings<br>• Alcohol misuse screenings and counseling<br>• Bone mass measurements<br>• Cardiovascular disease screenings<br>• Cardiovascular disease (behavioral therapy)<br>• Cervical and vaginal cancer screenings<br>• Colorectal cancer screenings<br>  o Blood-based biomarker tests<br>  o Colonoscopies<br>  o Computed tomography (CT) colonography<br>  o Fecal occult blood tests<br>  o Flexible sigmoidoscopies<br>  o Multi-target stool DNA tests<br>• Counseling to prevent tobacco use and tobacco-caused disease<br>• Depression screenings<br>• Diabetes screenings<br>• Diabetes self-management training<br>• Glaucoma screenings<br>• Hepatitis B Virus (HBV) infection screenings<br>• Hepatitis C virus screenings<br>• Human immunodeficiency virus (HIV) services:<br>  o HIV screenings<br>  o Pre-exposure prophylaxis (PrEP) for HIV prevention<br>• Lung cancer screenings<br>• Mammograms (screening)<br>• Medical nutrition therapy services<br>• Medicare Diabetes Prevention Program<br>• Obesity behavioral therapy<br>• Preventive visits:<br>  o “Welcome to Medicare” preventive visit<br>  o Yearly “Wellness” visit<br>• Pre-exposure prophylaxis (PrEP) for HIV prevention<br>• Prostate cancer screenings<br>• Sexually transmitted infections screenings and counseling<br>• Shots:<br>  o COVID-19 vaccines<br>  o Flu vaccines | Out-of-Network:<br>30% co-insurance |

| Medical Benefits | THE HEALTH PLAN SECURECHOICE OPTIMUM (PPO) H8604-014-2<br>What You Pay On This Plan | |
|---|---|---|
| | ○ Hepatitis B vaccines<br>○ Pneumococcal vaccines<br>Any other preventive services approved by Medicare during the contract year will be covered | |
| | **Annual Physical Exam**<br>$0 copay/1 per year | Out-of-Network:<br>$25 copay |
| **Emergency Care (Worldwide)** | In-Network:<br>$130 copay | Out-of-Network:<br>$130 copay |
| | If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care<br>Covered emergency services outside of the U.S. have a $25,000 annual plan max | |
| **Urgently Needed Services** | In-Network:<br>$40 copay | Out-of-Network:<br>$40 copay |
| | If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services | |
| **Diagnostic Radiological Service* (such as MRIs, CT scans)** | In-Network:<br>$0 or $250 copay<br>$250 for CT scans, MRI, MRA, PET and SPECT scans<br>$0 copay for all diagnostic mammograms and diagnostic bone density exams | Out-of-Network:<br>30% co-insurance |
| **Therapeutic Radiological Services* (such as radiation treatment for cancer)** | In-Network:<br>20% co-insurance | Out-of-Network:<br>30% co-insurance |
| **Lab Services*** | In-Network:<br>$0 copay | Out-of-Network:<br>30% co-insurance |
| **Diagnostic Tests and Procedures*** | In-Network:<br>$50 copay | Out-of-Network:<br>30% co-insurance |
| **Outpatient X-rays*** | In-Network:<br>$95 copay | Out-of-Network:<br>30% co-insurance |

| Medical Benefits | THE HEALTH PLAN SECURECHOICE OPTIMUM (PPO) H8604-014-2<br>What You Pay On This Plan | |
|---|---|---|
| **Hearing Services** | Medicare-covered hearing exam to diagnose and treat hearing and balance issues<br>In-Network:<br>$20 copay | Out-of-Network:<br>$20 copay |
| | Routine Hearing exam<br>In-Network:<br>$0 copay for one exam every year | Out-of-Network:<br>$60 copay for one exam every year |
| | Hearing aids:<br>Hearing aids are covered up to one per ear, every two years<br>- $399 copayment for Standard level hearing aid<br>- $599 copayment for Advanced level hearing aid<br>- $899 copayment for Premium level hearing aid<br>- Includes 2-year supply of batteries per aid (non-rechargeable models only) after purchase<br>- $0 copay for provider visits for fittings and adjustments, covered for 12 months after hearing aid purchase<br>A TruHearing provider must be used. | Out-of-Network:<br>80% co-insurance |
| **Medicare-covered Dental Services*** | In-Network:<br>$45 copay | Out-of-Network:<br>$60 copay |
| | This does not include services in connection with care, treatment, filling, removal, or replacement of teeth | |
| **Routine Dental Services** | This plan covers preventive and comprehensive dental services<br><u>Preventive Dental</u><br>You pay a $0 copay for:<br>• 3 oral exams every year<br>• 2 cleanings and 1 set of bitewing X-rays every year<br>• 1 full mouth X-ray every 3 years<br><u>Comprehensive Dental</u><br>This plan also covers up to a $1,000 allowance for covered comprehensive dental services every year. You pay $0 for covered in network dental services through Liberty Dental providers, and $0-50% for covered out of network dental services through non-Liberty Dental providers. This may include but is not limited to:<br>• Fillings<br>• Root canal | |

| Medical Benefits | THE HEALTH PLAN SECURECHOICE OPTIMUM (PPO) H8604-014-2<br>What You Pay On This Plan | |
|---|---|---|
| | • Periodontal scaling and root planing<br>• Extractions<br>• Crowns<br>• Dentures<br>Please refer to Chapter 4 in the plan's Evidence of Coverage for more details on prior authorizations, covered dental services, limitations, and exclusions.<br>Liberty Dental providers are considered in-network for this plan. You can find the dental directory on our website at healthplan.org/medicare, or by calling us at 1.877.847.7915 (TTY: 711). | |
| **Optional Supplemental Dental** | Additional comprehensive dental benefits are available with a separate monthly premium. See the "Optional Supplemental Benefits" section in the back of this book | |
| **Vision Services: Medicare-covered exam to diagnose and treat conditions of the eye** | In-Network:<br>$0 copay | Out-of-Network:<br>$25-$60 copay |
| **Vision Services: Medicare-covered eyewear** | In-Network:<br>$0 copay<br>Limited coverage of eyewear related to cataract surgery. | Out-of-Network:<br>30% co-insurance |
| **Vision Services: Routine eye exam** | In-Network:<br>$0 copay for one exam every year<br>Routine vision services are provided through plan participating providers.Contact the plan for more details. | Out-of-Network:<br>$60 copay for one exam every year |
| **Vision Services: Routine Eyewear** | In-Network:<br>$0 copay<br>This plan has a coverage limit for routine eyewear. We will cover up to $150 toward glasses (lens and frames) or contacts (including fitting exam) every year if purchased at a participating provider | Out-of-Network:<br>$15 copay |
| **Inpatient Mental Health Services* (Per admission or stay)** | In-Network:<br>Days 1-5: $375 copay per day<br>Days 6-90: $0 copay | Out-of-Network:<br>30% co-insurance |
| **Outpatient Individual or Group Mental Health Therapy Visit** | In-Network:<br>$45 copay | Out-of-Network:<br>$60 copay |

| Medical Benefits | THE HEALTH PLAN SECURECHOICE OPTIMUM (PPO) H8604-014-2<br>What You Pay On This Plan | |
|---|---|---|
| **Skilled Nursing Facility***<br>**(Per benefit period, as defined by Original Medicare)** | In-Network:<br>Days 1-20: $0 copay<br>Days 21-100 $221 copay per day<br>This plan covers up to 100 days in a skilled nursing facility during each benefit period. | Out-of-Network:<br>20% co-insurance |
| **Physical Therapy*** | In-Network:<br>$40 copay | Out-of-Network:<br>$60 copay |
| **Ambulance**<br>Authorization required for non-emergency Medicare services. | In-Network:<br>$275 copay for all other ambulance services<br>$500 copay for air ambulance services<br>The above cost shares are for Medicare-covered ambulance services only<br>Emergency transportation is covered worldwide. Covered emergency transportation services outside of the U.S. have a $25,000 annual plan maximum | Out-of-Network:<br>$275 copay for all other ambulance services<br>$500 copay for air ambulance services |
| **Transportation (Routine)** | Not covered | Not covered |
| **Medicare Part B Drugs***<br>Part B drugs may be subject to step therapy. See Evidence of Coverage for details | **In-Network:**<br>Most Part B drugs and biologicals will have a 20% coinsurance. However, Medicare publishes a list of certain Part B drugs and biologicals with prices that have increased faster than the rate of inflation. For these drugs and biologicals, the coinsurance will be 20% of the inflation-adjusted payment amount, which will be less than what they would pay in coinsurance otherwise. The amount could change throughout the year depending on the rate of inflation.<br>**Out-of-Network:**<br>Most Part B drugs and biologicals will have a 30% coinsurance. However, Medicare publishes a list of certain Part B drugs and biologicals with prices that have increased faster than the rate of inflation. For these drugs and biologicals, the coinsurance will be 30% of the inflation-adjusted payment amount, which will be less than what they would pay in coinsurance otherwise. The amount could change throughout the year depending on the rate of inflation. | |

**Services with an * may require your provider to obtain prior authorization from the plan.**

# Prescription Coverage

Costs may differ based on pharmacy type and status. For example, preferred/standard retail, mail order, long term care or home infusion pharmacies. For more information, please call us or access our Evidence of Coverage online at healthplan.org/medicare.

| **THE HEALTH PLAN SECURECHOICE OPTIMUM (PPO) H8604-014-2** | | | | |
|---|---|---|---|---|
| **Outpatient Prescription Drugs** | | | | |
| **Stage 1:**<br>**Annual Prescription (Part D) Deductible** | $0 deductible for Tier 1 and Tier 2<br>$425 for Tier 3, Tier 4, and Tier 5 Part D prescription drugs. | | | |
| **Stage 2:**<br>**Initial Coverage** | After you pay your yearly deductible, you pay the amount listed in the table(s) until your total yearly drug costs reach **$2,400**<br>There are preferred and standard retail pharmacies in our network. You will generally pay a lower copay at a preferred pharmacy. | | | |
| | **Preferred Retail Pharmacy 30-day supply** | **Standard Retail Pharmacy 30-day supply** | **Preferred Mail Order Pharmacy 30-day supply** | **Standard Mail Order Pharmacy 30-day supply** |
| **Tier 1: Preferred Generic** | $0 | $13 | $0 | $13 |
| **Tier 2: Generic** | $5 | $20 | $5 | $20 |
| **Tier 3: Preferred Brand** | 20% | 20% | 20% | 20% |
| **Tier 4: Non-Preferred Drug** | 25% | 25% | 25% | 25% |
| **Tier 5: Specialty Tier (Extended day supply not available in this Tier)** | 28% | 28% | 28% | 28% |
| | **Preferred Retail Pharmacy 90-day supply** | **Standard Retail Pharmacy 90-day supply** | **Preferred Mail Order Pharmacy 90-day supply** | **Standard Mail Order Pharmacy 90-day supply** |
| **Tier 1: Preferred Generic** | $0 | $39 | $0 | $39 |
| **Tier 2: Generic** | $15 | $60 | $15 | $60 |
| **Tier 3: Preferred Brand** | 20% | 20% | 20% | 20% |
| **Tier 4: Non-Preferred Drug** | 25% | 25% | 25% | 25% |
| **Tier 5: Specialty Tier (Extended day supply not available in this Tier)** | N/A | N/A | N/A | N/A |

| THE HEALTH PLAN SECURECHOICE OPTIMUM (PPO) H8604-014-2 | |
|---|---|
| **Stage 3:**<br>**Catastrophic Coverage** | You pay nothing for covered Part D drugs if you reach the Catastrophic Coverage Stage. |
| **IMPORTANT MESSAGE ABOUT WHAT YOU PAY FOR INSULIN AND VACCINES** | |
| You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible. | |
| Our plan covers most Part D vaccines at no cost to you. Call member services for more information. | |

## Medicare Prescription Payment Plan- Part D Rx

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January-December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan with drug coverage) can use this payment option. **All plans offer this payment option and participation is voluntary**.

If you select this payment option, each month you'll continue to pay your plan premium (if you have one), and you'll get a bill from your health or drug plan to pay for your prescription drugs (instead of paying the pharmacy). There's no cost to participate in the Medicare Prescription Payment Plan. Please contact the plan for details.

| Additional Benefits | THE HEALTH PLAN SECURECHOICE OPTIMUM (PPO) H8604-014-2<br>What You Pay On This Plan | |
|---|---|---|
| **Medicare-covered Foot Exams and Treatment (Podiatry)** | In-Network:<br>$45 copay | Out-of-Network:<br>$60 copay |
| **Routine Foot Care(Podiatry)** | In-Network:<br>$45 copay<br>Routine foot care covered for up to 2 visits every year | Out-of-Network:<br>$60 copay |
| **Durable Medical Equipment* (like wheelchairs and oxygen) and Prosthetics* (like braces and artificial limbs)** | In-Network:<br>20% co-insurance<br>Must meet certain criteria to be covered. Contact the plan for more details | Out-of-Network:<br>40% co-insurance |
| **Diabetic Monitoring Supplies*** | In-Network:<br>$0-20% coinsurance for each Medicare-covered supply to monitor blood glucose.<br>• $0 copay for Roche/Accu-Check or Abbott/Freestyle supplies including test strips, glucose monitors, solutions, lancets, and lancing devices at a network pharmacy.<br>• 20% coinsurance for NON-Roche/Accu-Check or Abbott/Freestyle supplies including test strips, glucose monitors, solutions, lancets, and lancing devices, with a medical exception, at a network pharmacy.<br>• 20% coinsurance for supplies including test strips, glucose monitors, solutions, lancets, and lancing devices when obtained through a contracted DME Provider.<br>Coverage is limited to 100 strips for a 30-day supply. Additional quantities require coverage review. | Out-of-Network:<br>40% co-insurance |

| Additional Benefits | THE HEALTH PLAN SECURECHOICE OPTIMUM (PPO) H8604-014-2<br>What You Pay On This Plan | |
|---|---|---|
| **Diabetic Therapeutic Shoes or Inserts*** | In-Network:<br>20% co-insurance | Out-of-Network:<br>40% co-insurance |
| **Health/Wellness Programs (e.g., fitness, tobacco cessation, etc.)** | In-Network:<br>$0 copay<br>SilverSneakers is the covered In-Network fitness program. | Out-of-Network:<br>80% co-insurance |
| **Home Health Services** | In-Network:<br>$0 copay | Out-of-Network:<br>30% co-insurance |
| **Cardiac/Pulmonary Rehabilitation Services** | In-Network:<br>$5 copay | Out-of-Network:<br>30% co-insurance |
| **Chiropractic Services*** | In-Network:<br>$15 copay<br>Medicare-covered chiropractic services only | Out-of-Network:<br>$60 copay |
| **Flex Debit Card:**<br>**Over-the-Counter Items (OTC)**<br>**Healthy Food ◄**<br>**Utility Bills ◄** | $0 copay<br>$50 allowance per calendar quarter will be loaded onto a provided debit card.<br>The unused quarterly allowance amount will not carry over to the next quarter. Unused amounts will not carry over to the next calendar year.<br>Members can shop in-store or online through our contracted vendor.<br>◄ For SSBCI eligible members, funds can be used for Over-the-Counter items, Healthy Food purchases, and Utility Bill Assistance<br>For non-SSBCI eligible members, funds can be used for Over-the-Counter items only.<br>Benefits marked with ◄ are Special Supplemental Benefits for the Chronically Ill (SSBCI), for qualifying members with conditions such as diabetes mellitus, cardiovascular disorders, chronic heart failure, cancer, and chronic lung disorders. A complete list of conditions and more details are available at the end of this benefit chart. Having a listed condition does not guarantee eligibility. Other requirements apply. | |
| **Telehealth Services** | $0 copay<br>This applies to:<br>• Primary Care Physician Services | |

| Additional Benefits | THE HEALTH PLAN SECURECHOICE OPTIMUM (PPO) H8604-014-2<br>What You Pay On This Plan |
|---|---|
| | • Physician Specialist Services<br>• Individual Sessions for Mental Health Specialty Services<br>• Individual Sessions for Psychiatric Services<br>Individual Sessions for Outpatient Substance Abuse Services must be accessed through our contracted vendor. |
| **Wellness Incentive Program** | Earn $25 on your InComm card after receiving any of these services:<br>• Breast Cancer Screening<br>• Colorectal Cancer Screening<br>• Annual Wellness Visit<br>Limit one incentive reward per service per year. |

**Services with an * may require your provider to obtain prior authorization from the plan.**

Services marked with ◄ are Special Supplemental Benefits for the Chronically Ill (SSBCI), for qualifying members with one or more of the following chronic conditions: cardiovascular disorders, chronic heart failure, diabetes mellitus, chronic alcohol use disorder and other substance use disorders (SUDs), autoimmune disorders, cancer, dementia, overweight, obesity, and metabolic syndrome, chronic gastrointestinal disease, chronic kidney disease (CKD), severe hematologic disorders, HIV/AIDS, chronic lung disorders, chronic and disabling mental health conditions, neurologic disorders, stroke, post-organ transplantation, immunodeficiency and immunosuppressive disorders, conditions associated with cognitive impairment, conditions with functional challenges, chronic conditions that impair vision, hearing (deafness), taste, touch, and smell, and conditions that require continued therapy services in order for individuals to maintain or retain functioning.

Having a listed condition does not guarantee eligibility for SSBCI benefits; you must be chronically ill to qualify, with one or more medically complex conditions that are life threatening or significantly limit overall health or function, have a high risk of hospitalization or other adverse health outcomes, and require intensive care coordination.

Eligibility will be determined upon member or provider request by The Health Plan after enrollment, based on information collected from you and your health care providers. All applicable eligibility requirements must be met before the benefits are provided. For details, please contact us.

# Optional Supplemental Benefits - Dental

This coverage is available to you for an additional monthly cost of **$16.30**. This will be in addition to your The Health Plan SecureChoice Optimum PPO monthly premium.

Our plan will cover up to $1,500 for dental services per plan year. You will be responsible for a portion of the cost for services, as indicated below. The benefit is administered through Liberty Dental providers.

This is not a complete description of benefits. There are covered services that are not listed here. In addition, some of the following services have limitations, exclusions, and maximums. Please contact the plan for complete details.

| | |
|---|---|
| **Monthly Premium** | **$16.30** |
| **Maximum Benefit – Plan Coverage Limit** | **$1,500 per year** |

| Covered Dental Benefits | In-Network: You Pay | Out-of-Network: You Pay |
|---|---|---|
| **Basic Benefits** | | |
| Fillings | 20% | 50% |
| Resin-based Composite | 20% | 50% |
| Endodontics | 50% | 75% |
| Scaling and Root Planing | 50% | 75% |
| Periodontal Maintenance | 50% | 75% |
| General Anesthesia/Intravenous Sedation | 50% | 75% |
| **Major Benefits** | | |
| Crown | 50% | 75% |
| Extractions | 50% | 75% |
| Complete and Partial Dentures | 50% | 75% |
| Denture Adjustment | 50% | 75% |
| Denture Repair | 50% | 75% |
| Denture Reline/Rebase | 50% | 75% |

**How to add this additional Optional Supplemental dental coverage to your plan:** Mark the appropriate section on your initial Medicare Advantage plan enrollment form. You can also add this coverage: Up to 60 days after your effective date or during the Annual Enrollment Period (AEP). This coverage will have an additional monthly cost. Your options are listed on the enrollment form. Please contact the plan for complete details.

## *Discrimination is Against the Law*

The Health Plan of West Virginia (The Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex (consistent with the scope of sex discrimination as described by applicable law).
The Health Plan does not exclude people or treat them less favorably because of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex.

The Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Director, Health Equity & Wellness.

If you believe that The Health Plan of West Virginia has failed to provide these services or discriminated in another way on the basis of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex, you can file a grievance with: Director, Health Equity & Wellness, 1110 Main Street, Wheeling, West Virginia 26003, Phone: 740.699.6142, TTY: 711, Fax: 740.699.6163, civilrightscoordinator@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Director, Health Equity & Wellness is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at The Health Plan's website: healthplan.org.

TheHealthPlan
1110 Main Street, Wheeling, WV 26003-2704 | healthplan.org

**English**

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1.877.847.7907 (TTY: 711) or speak to your provider.

**Spanish**

Español
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1.877.847.7907 (TTY: 711) o hable con su proveedor.

**Chinese (Simplified)**

中文 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提 供适当的辅助工具和服务，以无障碍格式提供信息。致电 1.877.847.7907 (TTY: 711) 或咨询您的服务提供商。

**Chinese (Traditional)**

中文
注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1.877.847.7907 (TTY: 711) 或與您的提供者討論。

**German**

Deutsch
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1.877.847.7907 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

**Arabic**

العربية
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1.877.847.7907 (TTY: 711) أو تحدث إلى مقدم الخدمة.

**Pennsylvania Dutch**
Hinweis: Wenn du Pennsylvaniä Deitsch redst, kannscht du kostenlose Sprachhilfe-Dienste nutze. Auwersichtliche Hilfsmittel und Dienste, um Information in zugängliche Formate zu gebbe, sin au kostenlos verfügbar. Ruf 1.877.847.7907 (TTY: 711) an oder red mit deinem Anbieter für Hilfe.

**Russian**
РУССКИЙ
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1.877.847.7907 (TTY: 711) или обратитесь к своему поставщику услуг.

**French**
Français
ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1.877.847.7907 (TTY: 711) ou parlez à votre fournisseur.

**Vietnamese**
Việt
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1.877.847.7907 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

**Korean**
한국어
주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1.877.847.7907 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Cushite (Oromo)**
HUBACHIISA: Afaan Oromoo dubbattu yoo ta'eef, tajaajilli gargaarsa Afaan Hiikuu (Turjumaanaa) bilisaan kan isiniif dhiyaatu ta'a. Gargaarsi walqabataa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa unkaalee dhaqqabamoo ta'aniin kennuunis bilisaan ni argama. 1.877.847.7907 (TTY: 711) irratti bilbilaa ykn dhiyeessaa keessan waliin haasa'aa.

**Japanese**
日本語
注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1.877.847.7907 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

**Italian**
Italiano
ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama 1.877.847.7907 (TTY: 711) o parla con il tuo fornitore.

**Dutch**
Nederlands
LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1.877.847.7907 (TTY: 711) of spreek met je provider.

**Ukrainian**
українська мова
УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1.877.847.7907 (TTY: 711) або зверніться до свого постачальника.

**Romanian**
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. De asemenea, sunt disponibile gratuit ajutoare și servicii auxiliare adecvate pentru a furniza informații în formate accesibile. Sunați la 1.877.847.7907 (TTY: 711) sau vorbiți cu furnizorul dvs.

**Tagalog**
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1.877.847.7907 (TTY: 711) o makipag-usap sa iyong provider.

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