Summary of Benefits
Plan B

Medical Benefit		
Annual Deductible	Individual Coverage, In-Network	$800
	Family Coverage, In-Network	$1,600
	Individual Coverage, Out-of-Network	$1,600
	Family Coverage, Out-of-Network	$3,200

Annual Out-of-Pocket Maximum	Individual Coverage, In-Network	$2,500
	Family Coverage, In-Network	$5,000
	Individual Coverage, Out-of-Network	$5,000
	Family Coverage, Out-of-Network	$10,000

Annual Medical Benefit Maximum per Member	Individual & Family Coverage	$200,000

Prescription Drug Benefit		
Annual Deductible	Individual Coverage	$400
	Family Coverage	$800
Annual Out-of-Pocket Maximum	Individual Coverage	$2,000
	Family Coverage	$4,000

Annual Prescription Drug Benefit Maximum Per Member	Individual & Family Coverage	$25,000

All Benefits		
Combined Lifetime Benefit Maximum Per Member – Medical & Prescription Drugs	Individual & Family Coverage	$1,000,000

This Summary of Benefits is part of your Policy for health coverage with AccessWV.

Note: Some members will be subject to a 6-month waiting period for pre-existing conditions before claims for services related to their pre-existing health condition will paid by AccessWV.

AccessWV Summary of Benefits – Partial Listing of Covered Services

Medical Benefits			
	Cost to Member		
Physician Services	WV Network	Out-of-State Network ♦	Out-of-Network ♦
Adult routine physical exams (including prostate & gyn exam with Pap Smear)	$10 copay (for office visit, other services additional)	30% coinsurance*	40% coinsurance*
Diagnostic x-ray, lab & testing	20% coinsurance*		
Screening mammogram	$0, Covered in full		
Physician inpatient visits	20% coinsurance*		
Office visits - primary care	$15 copay		
Office visits - specialty care	$15 copay		
Prenatal care (routine care only)	$0 copay*		
Second surgical opinion	$15 copay, $0 copay if required by AccessWV		
Well child care & immunizations	$0, Covered in full	$0, Covered in full	$0, Covered in full
Inpatient Services	WV Network	Out-of-State Network ♦	Out-of-Network ♦
Semi-private room; ancillaries; therapy services; x-ray, lab, surgical services & general nursing care	20% coinsurance*	30% coinsurance*	$500 copay + 40% coinsurance*
Maternity care (delivery)			
Rehabilitation facility (150 day limit per member per plan year)			
Skilled nursing facility (100 day limit per member per plan year)			
Hospital Outpatient Services	WV Network	Out-of-State Network ♦	Out-of-Network ♦
Ambulatory/outpatient surgery	$50 copay + 20% coinsurance*	$75 copay + 30% coinsurance*	$100 copay + 40% coinsurance*
Preadmission testing	20% coinsurance*	30% coinsurance*	40% coinsurance*
Mental Health & Chemical Dependency Benefits	WV Network	Out-of-State Network ♦	Out-of-Network ♦
Outpatient mental health & chemical dependency (20 visit limit per member per plan year)	20% coinsurance*	30% coinsurance*	40% coinsurance*
Inpatient mental health & chemical dependency (30 day limit per member per plan year)	20% coinsurance*	30% coinsurance*	$500 copay + 40% coinsurance*
Inpatient detoxification	20% coinsurance*	30% coinsurance*	$500 copay + 40% coinsurance*

* Medical deductible applies, if not already met.

♦ **Prior Authorization Requirement for Out-of-State Services:** To qualify for the coverage shown, services received from "Out-of-State Network" providers or "Out-of-Network" providers must receive prior authorization from AccessWV. Without prior authorization, a penalty will apply. This requirement does not apply to Emergency Care.

This is a Summary of Benefits provided by AccessWV and other limitations of coverage apply. Please see your Policy for more details.

AccessWV Summary of Benefits – Partial Listing of Covered Services

		Cost to Member	
Other Services	WV Network	Out-of-State Network ♦	Out-of-Network ♦
Allergy testing & treatment	20% coinsurance*	30% coinsurance*	40% coinsurance*
Cardiac & pulmonary rehabilitation (36 session limit per member per plan year)			
Dental services – accident related or coverage for impacted teeth only			
Diabetic supplies	Covered under prescription drug plan		
Durable medical equipment (DME)	20% coinsurance*	30% coinsurance*	40% coinsurance*
Home health services and supplies			
Hospice			
Infertility treatment (diagnostic service only, artificial methods of treatment & prescriptions not covered)			
Medical supplies			
Outpatient therapies (acupuncture, chiropractic, occupational therapy, physical therapy, speech therapy, etc.) (combined limit of 20 visits per member per plan year)			
Prosthetics			
Radiation & chemotherapy			
Emergency Care	WV Network	Out-of-State Network	Out-of-Network
Emergency ambulance (medically necessary)	20% coinsurance*	30% coinsurance*	40% coinsurance*
Emergency services (certified as emergency)	$25 copay + 20% coinsurance*		
Emergency room treatment (non-emergency)	$50 copay + 20% coinsurance*	$50 copay + 30% insurance*	$50 copay + 40% coinsurance*
Urgent care	20% coinsurance*	30% coinsurance*	40% coinsurance*
Special Benefit	WV Network & Out-of-State Network *(if not available in WV)*	Out-of State Network *(if available in WV)* ♦	Out-of-Network ♦
Transplants	20% coinsurance*	$7,500 additional deductible + 30% coinsurance*	$10,000 additional deductible + 40% coinsurance*
Transplant-related transportation & lodging	$0 up to $5,000* then member pays all	Member pays all expenses	Member pays all expenses

* Medical deductible applies if not already met.

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Prescription Drug Benefits (Preferred Drug List with Mandatory Generics)		
	Cost to Member*	
	In-Network	Out-of-Network
Generic drug	$5	$5 + $3 out-of-network copay
Formulary brand necessary	$15	$15 + $3 out-of-network copay
Brand requested by member	$5 + full cost difference from generic	$5 + $3 out-of-network copay + full cost difference from generic
Non-formulary brand	$50	$50 + $3 out-of-network copay
Maintenance medication discount	90-day supply for 2-month copay in mail order program or Retail Maintenance Network (some restrictions apply)	No discount available

* All costs are after the pharmacy deductible is met.