



Summary of Benefits

This is a summary of benefits provided by AccessWV and other limitations of coverage apply. Full coverage details are provided in the AccessWV Policy with members. Annual deductibles and maximums are based on a Plan Year, which begins July 1 and ends June 30 of the following year.

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

MEDICAL BENEFITS		Plan A	Plan B	Plan C	Plan D
Annual Deductible:	Individual, In-Network	\$400	\$800	\$2,000	\$4,000
	Family, In-Network	\$800	\$1,600	\$4,000	\$8,000
	Individual, Out-of-Network	\$800	\$1,600	\$4,000	\$8,000
	Family, Out-of-Network	\$1,600	\$3,200	\$8,000	\$16,000
Annual Out of Pocket Maximum: (after deductible)	Individual, In-Network	\$2,000	\$2,500	\$3,000	\$5,000
	Family, In-Network	\$4,000	\$5,000	\$6,000	\$10,000
	Individual, Out-of-Network	\$4,000	\$5,000	\$6,000	\$10,000
	Family, Out-of-Network	\$8,000	\$10,000	\$12,000	\$20,000
Annual Benefit Maximum Per Member		\$1 million	\$1 million	\$1 million	\$1 million
PRESCRIPTION DRUG BENEFITS		Plan A	Plan B	Plan C	Plan D
Annual Deductible:	Individual	\$200	\$400	\$1,000	\$2,000
	Family	\$400	\$800	\$2,000	\$4,000
Annual Out-of-Pocket Maximum: (after deductible)	Individual	\$2,000	\$2,000	\$2,000	\$2,000
	Family	\$4,000	\$4,000	\$4,000	\$4,000
Annual Benefit Maximum Per Member:		\$50,000	\$50,000	\$50,000	\$50,000
Lifetime Benefit Maximum Per Member – All Benefits		\$1 million	\$1 million	\$1 million	\$1 million



PHYSICIAN SERVICES	In-Network, WV	In-Network, non-WV**	Out-of-Network**
Adult Routine Physical Exams (including prostate and gyn with pap smear)	\$10 Copay (for office visit, other services additional)	30% Coinsurance*	40% Coinsurance*
Diagnostic X-ray, lab and testing	20% Coinsurance*	30% Coinsurance*	40% Coinsurance*
Screening Mammogram	\$0, Covered in full	30% Coinsurance*	40% Coinsurance*
Physician inpatient visits	20% Coinsurance*	30% Coinsurance*	40% Coinsurance*
Physician office visits - primary care	\$15 Copay	30% Coinsurance*	40% Coinsurance*
Physician office visits - specialty care	\$25 Copay	30% Coinsurance*	40% Coinsurance*
Prenatal Care (Routine care only)	\$0, Covered in full	30% Coinsurance*	40% Coinsurance*
Second surgical opinion	\$15 Copay (no copay if required by AccessWV)	30% Coinsurance*	40% Coinsurance*
Well child exams and immunizations	\$0, Covered in full	\$0, Covered in full	\$0, Covered in full
INPATIENT SERVICES	In-Network, WV	In-Network, non-WV**	Out-of-Network**
Semiprivate room; ancillaries; therapy services, x-ray, lab, surgery related, and general nursing care	20% Coinsurance*	30% Coinsurance*	\$500 Copay + 40% Coinsurance*
Maternity Care (delivery)	20% Coinsurance*	30% Coinsurance*	\$500 Copay + 40% Coinsurance*
Rehabilitation Facility (150 day limit per member per plan year)	20% Coinsurance*	30% Coinsurance*	\$500 Copay + 40% Coinsurance*
Skilled Nursing Facility (100 day limit per member per plan year)	20% Coinsurance*	30% Coinsurance*	\$500 Copay + 40% Coinsurance*
HOSPITAL OUTPATIENT SERVICES	In-Network, WV	In-Network, non-WV**	Out-of-Network**
Ambulatory/Outpatient Services	\$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	In-Network, WV	In-Network, non-WV**	Out-of-Network**
Outpatient Chemical Dependency & Mental Health (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*
OTHER SERVICES	In-Network, WV	In-Network, non-WV**	Out-of-Network**
Allergy Testing and Treatment	20% Coinsurance*	30% Coinsurance*	40% Coinsurance*
Cardiac and Pulmonary Rehabilitation (36 session limit per member per plan year)	20% Coinsurance*	30% Coinsurance*	40% Coinsurance*
Dental Services - Accident Related	20% Coinsurance* + \$500 Copay	30% Coinsurance* + \$500 Copay	40% Coinsurance* + \$500 Copay
Diabetic Supplies	Covered under prescription drug plan	Covered under prescription drug plan	Covered under prescription drug plan
Durable Medical Equipment (DME)	20% Coinsurance*	30% Coinsurance*	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 "In-Network, Non-WV 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.

OTHER SERVICES	In-Network, WV	In-Network, non-WV**	Out-of-Network**
Home Health Services & Supplies	20% Coinsurance*	30% Coinsurance*	40% coinsurance*
Hospice	20% Coinsurance*	30% Coinsurance*	40% coinsurance*
Medical Supplies	20% Coinsurance*	30% Coinsurance*	40% coinsurance*
Outpatient Therapies (20 visit combined limit per member per plan year)	20% Coinsurance* + \$10 Copay per visit	30% Coinsurance* + \$10 Copay per visit	40% coinsurance* + \$10 Copay per visit
Prosthetics	20% Coinsurance*	30% Coinsurance*	40% coinsurance*
Radiation and Chemotherapy	20% Coinsurance*	30% Coinsurance*	40% coinsurance*
EMERGENCY CARE	In-Network, WV	In-Network, non-WV**	Out-of-Network**
Emergency Ambulance (Medically Necessary)	NO Copay + deductible + 20% Coinsurance*	\$25 Copay + deductible + 30% Coinsurance*	\$25 Copay + deductible + 40% Coinsurance*
Emergency services at Emergency Room (and Hospital Admission)	NO Copay + deductible + 20% Coinsurance*	\$25 Copay + deductible + 20% Coinsurance*	\$25 Copay + deductible + 20% Coinsurance*
Emergency services at Emergency Room (Certified Emergency)	\$50 Copay + deductible + 20% Coinsurance*	\$50 Copay + deductible + 30% Coinsurance*	\$50 Copay + deductible + 40% Coinsurance*
Emergency services at Emergency Room (non-emergency)	\$100 Copay + deductible + 20% Coinsurance*	\$100 Copay + deductible + 30% Coinsurance*	\$100 Copay + deductible + 40% Coinsurance*
Urgent Care	\$25 Copay + deductible + 20% Coinsurance*	\$50 Copay + deductible + 30% Coinsurance*	\$50 Copay + deductible + 40% Coinsurance*
SPECIAL BENEFIT	In-Network, WV (not available in WV)	In-Network, non-WV** (if available in WV)**	Out-of-Network**
Transplants	20% Coinsurance*	\$7,500 add'l deductible + 30% Coinsurance*	\$10,000 add'l deductible + 40% Coinsurance*
Transplant Related Transportation and 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. ** Prior Authorization Requirement for Out-of-State Services: To qualify for the coverage shown, services received from "In-Network, Non-WV 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.			
PRESCRIPTION DRUGS (Preferred Drug List with Mandatory Generics)	Cost to Member (After Pharmacy Deductible)		
	In-network	out-of-network	
I. Generic	\$5	\$5 + \$3 out-of-network copay	
II. Formulary Brand Necessary Brand Requested by Patient difference from generic	\$15 \$5 + full cost difference from generic	\$15 + \$3 out-of-network copay \$5 + \$3 out-of-network copay + full cost difference from generic	
III. Non-formulary Maintenance Medication (not applicable to Tier III drugs)	75% coinsurance 90 day supply for 2 months copay in mail order program or Retail Maintenance Network	75% coinsurance	
(Some restrictions may apply.)		No discount available	

*For current information on drug requirements for prior authorization, Step Therapy, quantity limits, and Common Specialty Medications, consult Express Scripts at 1-877-256-4680 or <http://www.peia.WV.gov/customers/providers/Pages/default.aspx>, Prescription Drug Benefits.

