



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		\$25,000	\$25,000	\$25,000	\$25,000

Lifetime Benefit Maximum Per Member - All Benefits	\$1 million	\$1 million	\$1 million	\$1 million
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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.

Annual deductibles and maximums are based on a Plan Year, which begins July 1 and ends June 30 of the following year.

This is a summary of benefits provided by AccessWV and other limitations of coverage apply. Full coverage details are provided in AccessWV's Policy with members.

AccessWV Summary of Benefits – Partial Listing of Covered Services Cost to Member

Physician Services	In-Network, WV	In-Network, Non-WV**	Out-of-Network**
Adult routine physical exams (including prostate & gyn exam with pap smear) (for office visit, other services additional)	\$10 copay	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	\$15 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 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	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 and 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*	30% coinsurance*	40% coinsurance*
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.

AccessWV Summary of Benefits – Partial Listing of Covered Services Cost to Member

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 visits combined limit per member per plan year)	20% coinsurance*	30% coinsurance*	40% coinsurance*
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)	20% coinsurance*	30% coinsurance*	40% coinsurance*
Emergency services (Certified as an emergency)	\$25 copay + 20% coinsurance*	\$25 copay + 20% coinsurance*	\$25 copay + 20% coinsurance*
Emergency room treatment (Non-emergency)	\$50 copay + 20% coinsurance*	\$50 copay + 30% coinsurance*	\$50 copay + 40% coinsurance*
Urgent Care	20% coinsurance*	30% coinsurance*	40% coinsurance*

Special Benefit	In-Network, WV & In-Network, Non-WV (not available in WV)	In-Network, Non WV (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 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
Generic	\$ 5	\$5 + \$3 Out-of-Network copay
Formulary brand necessary	\$15	\$15 + \$3 Out-of-Network copay
Brand requested by patient	\$5 + full cost difference from generic	\$5 + \$3 Out-of-Network copay+ full cost difference from generic
Non-Formulary	\$50	\$50 + \$3 Out-of-Network copay
Maintenance medication discount	90-day supply for 2 months copay in mail order program or Retail Maintenance Network. (Some restrictions may apply)	No discount available

