

**MedBen West
Virginia
BENEFIT SUMMARY**



CONTACTS

MedBen Sales Service
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Pharmacy Data Management (PDM)
Pharmacy Benefits Manager
(800) 800-7364 • www.pdmi.com



WELLNESS SERVICES	IN NETWORK	OUT OF NETWORK
Well Adult Care – Includes one routine physical per year and routine gynecological care	\$20 Copay	Not Covered
Well Baby and Child Care	\$20 Copay – Age 18 and under – Includes development assessment and anticipatory guidance, routine physical exams and medical history	Not Covered
Routine Immunizations – To Age 16	Paid at 100%, no Deductible	Paid at 100%, no Deductible
Hearing Screening – Birth to age 1, subject to \$75 calendar year maximum	\$20 Copay, if done in the physician's office; otherwise, Deductible and Coinsurance apply	Deductible and Coinsurance apply
Routine Screening Mammography – One screening per year, age 35 and older covered to state-mandated maximums	Paid at 100%, no Deductible	Deductible and Coinsurance apply
Cytologic Screening	\$20 Copay	Deductible and Coinsurance apply
Colorectal Cancer Screening	\$20 Copay	Deductible and Coinsurance apply
OUTPATIENT SERVICES (Other than maternity, mental health/drug abuse and alcoholism)	IN NETWORK	OUT OF NETWORK
Diagnostic Mammography	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Office Visits , including diagnostic x-ray and laboratory services performed in the office	\$20 Copay	Deductible and Coinsurance apply
Outpatient Diagnostic X-ray and Laboratory Services Not Performed in the Office , including ultrasounds and amniocentesis	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Outpatient Surgery , including surgery performed in the office	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Outpatient Hospice Care (Subject to \$10,000 lifetime maximum for inpatient/outpatient and in-network/out-of-network combined)	Deductible and Coinsurance apply	Deductible and Coinsurance apply
INPATIENT SERVICES	IN NETWORK	OUT OF NETWORK
Inpatient Hospital Care , including maternity	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Inpatient Hospice Care (Subject to \$10,000 lifetime maximum for inpatient/outpatient and in-network/out-of-network combined)	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Inpatient Physician Services	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Skilled Nursing and Sub-Acute Care (Subject to a maximum of 100 days per year for in-network/out-of-network combined)	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Urgent Care Services	Waiver of Deductible after \$50 Copay, and Coinsurance applies (Copay waived if admitted to hospital directly from ER or urgent care facility)	\$50 Copay, Deductible and Coinsurance apply (Copay waived if admitted to hospital directly from ER or urgent care facility)
Emergency Room (ER) Services	Waiver of Deductible after \$100 Copay, and Coinsurance applies (Copay waived if admitted to hospital directly from ER)	\$100 Copay, Deductible and Coinsurance apply (Copay waived if admitted to hospital directly from ER)
Follow-Up Care at Emergency Room	Not Covered	Not Covered
MATERNITY	IN NETWORK	OUT OF NETWORK
Pre- and Post-Natal Care (First visit only, per pregnancy)	\$20 Copay	Deductible and Coinsurance apply
Pre- and Post-Natal Care (after first visit), including delivery and in-hospital physician visits for mother and baby	Deductible and Coinsurance apply	Deductible and Coinsurance apply

OTHER MEDICAL SERVICES	IN NETWORK	OUT OF NETWORK
Inpatient Serious Mental Illness, including Alcoholism and Drug Abuse	Paid same as any other illness	Paid same as any other illness
Outpatient Serious Mental Illness, including Alcoholism and Drug Abuse	Paid same as any other illness	Paid same as any other illness
Outpatient Physical Therapy and Non-Surgical Spinal or Vertebral Column Treatment , subject to a maximum benefit of \$1,000 per year for in-network/out-of-network combined	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Occupational Therapy , subject to a maximum benefit of \$1,000 per year for in-network/out-of-network combined	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Restorative Speech Therapy , subject to a maximum benefit of \$1,000 per year for in-network/out-of-network combined	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Home Health Care Services , subject to a maximum benefit of 100 visits per year (4 hours = 1 visit) for in-network/out-of-network combined	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Primary Health Care Nursing Services	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Diabetes Treatment (Re-education/Refresher) , subject to a maximum benefit of \$100 per calendar year in-network/out-of-network combined	Deductible and Coinsurance apply	Deductible and Coinsurance apply
TMJ , subject to a lifetime maximum benefit of \$1000 for in-network/out-of-network combined	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Durable Medical Equipment , subject to a maximum of \$3,000 per year for in-network/out-of-network combined	Deductible and Coinsurance apply	Deductible and Coinsurance apply
Organ Transplants , including allogenic donor searches	Deductible and Coinsurance apply; in-network transplant benefit limited to \$1,000,000 lifetime maximum	Deductible and 50% Coinsurance apply; out-of-network transplant benefit limited to \$5,000 per transplant and \$1,000 per transplant for allogenic donor searches
PRESCRIPTION DRUG COVERAGE	IN NETWORK	OUT OF NETWORK
Covered Prescriptions via Retail Pharmacy <i>(Most self-injected speciality drugs fall under Tier III.)</i>	<ul style="list-style-type: none"> • Tier I – Lower Cost Generic/Brand Drugs & Select OTC – \$10 Copay • Tier II – Higher Cost Generic & Most Brand Drugs – \$25 Copay • Tier III – Higher Cost Brand Drugs – \$50 Copay 	50% Coinsurance for all out-of-network prescriptions
Covered Prescriptions via Mail Order <i>(Most self-injected speciality drugs fall under Tier III.)</i>	<ul style="list-style-type: none"> • Tier I – Lower Cost Generic/Brand Drugs & Select OTC – \$25 Copay • Tier II – Higher Cost Generic & Most Brand Drugs – \$60 Copay • Tier III – Higher Cost Brand Drugs – \$125 Copay 	Not Covered
About Our Prescription Drug Coverage		
MedBen offers a percentage copay option for employers seeking a more cost-effective benefit approach. Plan participants have 24/7 access to Rx claims and benefits information via our RxEOB website . Go to www.medben.com and click on "Online Client Services", select "MedBen Access", log in and click on "My Rx". MedBen uses Pharmacy Data Management for plan oversight and AmeriPharm for mail order service.		

This summary of benefits applies only to residents of the State of West Virginia. In addition, this summary contains only a partial description of the certificate and policy provisions. All benefits, services and supplies are subject to the terms and conditions of the certificate and policy as issued by Medical Benefits Mutual Life Insurance Co. In the event of a discrepancy between this summary and the actual policy and certificate documents, the certificate and policy will govern. The complete terms of coverage are set forth in the certificate of coverage (CMM-CERT-(MB/WV)-002) and policy (MBM-COMP-GM003) issued by Medical Benefits Mutual Life Insurance Co.