

**MedBen West  
Virginia  
BENEFIT SUMMARY**



**CONTACTS**

**MedBen Sales Service**  
(888) 633-2366 • www.medben.com

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



WELLNESS SERVICES	IN NETWORK	OUT OF NETWORK
<b>Well Adult Care</b> – Includes one routine physical per year and routine gynecological care	\$20 Copay	Not Covered
<b>Well Baby and Child Care</b>	\$20 Copay – Age 18 and under – Includes development assessment and anticipatory guidance, routine physical exams and medical history	Not Covered
<b>Routine Immunizations</b> – To Age 16	Paid at 100%, no Deductible	Paid at 100%, no Deductible
<b>Hearing Screening</b> – 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
<b>Routine Screening Mammography</b> – One screening per year, age 35 and older covered to state-mandated maximums	Paid at 100%, no Deductible	Deductible and Coinsurance apply
<b>Cytologic Screening</b>	\$20 Copay	Deductible and Coinsurance apply
<b>Colorectal Cancer Screening</b>	\$20 Copay	Deductible and Coinsurance apply
OUTPATIENT SERVICES (Other than maternity, mental health/drug abuse and alcoholism)	IN NETWORK	OUT OF NETWORK
<b>Diagnostic Mammography</b>	Deductible and Coinsurance apply	Deductible and Coinsurance apply
<b>Office Visits</b> , including diagnostic x-ray and laboratory services performed in the office	\$20 Copay	Deductible and Coinsurance apply
<b>Outpatient Diagnostic X-ray and Laboratory Services Not Performed in the Office</b> , including ultrasounds and amniocentesis	Deductible and Coinsurance apply	Deductible and Coinsurance apply
<b>Outpatient Surgery</b> , including surgery performed in the office	Deductible and Coinsurance apply	Deductible and Coinsurance apply
<b>Outpatient Hospice Care</b> (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
<b>Inpatient Hospital Care</b> , including maternity	Deductible and Coinsurance apply	Deductible and Coinsurance apply
<b>Inpatient Hospice Care</b> (Subject to \$10,000 lifetime maximum for inpatient/outpatient and in-network/out-of-network combined)	Deductible and Coinsurance apply	Deductible and Coinsurance apply
<b>Inpatient Physician Services</b>	Deductible and Coinsurance apply	Deductible and Coinsurance apply
<b>Skilled Nursing and Sub-Acute Care</b> (Subject to a maximum of 100 days per year for in-network/out-of-network combined)	Deductible and Coinsurance apply	Deductible and Coinsurance apply
<b>Urgent Care Services</b>	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)
<b>Emergency Room (ER) Services</b>	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)
<b>Follow-Up Care at Emergency Room</b>	Not Covered	Not Covered
MATERNITY	IN NETWORK	OUT OF NETWORK
<b>Pre- and Post-Natal Care</b> (First visit only, per pregnancy)	\$20 Copay	Deductible and Coinsurance apply
<b>Pre- and Post-Natal Care</b> (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
<b>Inpatient Serious Mental Illness, including Alcoholism and Drug Abuse</b>	Paid same as any other illness	Paid same as any other illness
<b>Outpatient Serious Mental Illness, including Alcoholism and Drug Abuse</b>	Paid same as any other illness	Paid same as any other illness
<b>Outpatient Physical Therapy and Non-Surgical Spinal or Vertebral Column Treatment</b> , 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
<b>Occupational Therapy</b> , 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
<b>Restorative Speech Therapy</b> , 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
<b>Home Health Care Services</b> , 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
<b>Primary Health Care Nursing Services</b>	Deductible and Coinsurance apply	Deductible and Coinsurance apply
<b>Diabetes Treatment (Re-education/Refresher)</b> , subject to a maximum benefit of \$100 per calendar year in-network/out-of-network combined	Deductible and Coinsurance apply	Deductible and Coinsurance apply
<b>TMJ</b> , subject to a lifetime maximum benefit of \$1000 for in-network/out-of-network combined	Deductible and Coinsurance apply	Deductible and Coinsurance apply
<b>Durable Medical Equipment</b> , subject to a maximum of \$3,000 per year for in-network/out-of-network combined	Deductible and Coinsurance apply	Deductible and Coinsurance apply
<b>Organ Transplants</b> , 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
<b>Covered Prescriptions via Retail Pharmacy</b> <i>(Most self-injected speciality drugs fall under Tier III.)</i>	<ul style="list-style-type: none"> <li>• <b>Tier I</b> – Lower Cost Generic/Brand Drugs &amp; Select OTC – \$10 Copay</li> <li>• <b>Tier II</b> – Higher Cost Generic &amp; Most Brand Drugs – 40% of prescription cost</li> <li>• <b>Tier III</b> – Higher Cost Brand Drugs – 40% of prescription cost + \$25 Copay; maximums per prescription are \$300 per 30-day supply, \$600 per 60-day supply, and \$900 per 90-day supply</li> </ul>	50% Coinsurance for all out-of-network prescriptions
<b>Covered Prescriptions via Mail Order</b> <i>(Most self-injected speciality drugs fall under Tier III.)</i>	<ul style="list-style-type: none"> <li>• <b>Tier I</b> – Lower Cost Generic/Brand Drugs &amp; Select OTC – \$25 Copay</li> <li>• <b>Tier II</b> – Higher Cost Generic &amp; Most Brand Drugs – 40% of prescription cost</li> <li>• <b>Tier III</b> – Higher Cost Brand Drugs – 40% of prescription cost + \$50 Copay; maximum per mail order prescription is \$900</li> </ul>	Not Covered
<b>About Our Prescription Drug Coverage</b>		
MedBen offers a <b>fixed copay</b> option for employers preferring a preset contribution structure. Plan participants have 24/7 access to Rx claims and benefits information via our <b>RxEOB website</b> . Go to <b>www.medben.com</b> 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.