Bob Wise
Governor

Tom Susman
Director

WV Toll-free: 1-888-680-PEIA • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: www.peia.state.wv.us

July 3, 2002

The Honorable Joe Manchin III
Secretary of State
State Capitol Complex
Building 1, Suite 157-K
1900 Kanawha Blvd., East
Charleston, WV 25305-0770

Dear Secretary Manchin:

Enclosed please find for filing an amended version of the West Virginia Public Employees Insurance Agency's Plan Document effective immediately for the Plan Year 2003 forward. This document supercedes the previous PEIA Plan Document.

Your cooperation and assistance are appreciated.

Sincerely,

Tom Susman
Director

TS/KH/jt

Enclosure

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Bob Wise
Governor

Tom Susman
Director

WV Toll-free: 1-888-680-PEIA • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: www.peia.state.wv.us

July 8, 2002

The Honorable Joe Manchin III
Secretary of State
State Capitol
Building 1, Suite 157-K
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0770

Dear Secretary Manchin:

Enclosed please find for filing an amended version of the West Virginia Public Employees Insurance Agency's Summary Plan Description effective immediately for the Plan Year 2003 forward. This document supercedes the previous PEIA Summary Plan Description.

Your cooperation and assistance are appreciated.

Sincerely,

Tom Susman
Director

TS/BKH/pb

Enclosure

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SECRETARY OF STATE

West Virginia Public Employees Insurance Agency Plan Document

West Virginia Public Employees Insurance Agency
1900 Kanawha Boulevard, East
Building 5, Room 1001, Capitol Complex
Charleston, WV 25305

Tom Susman
Director

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I

GENERAL INFORMATION

Introduction

The West Virginia Public Employees Insurance Agency ("PEIA") was created by an Act of the West Virginia Legislature effective July 1, 1990, replacing the West Virginia Public Employees Insurance Board. The PEIA is the State Agency responsible for administering a health and life benefit plan and other benefit offerings to eligible employees and retirees of the State, county boards of education, local governmental entities as well as other persons as specifically authorized to participate by statute. The PEIA also provides coverage for eligible dependents of participating employees and retirees.

The purpose of this Plan Document is to describe the various benefits offered by the PEIA to its insureds and how those benefits are administered. The PEIA also publishes a Summary Plan Description Booklet for its insureds, a less technical explanation of Plan benefits and how to use them.

Mission Statement

Administer affordable insurance-oriented programs and quality services that protect, promote, and benefit the health and well being of our members.

PEIA *diligently works to achieve this by...*

- improving benefits and choices for members.
- offering exceptional and caring customer service.
- providing education and awareness related to insurance and health care.
- advocating for members in matters that enhance being a PEIA member.
- implementing improved processes and updated documented policies.
- assisting members regarding insurance and health care benefits.
- administrating effective and efficient programs and services.
- collaborating with others so as to improve PEIA programs and services.
- improving benefits and choices for members.
- ensuring that claims and other requests are processed promptly and accurately.
- working with providers to ensure ample access to medical services at reasonable cost.

Organizational Overview

Director. The Director of the PEIA is appointed by the Governor with the advice and consent of the West Virginia Senate. He/she serves at the will and pleasure of the Governor and must have at least three years experience in health insurance administration prior to appointment. The Director is responsible for the day-to-day administration and management of the PEIA, makes all rules and regulations, and enters into any contracts necessary to carry out the PEIA's mission.

PEIA Staff. The Director is authorized to employ such administrative, technical and clerical staff as is necessary to properly administer the Plan. All positions in the PEIA, except for the Director, Deputy Director, Chief Financial Officer and the Director's Secretary will be included as classified personnel under the classification system of the Division of Personnel, of the Department of Administration.

Finance Board. The PEIA Finance Board consists of the Director and six members appointed by the Governor with the advice and consent of the West Virginia Senate for terms of four years and until the appointment of their successors. Of the six members appointed by the Governor, one member shall represent the interests of education employees, one member to represent the interests of public employees, one shall represent the interests of organized labor and three members to represent the public-at-large. The three at-large members must have experience in the financing, development or administration of benefit programs. All members must be citizens of West Virginia. Members are to be selected to represent, as broadly as possible, the different geographic areas of the State and no more than four (including the director) may be of the same political party.

The Finance Board is responsible for approving the Agency's Annual Financial Plan, monitoring the implementation of the Financial Plan and insuring the financial stability of the Agency.

Actuaries. The Finance Board will employ an impartial, professional actuary with demonstrated experience in analysis of large group health insurance plans to estimate the total financial requirements of the Agency for each fiscal year and to review and render a written professional opinion as to the fiscal soundness of any proposed financial plan or amendment to a financial plan. In addition, at the request of the Finance Board, the actuary shall develop alternative financing options and perform such other services as required.

Third-Party Administrators. The PEIA employs Third-Party Administrators (TPAs) to administer the claims processing and utilization review procedures for the Medical Benefits Plan, subrogation, the Prescription Drug Plan and to administer the Mountaineer Flexible Benefits Plan. A current listing of TPAs is contained in Appendix A.

Consultants and Other Contractors. The Director may contract with such consultants and other contractors as is necessary to administer the Plan.

Overview of Benefits

Medical Benefits Plan. The Medical Benefits Plan offers a broad range of benefits including:

- medically necessary services and supplies;
- pre-admission review and case management;
- wellness benefits; and
- an organ transplant network.

Prescription Drug Plan. The Prescription Drug Plan benefits include:

- coverage of medically necessary prescription drugs and supplies;
- discounts to the insured when using a Network pharmacy, a maintenance supply of medication and/or generic drugs;
- utilization review to detect contraindicated prescriptions and improper utilization of prescription drugs; and
- direct claims filing through Network pharmacies.

Basic and Optional Life and Accidental Death & Dismemberment (AD&D) Insurance. The PEIA's life insurance plan offers the following:

- Basic term life and AD&D coverage at no cost to the policyholder; and
- Optional term life insurance for the policyholder and qualified dependents that can be purchased by the policyholder.

Flexible Benefits Plan. The Mountaineer Flexible Benefits Plan includes the following:

- Dental, Vision, Short- and Long-Term Disability Insurance;
- a Medical Flexible Spending Account;
- a Dependent Care Flexible Spending Account;
- a Life Events Plan*; and
- a Legal Plan.*

*These are post-tax benefit options. Benefits for these plans are described in the Open Enrollment material mailed (annually) by the Plan Administrator.

Interpretation of Plan

The Director shall have ultimate authority to interpret the Plan for the PEIA. The Director may authorize others to interpret the Plan on the Agency's behalf, such as TPAs; however, such delegation shall not supersede the authority of the Director.

From time-to-time, this Plan may be superseded by legislation, enacted rules or regulations, court decisions, actions of the Finance Board or such other actions that may have a binding effect on the Agency. In such cases, the Plan Document will be amended, within a reasonable time, to reflect such actions.

Amendments to Plan Document

The PEIA reserves the right to amend all or any portion of this Plan Document in order to reflect changes required by court decisions, legislation, actions by the Finance Board, actions by the Director and for any other matters as are appropriate. The Plan Document will be amended within a reasonable time of any such actions. All amendments to the Plan Document must be in writing, dated and approved by the Director. The Director shall have sole authority to approve amendments to the Plan Document. The Plan Document and all approved amendments will be filed with the State of West Virginia Secretary of State's Office.

Appendices

The appendices to this Plan Document are incorporated into and made a part of this document.

HIPAA – Privacy Amendments – Information From Health Plans to Plan Sponsor

All health plans addressed in this Plan Document are amended consistent with the provisions contained in Appendix I and Appendix J hereto.

Definitions

The following definitions apply to all terms used in this Plan Document, except to the extent that the definitions may be contrary to definitions contained in Section IX (Medical Reimbursement Plan) and Section X (Dependent Care Reimbursement Plan), in which case the definitions contained in Sections IX and X will apply exclusively to those sections.

Average Wholesale Price (AWP) – Average wholesale price in relation to prescription drugs.

Active Employee - A person who is actively employed with a PEIA participating agency.

Acordia/PEIA Network - Any of the networks of medical providers available to PEIA insureds through direct or indirect contractual relationships with PEIA, including, but not limited to the Beech Street Network and the Medical Mutual of Ohio (MMO) SuperMed Plus Network.

Allowed Amount - The lesser of the actual charge and the maximum for a service as set by the PEIA.

Annual Deductible - The amount an insured must pay each year before the Plan pays any portion of the cost. Under the PPB Plan, office visits are not subject to the deductible. Only the Allowed Amounts for covered expenses will be applied to deductibles.

Beech Street - A national network of health care providers used for out-of-state care by the PEIA PPB Plan.

Beneficiary - The person who receives the proceeds of an insured's PEIA life insurance policy.

Coordination of Benefits - A practice insurance companies use to avoid double or duplicate payments when a person is covered by more than one policy.

Coinsurance - The percentage of the allowed amount that the insured must pay after the deductible has been met. This is the amount applied to the insured's annual out-of-pocket maximum. The insured is responsible for paying the coinsurance and deductible amounts directly to the provider of service.

Copayment - The set dollar amount an insured pays when using services, such as the flat dollar amount an insured pays for an office visit in the PEIA PPB Plan. Copayments are not applied to the annual deductible or out-of-pocket maximum.

Dependent - A person, other than a policyholder, who is eligible to participate in the Plan and who has been properly enrolled in the Plan by a policyholder.

Diagnosis-Related Groups (DRGs) - System of classifying medical cases and surgical procedures for payment based on diagnoses; used under Medicare's prospective payment system (PPS) for inpatient hospital services.

Director - The Director of the West Virginia Public Employees Insurance Agency.

Durable Medical Equipment (DME) - Medical equipment which can withstand repeated use and is not disposable, is used for a medical purpose, and is generally not useful to a person who is not sick or injured.

Eligible Expense - A necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Allowable expenses under the Plan are calculated according to PEIA fee schedules, rates and payment policies in effect at the time of services.

Emergency - An acute medical condition resulting from injury, sickness, pregnancy or mental illness which arises suddenly and unexpectedly and which a reasonably prudent lay person would believe requires immediate care and treatment to prevent the death, severe disability, or impairment of bodily function of an insured.

Employee - An active or retired employee as defined by the Plan.

Exclusions - Services, treatments, supplies, conditions, or circumstances that are not covered under the PEIA Plan.

Experimental, Investigative, or Unproven Procedures - Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan (at the time it makes a determination regarding coverage in a particular case) to be: (1) not approved by the United States Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, the United States Pharmacopoeia Dispensing Information, or the American Medical Association Drug Evaluations as appropriate for the proposed use; or (2) subject to review and approval by the Institutional Review Board for the proposed use; or (3) the subject of an ongoing clinical trial that meets the definition of Phase 1, 2, 3 Clinical Trial FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which it is proposed.

Explanation of Benefits (EOB) - A form sent to the policyholder after the claim has been evaluated or processed by the TPA-C or TPA-P. The EOB explains the action taken on the claim and includes information such as the PEIA allowed amount, the co-insurance amount, benefits available, reasons for denying payment, etc.

Express Scripts, Inc. (ESI) – The prescription drug TPA for PEIA.

Fringe Benefits Management Company (FBMC) -The flexible benefits TPA for PEIA.

Health Maintenance Organization (HMO) - The most restrictive type of managed care plan offered by PEIA. HMOs both provide and pay for health care for their members. Services received outside the HMO's network of providers are not covered unless they are required to treat a medical emergency, or otherwise authorized by the HMO.

Inpatient - An insured admitted as a bed patient to a hospital or other treatment facility for medical services.

Insureds - All persons who participate in the PEIA Plan, regardless of whether they are enrolled in the PPB Plan, a managed care plan or life insurance only. Insured refers to anyone who has coverage under any plan offered by PEIA.

Intracorp - The utilization management company handling precertification, medical case management and other utilization management functions for the PEIA PPB Plan.

Life Insurance Carrier - The life insurance company with whom PEIA contracts to provide life insurance benefits to PEIA members. Unum Provident is the life insurance carrier for PEIA.

Maximum Allowable Charge (MAC) - A limitation on billed charges for prescription costs allowable by the PEIA.

Managed Care Organization (MCO) - A generic term for HMOs or other similar models with which PEIA contracts. An MCO provides and pays for health care services.

Medical Case Management - A process by which Intracorp assures appropriate available resources for the care of serious long-term illness or injury. Intracorp's case management program can assist in providing alternative care plans.

Medicare Beneficiary - An individual eligible for Medicare as established by Title XVII of the Social Security Act of 1965, as amended.

Medicare Part A - The Medicare Hospital Insurance program, which covers the cost of hospital and related post-hospital services. As an entitlement program, it is available without payment of a premium. Beneficiaries are responsible for an initial deductible per episode of illness, and coinsurance for some services.

Medicare Part B - The Medicare Supplementary Insurance Program (SMI); covers the costs of physician services, outpatient laboratory and X-ray tests, durable medical equipment, outpatient hospital care, and certain other services. As a voluntary program, Part B requires payment of a monthly premium. Beneficiaries are responsible for a deductible and coinsurance payment for most covered services.

Member - A policyholder or dependent enrolled in a managed care plan offered by PEIA.

Mountaineer Flexible Benefits - Flexible benefits plan offered by PEIA.

Organ Transplant Network - Network of providers through which the PEIA PPB Plan offers organ transplant services. Providers are available nationally.

Outpatient - An insured who receives services in a hospital, alternative care facility, free-standing facility, or physician's office but who is not admitted as a bed patient.

PEIA - The West Virginia Public Employees Insurance Agency

PEIA Member - PEIA insureds who are participating in one of the managed care plans offered through the PEIA.

PEIA - PPO The PEIA **Preferred Provider Organization** (PPO) is the network of providers from whom PEIA Preferred Provider Benefit (PPB) members can receive care to get the highest benefit level. This network consists of West Virginia providers who accept PEIA's reimbursement, and out-of-state providers who participate in the Acordia/PEIA Network. These include, but are not limited to, the Beech Street Network and the Medical Mutual of Ohio SuperMed Plus Network.

Plan Year - A benefit period beginning July 1 and ending June 30. Prior to July 1, 1999, a benefit period began January 1 and ended December 31, with the exception of the Transitional Plan Year (January 1, 1999 through June 30, 1999).

Policyholder - The primary person who is eligible for and enrolled in the PEIA coverage, including active or retired employees, surviving dependents and those who are eligible and elect continued coverage under COBRA.

Preauthorization - A program which allows the insured to obtain prior approval for a service to assure that it will be covered by the Plan. Preauthorization is handled by Acordia National.

Precertification - The required process of reporting any inpatient stay and some outpatient procedures in advance to obtain approval for the admission or service. Intracorp handles precertification.

Pre-existing condition - A physical or mental condition that had been diagnosed, treated or for which the patient had incurred expenses before the patient became covered by the Plan.

Preferred Provider Benefit Plan (PPB) - The PEIA PPB Plan is the preferred provider benefit (PPB) plan offered by PEIA and includes the PEIA PPB Plan A and PEIA PPB Plan B as applicable. This plan replaced the PEIA Indemnity Plan on July 1, 1999. The PEIA PPB Plan provides medical care through a PPO Network of providers based on where an insured lives and where care is received.

PEIA PPB PLAN A - The standard PEIA PPB Plan offered to all eligible employees, regardless of employer. This plan is typically referred to as the PPB Plan.

PEIA PPB Plan B - The PPB Plan offered only to non-State agencies and deputy sheriffs who retire before age 55. Plan B offers lower premiums with higher deductibles, higher out-of-pocket maximums, and higher copayments for prescription drugs. The medical coverage is the same as in Plan A. The differences in deductibles, out-of-pocket maximums and drug copayments are noted in the benefit tables in the

Medical Benefits section and the Prescription Drug section of the Summary Plan Description (SPD). This plan is referred to as PPB Plan B.

Preferred Provider Organization (PPO) - The PEIA PPO is the network of physicians from whom PEIA PPB insureds can receive care to get the highest level of benefit.

This network consists of West Virginia physicians who accept PEIA's reimbursement and out-of-state physicians who participate in the Acordia/PEIA Network.

Premium - The payment required to keep a policy in force.

Prescription Drug Network - A group of pharmacies that have an agreement with the prescription drug TPA to provide services to PEIA insureds.

Primary Care Physician (PCP) - The medical provider selected by the PEIA member to serve as the primary care provider in accordance with the policies of a managed care plan.

Prior Approval - The required process of obtaining approval from Acordia for out-of-state or out-of-network care under the PEIA PPB Plan.

Prospective Payment System (PPS) - The methodology used for reimbursing inpatient hospital services.

Provider - A hospital, physician or other health care provider, licensed where required and performing within the scope of that license.

Provider Discount - A previously determined percentage which is deducted from a provider's charge or payment amount and is not billable to the insured when PEIA is the primary payor and the service is provided in West Virginia, or by a PPO Network provider.

Public Employees Insurance Agency (PEIA) - The state Agency that arranges for health and life insurance benefits for West Virginia's public employees. PEIA administers the PEIA PPB Plan, and contracts with all of the MCOs that are offered to public employees.

Reasonable and Customary - The prevailing range of charges and fees charged by Providers of similar training and experience, located in the same area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill or expertise to treat the patient successfully.

Resource-Based Relative Value Scale (RBRVS) - A fee schedule that bases professional services reimbursement on the amount of resource costs required to diagnose and/or treat patients – instead of paying based on charge histories.

Retired Employee - An insured who qualifies for PEIA by virtue of former employment with an agency eligible to participate in the PEIA Plan.

Secondary Payor - The plan or coverage whose benefits are determined after the primary plan has paid. The order of payment is determined by rule explained in Appendix G.

Specialty Care Physician (SCP) - A doctor who is a member of the HMO network. SCPs are specialists, and care from them requires a referral from the PCP.

Subrogation - The right of the PEIA to succeed to an insured's right of recovery against a third-party for benefits paid by the PEIA to, or on behalf of, an insured for services incurred for which a third-party is, or may be, legally liable.

Summary Plan Description (SPD) – An annual publication by PEIA which is provided to Policyholders and which summarizes the benefits, benefit levels, limitations and other requirements which are in the PEIA Plan Document.

TPA (Third-Party Administrator) - Any company with whom PEIA has contracted to provide services such as customer service, subrogation, utilization management and claims processing services to PEIA insureds.

TPA-C - Third-Party Administrator for Medical Claims.

TPA-P - Third-Party Administrator for the Prescription Drug Plan.

TPA-UM – Third-Party Administrator for Utilization Management for the Medical Benefits Program.

Utilization Management - A process by which PEIA controls health care and prescription drug costs. Components of utilization management include pre-admission and concurrent review of inpatient hospital stays, case management, and prior review of certain outpatient surgeries and prescription drug services.

Waiver of Premium - If an insured becomes disabled before the insured is age 60 and while insured, basic life insurance coverage will continue as long as the insured is disabled without further payment of premium if approved for a waiver of premium by the life insurance carrier. To be considered disabled, the insured must be unable to work for pay or profit. Application for a disability waiver of premium must be provided to the life insurance carrier.

II

PARTICIPATION

Eligibility to Participate

Active Employees. All regular full-time employees (including elected officials) of the following entities are eligible for enrollment in the PEIA insurance plans:

- State of West Virginia;
- West Virginia Legislature;
- State colleges and universities;
- county boards of education, including elected members of the boards of education;
- counties, cities, or towns (if the employer elects to participate in the program);
- comprehensive community mental health centers and mental retardation centers authorized pursuant to W.Va. Code § 27-2A-1, et seq.; and
- other individuals and government bodies specified in the West Virginia Code Chapter 5, Article 16 (if the employer elects to participate in the program).

Any eligible employer which is not mandated by State law to participate must enter a Participation Agreement with PEIA and agree to at least three years participation.

The term "full-time" means a permanent position that is considered full-time by the participating agency and that requires services to be performed at least 20 hours-a-week, unless otherwise exempt under the provisions of the West Virginia Code.

The PEIA is not an alternate plan for employees of local government agencies. Either PEIA is the only plan offered by the entity or the entity may not participate.

Twenty (20) Year Employees (Non-retirees). Employees who have 20 years of service with a participating employer and who have been covered by PEIA for 20 years and have separated from employment but not retired may participate and pay 105 percent of total cost of retiree coverage (W.Va. Code §5-16-13(K)). However, the employee must elect such coverage within two years of separation from employment.

Employees in this category will not be eligible for PEIA's premium assistance program or retiree premium subsidy.

Retired Employees. Active employees who retire are eligible for PEIA health and life benefits, provided they meet the minimum eligibility requirements of the applicable state retirement system and, as of March 13, 1999, if their last employer immediately prior to retirement is a participating employer under the State retirement system. Members of the Teacher's Defined Contribution Retirement plan must have twelve or more years of credited services to qualify to continue PEIA insurance benefits upon retirement.

Dependents. The term "dependent" includes the lawful spouse of the employee and all unmarried children under the age of 19 (see exceptions for students and disabled dependents). Included in this definition of children are:

- the employee's biological children;
- a legally adopted child (including a child living with the employee during a probationary period);
- a stepchild residing in the employee's household; and,
- a child residing with the employee in a household of which the employee is the head, who is fully dependent on the employee for support and maintenance, and who is actually supported solely by the employee.

Adopted children may be enrolled effective on the date of birth if enrolled during the calendar month of birth or the following two calendar months if legal documentation is provided stating that the PEIA policyholder became financially responsible for claims incurred by the adopted child on the date of birth. Any claim related to the birth mother is not payable under this Plan, unless she is PEIA eligible in her own right.

Coverage for a divorced spouse shall terminate on the last day of the month in which the final decree of divorce is entered. Coverage for a child shall terminate at the end of the month in which the child turns age 19, unless the child qualifies for continued coverage as a full-time dependent student or a disabled dependent as described in this Plan Document.

Student. A child who has reached the age of 19, is unmarried, a full-time student and fully dependent on the employee, may continue to be covered up to the end of the month that child turns 25, as long as the child remains unmarried, fully dependent and a full-time student. "Full-time student" is defined as a student attending courses in a graduate, undergraduate, trade, or professional school on a full-time basis.

A child enrolled in a U.S. military academy is not eligible for this continued coverage when the academy considers the student to be on active duty. Enrollment must be verified by information from the registrar of the school or university annually.

When a covered dependent attains age 19, PEIA will notify the employee that coverage will end unless the dependent child is a full-time student. PEIA will notify the TPA-C and TPA-P or managed care plan if the employee provides proof of continued eligibility. If a medical claim is submitted on behalf of a dependent student, the employee must provide proof of continued student status from the registrar's office of the university, school, or college to the TPA-C or managed care plan, as applicable. The verification remains in effect for one year. After the one-year period, verification of continued student status must again be obtained from the registrar's office.

A student who enters the U.S. Armed Forces on active duty to complete Basic Training and/or Advanced Individual Training (AIT) immediately after completing a school term/semester, and returns to full-time student status at the beginning of the next school term/semester after completion of such active duty training, will not be considered as having a lapse of insurance coverage. A copy of DD Form 214 (provided by U.S. Armed Forces at the time of discharge from active duty) must be provided to verify the period of active duty.

Full-time students between the ages of 19 and 25 who must temporarily withdraw from a college, university or other school for medical reasons may continue coverage. In order to continue coverage under this provision, the attending physician must certify in writing each month that the student is unable to attend classes on a full-time basis, state the medical diagnosis, and estimate when the student may be expected to return to full-time student status. If the PEIA, in consultation with the medical director of the TPA-C, determines the diagnosis does not warrant continuous coverage under this provision, proper notice terminating the student status will be forwarded to the insured. The medical leave of absence is reviewed after a twelve-month period to verify if the dependent qualifies for a disability. If not, then COBRA election must occur for coverage to continue.

Students who voluntarily withdraw from school or have a lapse of coverage and later re-enroll as a full-time student, may be reinstated for health benefit coverage; in this case, student health benefit coverage will become effective the first day of the month following the date of enrollment in the Plan and may be subject to pre-existing condition limitations.

Disabled Dependents. A dependent may be covered by the PEIA after age 19 (or age 25 if a full-time student) if he/she is:

- incapable of self support because of mental retardation, mental illness, or physical disability that began prior to age 19 (or age 25 if while covered as a full-time student); and

- incapable of self-sustaining employment and primarily dependent on the policyholder for support and maintenance.

Written verification of the illness or disability by the family physician is required when the dependent reaches age 19 (or at the time of the disability or illness if a full-time student), and periodically thereafter on the anniversary of the last date of verification unless the disability was approved for the dependent's lifetime.

The pre-existing conditions clause as, described in this Plan, is waived for a disabled dependent.

Surviving Dependents. The PEIA Medical Benefits Plan is available to the surviving spouse and dependents of a deceased active or retired employee who were enrolled and covered under the deceased employee's insurance coverage at the time of the employee's death. A surviving spouse who is pregnant at the time of the death of the employee may enroll the newborn child. Surviving dependents are not eligible for life insurance.

The surviving dependent must enroll in the calendar month the employee's death occurs or the following two calendar months to avoid any lapse in coverage and the imposition of limitations due to pre-existing conditions. Also, surviving dependents must enroll in the same plan in which they were covered at the time of the policyholder's death. During open enrollment, they may select any plan for which they are eligible. When surviving dependents become entitled to Medicare, the PEIA becomes the secondary payer. Coverage for surviving dependents terminates at the end of the month in which the surviving dependent no longer elects to participate, fails to pay the premium, or becomes ineligible due to age or marriage.

Enrollment

Procedures. Active employees may enroll in the PEIA Plan at their place of employment, retirees may enroll through their retirement system, and qualified surviving spouses and dependents may enroll either through PEIA or the policyholder's retirement system, as applicable. At the time of enrollment, the enrollee may select the type of coverage (PPB Plan or managed care) and enroll any eligible dependents. Eligible dependents covered by the PEIA must participate in the same health plan as the policyholder.

Participation in the PEIA benefits plan is not automatic. Policyholders must complete the proper enrollment forms. Enrollment in a PEIA benefit plan authorizes a policyholder's employer or retirement system to deduct premiums for coverage from his/her salary or pension. Policyholders are responsible for notifying their employer (if actively employed) or their retirement system (if retired) of any change in their address, marital status, or status of their dependent(s). It is the responsibility of the employer benefits coordinator or the retirement system to notify PEIA of such changes.

When both spouses are eligible for PEIA coverage:

1) each may enroll as a policyholder in the PPB Plan;

2) each may enroll separately, with one being a policyholder in the PPB Plan and one being a policyholder in a managed care plan;

3) each may select a different managed care plan, although both spouses can't be policyholders in the same managed care plan; or,

4) they may enroll as a family unit for family coverage with one spouse as the policyholder in either the PPB Plan or a managed care plan, and the other spouse covered as a dependent carrying life insurance only.

When dependent children are involved, spouses must decide which one will be the policyholder who covers the children. This decision must be made at the time of enrollment, and all eligible dependents must be enrolled under one policyholder.

The spouse of a deceased employee will be considered the policyholder for all other dependents of the deceased employee.

Enrollment Periods.

Active Employees. Active employees may enroll for PEIA health or life benefits at the time they are hired, although coverage will not begin until they are actively at work (see Commencement of Coverage in this Section). Active employees who enroll in the calendar month they are hired or the following two calendar months will not be required to submit a statement of health for optional life insurance not exceeding $100,000. Active employees who choose not to enroll for health coverage during this initial period may do so later, but may be subject to preexisting condition limitations. Active employees who choose not to enroll for life insurance coverage (basic, optional, or dependent) during this initial period may do so later in accordance with current guidelines, but will be required to submit a statement of health and must be approved by PEIA's life insurance carrier before coverage will begin.

Retired Employees. Retired employees continue coverage by enrolling in the PEIA Plan through their retirement system. All employees must enroll when changing to retired status in order to maintain coverage. Retired employees wishing to maintain life insurance or optional dependent life insurance upon retirement must enroll for this coverage during the month of retirement or the following month. Retired employees wishing to elect new or increased Optional Life Insurance or Optional Dependent Life Insurance, must enroll and submit a statement of health during the calendar month of or the two calendar months following their retirement. Coverage will be effective subject to the approval of the PEIA's life insurance carrier. Retired employees may not

elect or increase life insurance coverage after the two calendar months following their retirement.

Dependents. Dependents may be enrolled by a policyholder at the time the policyholder enrolls with the PEIA Plan. New dependents such as a new spouse, newborn or adopted child may be enrolled during the calendar month of or the two calendar months following the date of the qualifying event (i.e., marriage, birth, or placement of a child for adoption). Dependents are not covered unless enrolled, even if the dependent is a newborn child and the pregnancy was reported to the TPA-UM. Dependents of an active employee may be added to the PPB Plan and the Life Insurance Plan at any time; however, failure of the policyholder to enroll his/her dependents in the calendar month of or two calendar months following the qualifying event will result in the policyholder being required to submit a statement of health for the dependent(s), receiving approval by PEIA's life insurance carrier to obtain life insurance coverage, and may result in pre-existing condition limitations for health coverage for such dependents. Dependents of a retired employee cannot be enrolled for dependent life insurance outside the calendar month of, or the two calendar months following a qualifying event. Dependents may not be added to a managed care plan outside the open enrollment period unless there has been a qualifying event. (see **Enrollment** in this Section.)

Surviving Dependents. In the event of the death of an active or retired employee, dependents who were covered at the time of death are eligible to enroll for health coverage as surviving dependents. Surviving dependents are not eligible for life insurance.

Plan Choices. During the Spring of each year, the PEIA will have an open enrollment period to allow policyholders to select health care coverage from the PEIA PPB Plan or one of the PEIA's managed care offerings. Policyholders may make health insurance coverage changes during open enrollment without a qualifying event. Any coverage changes will become effective on July 1. The policyholder's dependents must participate in the same plan as the policyholder.

Medical Identification Cards. Policyholders will receive medical identification cards within 30 days of enrollment in the PEIA PPB Plan. The medical identification card shall include the insured's name and identification number. Policyholders will receive two cards for family coverage and one card for single coverage. Policyholders may obtain additional cards for children not residing in their household, or to replace lost cards, by contacting the TPA-P if they are enrolled in the PPB Plan, or their managed care plan.

Commencement of Coverage.

Active Employees. Coverage for active employees is effective the first day of the month following the later of the date of employment or the date of enrollment. If the

date of enrollment is the first day of the month, the effective date is the first day of the following month. The employee must be "actively-at-work" for coverage to commence. In order for an employee to be considered "actively at work" he/she must:

- perform the normal tasks of the job on a full-time basis for a full work day on the day coverage (or an increase in the coverage amount) is to begin; and

- perform the normal tasks at one of the normal places of business or at a location to which the employee must travel to do his/her job.

Employees who enroll for additional life insurance coverage outside of the initial enrollment period by providing a statement of health will have an effective date for that coverage of the first day of the month following approval by the insurance carrier.

Retired Employees. Retired employees and their dependents will have continuous, uninterrupted coverage only if they enroll in the calendar month retirement occurs or the following two calendar months. If the retired employee enrolls for medical coverage at a later date, the effective date of coverage will be the first day of the month following the date of enrollment and the PEIA's pre-existing condition limitations may apply. Retirees may not enroll for life insurance at later a date.

Retirees and their dependents who are Medicare eligible must enroll for Medicare Part A and B. The PEIA Plan will coordinate benefits as if the person has enrolled for both Part A and B coverage, regardless of whether the person has actually enrolled for such coverage.

Dependents. As long as the dependent has been enrolled by a newly enrolled active employee, the coverage of the dependent will begin on the same day as the employee's coverage. If the employee is not "actively at work" on the date coverage would be effective, coverage will become effective on the first day the employee is "actively at work." If a dependent, other than a newborn, is in a hospital, nursing home, or other facility which provides medical treatment on the date coverage is to begin, the coverage will not begin until the dependent is discharged.

If the employee acquires a dependent after the employee's initial effective date, the coverage for the new dependent will begin on the first day of the month following the new dependent's enrollment.

In the case of a newborn child of an employee covered by PEIA, the newborn must be enrolled by the employee in the calendar month the birth occurs or the following two calendar months in order to qualify for retroactive coverage to the date of birth. If the newborn is not enrolled in the month of birth or the following month, coverage will be effective the first day of the month following the date of enrollment and pre-existing condition limitations may apply. A statement of health will also be required for optional dependent life insurance.

Adopted children may also be enrolled effective from their date of birth if enrolled during the calendar month of birth or the following two calendar months if legal documentation is provided stating that the PEIA policyholder became financially responsible for claims incurred by the adopted child on the date of birth.

If a retired employee enrolls existing dependents in the calendar month retirement occurs or the following calendar month, the coverage will be continuous and uninterrupted. If the retired employee's dependents are enrolled after that time, coverage will begin the first day of the month following enrollment and the PEIA's pre-existing condition limitations may apply.

Surviving Dependents. If a surviving dependent enrolls in the calendar month the employee's death occurs or the following two calendar months, the coverage will be continuous and uninterrupted. If the surviving dependent enrolls at a later date, the coverage will be effective on the first day of the month following enrollment and the PEIA's pre-existing condition limitations may apply.

Termination of Coverage.

Active Employees. The coverage for the employee terminates when the employee is no longer eligible or when the group (employer's) coverage terminates, whichever occurs first.

In the case of voluntary termination, the basic medical coverage for the employee and dependents terminates at the end of the month in which the employee voluntarily ceases employment or is no longer on payroll.

In the case of involuntary termination, such as a reduction in work force, coverage may continue for three additional months after the end of the month in which the employee goes off the payroll. Eligible enrolled dependents are included in the three-month extension. The extension of the basic health and/or basic life coverage is provided at no additional cost to the employee; however, the employee is required to continue to pay his/her portion of the premium during the three month period in order to continue coverage.

An employee discharged due to misconduct is not entitled to or eligible for the three month extension of coverage which applies in other involuntary termination situations; however, to the extent the employee and/or dependents are contesting the charges of misconduct through the appropriate administrative processes, the three month extension of coverage will be provided. If the charges of misconduct are upheld, the full premium expense for the three months of extended coverage must be reimbursed by the employee through the respective payroll location.

Insurance coverage for an insured will be terminated retroactively to the beginning of the month if the monthly premium is not paid by the 25th day of the month of coverage.

Retired Employees. Coverage for retired employees terminates at the end of the month in which the retired employee terminates coverage or fails to pay the premium. If coverage has been terminated for failure to pay premium, the retiree is no longer eligible to participate or re-enter the Plan at a later date.

Dependents. Coverage for dependents terminates at the end of the month in which one of the following occurs:

- the policyholder terminates or loses coverage;
- for divorce from the spouse (termination is effective at the end of the month in which the divorce is final) whether or not the decree requires the policyholder to provide health benefits to the ex-spouse;
- the dependent child reaches age 19 and does not qualify as a full-time student;
- a dependent child marries;
- a dependent child who qualifies for extended coverage as a full-time student is no longer a full-time student or reaches age 25; or
- the dependent is voluntarily removed from the Plan by the policyholder.

Surviving Dependents. Coverage for surviving dependents terminates at the end of the month in which the surviving dependent no longer elects to participate, fails to pay the premium, or becomes ineligible due to age or marriage.

Confined Insured. An insured who is confined to a hospital or other facility rendering medical care on the date coverage would otherwise terminate will remain covered through the date of discharge.

Local Government Agencies and other Non-Mandatory Participants. Coverages for insureds participating through employment with a local government agency or other non-mandatory participating employer will terminate on the last day of the month in which the employer participates, unless the insured is a retiree or a dependent of a retiree and eligible to enroll by virtue of receiving an annuity from the respective state retirement system.

Changes in Participation Status

Dependent Status to Member Status. An employee (other than a spouse) who is covered as a dependent under a family plan and becomes eligible to enroll as a policyholder may become a policyholder by completing the proper enrollment forms and paying the proportionate share of the premium. If the change of status causes a lapse in coverage, the PEIA's pre-existing condition limitations may apply.

Transfers from one Participating Employer to Another. Any policyholder who transfers from one participating employer to another and re-enrolls during the calendar month of transfer or the following two calendar months will have continuous coverage in the same plan, provided he/she has completed the necessary enrollment forms with his/her employer. An individual changing employment from a State agency to a participating non-State agency will be treated as a new hire.

If the policyholder adds a spouse or other dependent at the time of the transfer, the spouse or dependent may be subject to the PEIA's pre-existing condition limitations. The policyholder may not add dependents to coverage if covered by a managed care plan until open enrollment, unless there is a qualifying event.

Leaves of Absences

Medical Leave. (W.Va. Code §5-16-24) Any employee on a medical leave of absence due to an injury or illness that is not incurred in the course of employment activity and is not considered a worker's compensation claim, will be entitled to continue coverage until he/she returns to work, provided the following conditions are met:

- the employee and employer continue to pay their proportionate shares of premium costs for the period of the medical leave, but not for a period greater than one year;

- if the medical leave extends beyond one year, the employee may be required to pay the full premium costs; and

- during the period of the medical leave, the employee is required to submit to the employer, at least once a month, a statement from a qualified physician certifying that the employee is unable to return to work

Medical Leave - Workers' Compensation. Any employee who is on a "workers' compensation" leave of absence due to injury or illness arising from employment and is receiving temporary total disability payments from the West Virginia Workers Compensation Fund is entitled to continue coverage until he/she can return to work. The employer is required to continue to pay its proportionate share of the medical insurance premium as long as the employer-employee relationship exists and the employee is receiving or actively seeking Workers' Compensation benefits. Once

the temporary total disability claim has been settled, the employee is no longer eligible to continue under this provision.

Personal Leave. An employee may continue insurance coverage while on a personal leave of absence if the leave is approved by the employer. Payment of the monthly premium will be according to any policy or agreement established between the employee and the employer. Failure to remit the monthly premium to PEIA will result in termination of insurance coverage.

Family Leave. Any employee may continue coverage while on an approved family leave in accordance with W. Va. Code § 21-5D-1 et. seq. Payment of the monthly premium will be according to any policy or agreement established between the employer and employee. Failure to remit the monthly premium will result in termination of coverage.

Military Leave. An employee who is on an approved military leave of absence without pay is entitled to continue health benefit coverage for as long as the employee continues to make the required premium payments. The employee is responsible for paying 100 percent of the health and life premium unless other arrangements are made with the employer or the Governor by Executive Order dictates otherwise.

An employee who terminates employment immediately prior to entering active duty who makes application for reinstatement within 90 days after leaving the military is eligible to re-enroll for PEIA health coverage upon reinstatement without being considered a new member, and without other penalty (e.g. pre-existing condition limitations). In addition, an employee and any dependents may be enrolled with coverage effective on the date the employee returns actively at work or, at the discretion of the employee, may elect to have coverage effective the first day of the month following the date of election to re-enroll as long as the employee is actively-at-work.

Leaves of Absence for Teachers and School Service Personnel. Any teacher or school service personnel employee returning from an approved leave of absence that extended for a period of one year or less shall be restored to the same benefits to which that employee had at the time of the approved leave of absence.

Extending Employer-Paid Coverage for Certain Retirees

West Virginia Code § 5-16-13 allows participating employees compelled or required by law to retire before age 65 or who voluntarily retire as provided by law to use accumulated sick and annual leave days to extend their employer-paid PEIA coverage. In order to participate in this benefit, the employee must retire from a participating employer and be drawing a pension from his/her respective retirement system. Policyholders who elect to defer retirement or who are not eligible for payment of retirement benefits at the time they leave active employment are not eligible for the

extension of coverage. Eligible retired employees may not use this extension for part of a month. When both spouses are eligible for this benefit and are retired, they may combine their sick and annual leave to extend their family coverage. If an employee dies before using all the extension of service credit, the benefit ceases and does not pass on to the spouse or dependents.

Employees hired on or after July 1, 2001, are not eligible for this benefit.

Participating Employees (Other than Certain Higher Education Faculty). Employees eligible for extended employer-paid PEIA coverage, other than certain higher education faculty as described in this Section, may extend the employer-paid PEIA coverage by surrendering their accrued sick and annual leave days in accordance with the following formula:

- For eligible employees continuously covered by the PEIA since before July 1, 1988, 2 days of sick or annual leave may be converted into the full premium for one month's single coverage and three days' sick or annual leave may be converted into one month's family coverage; and,

- For all other eligible employees, 2 days of accrued annual or sick leave may be converted into 50% of the premium for one month of single coverage and 3 days of sick or annual leave may be converted into 50% of the premium for one month of family coverage.

Higher Education Faculty. Participating employees who are full-time higher education faculty members employed on an annual contract basis other than for twelve months may convert 3 1/3 years of teaching service to 1 year of PEIA single coverage or 5 years of teaching service for 1 year of PEIA family coverage.

Continuation of Coverage After Termination.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) entitles employees, retired employees, and covered dependent(s) to continue medical coverage in certain cases when coverage would otherwise terminate, provided the employee, retired employee, and/or dependent(s) pays the full premium. These circumstances and provisions are described in this section.

Active Employees. Covered active employees who lose eligibility for coverage because of ***i)*** voluntary or involuntary termination (except for gross misconduct), ***ii)*** reduction in hours to part-time status, or ***iii)*** assignment to active duty military service may elect to continue medical coverage for themselves and their dependents at their own expense for up to 18 months from the date coverage would have terminated. It is the responsibility of the employer to report to PEIA any employees who are COBRA-eligible within 30 days of the date their coverage would ordinarily have terminated under

the Plan. The PEIA will then notify the employee within 14 days of the right to continue coverage.

Retired Employees. An employee who retires and who meets the minimum eligibility requirements is eligible for COBRA coverage up to 18 months, as long as that person pays the full premium. The retiree may also be eligible to participate as a retired employee, without a time limitation, and pay PEIA's substantially reduced retiree premium.

Disabled Employees. The 18-month maximum period under COBRA may be extended to 29 months for any COBRA beneficiary who is determined to be disabled under the Social Security Act at any time during the first sixty (60) days of this COBRA coverage. It will be the responsibility of the COBRA beneficiary to notify the PEIA of his/her disabled status before the end of the 18-month coverage period, and within 60 days of any Social Security disability termination. If Social Security determines the employee is no longer disabled, the beneficiary must notify the PEIA within 30 days of final determination. PEIA may terminate the COBRA coverage at the beginning of the month starting 30 days after the final determination.

Dependent Children. An active employee or retired employee may continue coverage on a dependent child if the child no longer meets the definition of a covered dependent as defined in the Plan. Loss of eligibility may result from marriage, attainment of age 19, failure to maintain student status, etc. In such circumstances, coverage may be continued for up to 36 months following the date coverage would have terminated. It will be the responsibility of the active employee or retired employee to notify the PEIA within 60 days of loss of a dependent's eligibility. The TPA – C will then notify the employee or retiree of the right to elect continued coverage on that dependent within 14 days.

Divorced Spouse. In the event of a divorce from an active or retired employee, the divorced spouse may elect to continue medical coverage for up to 36 months from the date coverage would have otherwise terminated. It is the responsibility of the policyholder to notify the PEIA of the divorce within 60 days from the date coverage would terminate, and the TPA – C will notify the spouse of the option to continue coverage within 14 days.

Surviving Spouse/Dependent(s). Upon the death of an active employee or retired employee, the surviving spouse and dependent(s) may elect to continue coverage up to 36 months. For surviving dependent children, coverage may continue up to 36 months beyond the termination date for children as set forth in the Plan. Either the employer or the surviving dependent must notify the PEIA within 60 days of the death of the employee or retired employee. The TPA – C will then notify the dependent within 14 days of the right to continue coverage. The surviving spouse/dependent may also qualify for continued coverage as a policyholder (see, Eligibility to Participate in this Section).

Conditions of Coverage. The following provisions apply to all insureds for whom PEIA coverage is extended pursuant to COBRA:

- Continuation of coverage is optional on the part of the employee, retired employee, spouse, or dependent; and those for whom coverage is extended will be required to pay the full monthly group premium, which will include a 2 percent administrative fee, for the applicable coverage type.

- For disabled COBRA beneficiaries, PEIA may charge 150 percent of the applicable premium during the 19th through 29th months of coverage. There will be no contribution made from State or employer funds.

- All premiums must be remitted to TPA – C .

- PEIA is required by federal law to offer continuation of coverage for certain specified periods of time; however, failure to make prompt premium payments will constitute reason for termination of coverage prior to the expiration of the required extended coverage.

- PEIA may be required to offer continuation of coverage to a qualified beneficiary even if they are covered under another group health plan, if necessary for the beneficiary to avoid pre-existing condition limitations.

- After notification by TPA – C of the right to continue coverage, an insured who wishes to elect continued coverage must inform TPA – C, in writing, within 60 days. The insured will then have up to 45 days to pay the applicable premium to the TPA – C, retroactive to the date coverage would otherwise have terminated.

- During the period of continued coverage, medical benefits will be the same as those normally provided by PEIA. Should PEIA implement any changes in benefits or premium rates during the period of extension, the continuation coverage and cost will be affected accordingly.

- If continued coverage is elected, new dependents may be added during the period of continuation and cannot exceed the policyholder's duration of the original 18 months (employee) or 36 months (dependent) extension of coverage; however, they may be subject to the pre-existing condition limitations.

- The continuation option applies only to medical benefits. There are no extension provisions for employee, retired employee, or dependent life insurance other than the conversion options as addressed in this Plan.

- If an insured is enrolled in the PEIA and subject to the limitation for pre-existing conditions, this limitation will continue in effect under any continuation option until the expiration date of the 12-month pre-existing condition limitation period.

- An insured enrolled in an MCO will be offered continuation of coverage through the MCO Plan. Additionally, if the insured has elected to continue coverage, the insured will retain the right to change plan enrollment during the regular annual open enrollment period to be effective at the beginning of the next Fiscal Year.

- An insured enrolled in an MCO will be given the opportunity to elect either the PEIA's or the MCO's plan during open enrollment unless the insured moves outside of the MCO enrollment area.

COBRA coverage does not require evidence of insurability due to the continuous coverage provision.

Procedures for Notification of COBRA Eligibility. When a PEIA insured loses eligibility to participate in either the PEIA PPB Plan or a managed care plan, the TPA – C will, upon notice of the event, send a letter to the insured regarding the date the eligibility to participate ends and the terms under which coverage under COBRA may be extended. The letter will be sent to the last known address of the insured. COBRA letters will not be sent to the insured when PEIA coverage would terminate because of one of the following circumstances:

- COBRA coverage was refused on the termination form; or

- no qualifying event has occurred (i.e., a dependent being voluntarily removed by the policyholder).

Termination of COBRA Coverage. Coverage for those persons who elect to extend their PEIA medical benefits through COBRA will terminate at the end of the month in which any of the following events occur:

- At the end of the Period of Coverage specified by COBRA (e.g., 18, 29 or 36 month period);

- Upon the insured becoming covered as an employee under another group health plan that does not limit coverage for any pre-existing conditions;

- For a divorced spouse or dependent, who becomes covered under another group health plan that does not limit coverage for any pre-existing conditions;

- Failure of the insured to pay their premium within 30 days of the due date;

- The insured becoming entitled to Medicare after the election of COBRA; or,

- Upon a disabled employee no longer being considered disabled by Social Security.

A qualified insured who has elected COBRA benefits and continues coverage for the full 18, 29, or 36 months will be removed from the account by the PEIA automatically at the end of the coverage period.

A "Policyholder Termination of Coverage" form is required to remove a qualified beneficiary who has elected COBRA benefits and has not continued coverage for the full 18, 29 or 36 months. The COBRA policyholder must complete a "Change in Status" form to remove a qualified dependent from COBRA family coverage.

Conversion.

Health Care Coverage. Insureds covered continuously for at least 3 months (including persons participating through COBRA) under the PEIA PPB Plan or a managed care plan offered through PEIA may apply for individual health coverage when group health coverage ends. Covered dependents also have this right. Insureds are not eligible for an individual policy if:

- the insured is age 65 or older; or

- PEIA coverage ended because of failure to pay the premium.

Those persons covered under one of the managed care plans will be offered coverage conversion, but the insured must contact the managed care plan for instructions on this conversion. If the managed care conversion policy is unavailable due to licensing restrictions, the member will be offered a policy through the PEIA PPB Plan.

Those persons covered under the PEIA PPB Plan must submit an application and remit the first premium within 30 days after the termination of PEIA coverage. Coverage under the individual policy will become effective the day after coverage ends.

Persons interested in conversion should contact the PEIA. Individual health policies are issued by an independent insurance company. Premiums and benefits under an individual policy are determined by the insurer and may differ significantly from the PEIA PPB Plan.

Life Insurance Coverage. The PEIA's contract with the carrier for the Basic and Optional Life and Accidental Death provides that the carrier must offer a conversion policy for insureds who are no longer eligible to participate through the PEIA. Prior to

termination, the employee's benefit coordinator will notify the insured that the policy is being canceled because of loss of eligibility to participate under the PEIA Plan and will provide information on how the insured may convert the insurance to an individual policy.

III

PLAN ADMINISTRATION

Premium Accounts

Premium Accounts Section. The PEIA shall maintain a separate account for each participating employer and for each policyholder who pays premiums either directly to the PEIA or through a retirement plan. Separate accounts shall also be maintained for those policyholders participating in the Retiree Premium Assistance Program. The Premium Accounts section of the Agency has the responsibility for billing and collecting premiums and reports to the Chief Financial Officer.

Coverage Types. Coverage types are established by the Finance Board as part of the PEIA's annual financial plan. Coverage types are as follows:

- Policyholder
- Policyholder with child(ren)
- Family
- Family with Employee Spouse
- Retiree Only
- Retiree with Family Coverage
- Life Insurance only

Premium Rates. Premium rates are established by the Finance Board as part of the PEIA's annual financial plan. After determining the cost of administering the Plan and receiving from the Governor an estimate of the total revenues that the State will make available to fund the PEIA, the Finance Board apportions that cost between employers, providers, and policyholders.

In setting premium rates, the Finance Board may consider different levels of costs. For active employees, the levels may be based on the policyholder's ability to pay. For retired employees, the levels may be based on the retired employee's length of employment with a participating employer, ability to pay, or other relevant factors.

The Finance Board may allocate a portion of the premium costs to participating employers to subsidize the cost of coverage to participating retired employees.

The PEIA Finance Board sets rates payable by employers who have retirees, dependents of retirees or surviving dependents participating in the Plan. The PEIA may bill a non-participating employer a premium as established by the Finance Board to subsidize the cost of its retired employees, dependents of retired employees or surviving dependents that participate in the State Retirement Plan.

For local government agencies and other employers who are not mandatory participants in the Plan, the Finance Board will establish a rate per active employee participating in the Plan based on the coverage type. The employer will determine what portion of the premium will be paid by the employee.

Members participating in the Plan through COBRA will pay 102% of the active premium amount. Disabled COBRA Participants will pay 150% of the active premium amount.

Tobacco-Free Discount. PEIA's premiums are based on the tobacco-use status of insureds. Tobacco-free insureds will receive the preferred monthly premium rate, which is $10 lower for single coverage, and $20 lower for family coverage. Plan insureds must have been tobacco-free for 4 months prior to the beginning of the Plan Year to qualify for the discount. Newly hired PPB Plan insureds must have been tobacco-free for 4 months prior to their effective date of coverage to qualify for the discount.

Tobacco-free insureds must sign an affidavit each year and return it during Open Enrollment to receive the reduced premium rate for the following plan year. For family coverage, all enrolled family members must be tobacco-free to qualify the family for the reduced rate. PEIA reserves the right to review medical records to check for tobacco use. PEIA offers a tobacco cessation benefit.

Premium Payments. All premium payments shall be made payable to the Public Employees Insurance Agency and shall be sent to the PEIA's Premium Accounts Section. The full premium payment for policyholders is due by the 25th day of the month for which coverage is in effect (i.e. for coverage for February, payment must be made by February 25th).

For active employees of State Agencies, and State Colleges and Universities, the State of West Virginia Auditor's Office shall collect the employer and employee premium for health and life insurance through the EPIC system and will remit those funds to PEIA. For active employees of County Boards of Education, the employer shall collect the employee share through payroll deduction and shall pay to the PEIA the full premium amount monthly (employer and employee share).

For active employees of local government agencies and other employers that are not mandatory participants in the Plan, the employer shall forward the full premium amount by check to the PEIA.

For active employees on personal leave, the premium will be billed each month to the employer. Responsibility for payment of premium will be according to any policy or agreement established by the employer with the employee. Failure to remit the premium due each month to the PEIA will result in termination of the employee's insurance coverage retroactive to the first of that month.

For retirees participating in one of the Consolidated Public Retirement Board systems, their share of the premium may be deducted from their monthly retirement check and forwarded by the appropriate retirement system to the Agency. If the retiree's pension is not sufficient to cover the cost of the monthly premium, a direct-pay account will be established, and the retiree will be required to remit the balance of the premium due on a monthly basis.

Premiums for retirees using sick leave and/or years of service credit to extend their employer-paid health coverage must be submitted by State Agencies and State Colleges and Universities by intergovernmental transfer (IGT) by the respective agency. This premium is not collected through the EPIC system.

Furthermore, the annual administrative fees must also be remitted through IGT (i.e., fees are not collected and remitted through the EPIC system).

Retired Employees Who Retired Before July 1, 1997. Retired employees who retired prior to July 1, 1997, pay premiums based on the plan they choose and eligibility for Medicare. Some retired employees may use sick or annual leave to extend employer-paid health coverage.

Retired Employees Who Retired on or After July 1, 1997. Employees who retire on and after July 1, 1997, will pay premiums for the PEIA PPB Plan based on their eligibility for Medicare and credited years of service. These premiums may be adjusted annually for medical inflation. Managed care premiums will be based on premiums established by the managed care organizations and approved by the State of West Virginia Insurance Commissioner, less amounts contributed and approved by the PEIA Finance Board. Employees with 25 or more years of service will be charged the same premium as those who retired before July 1, 1997. Those with fewer than 25 years of service will pay higher premiums. Retired employees using accrued sick and/or annual leave (or years of service) to extend employer-paid insurance will have all, or a portion of this premium covered by the accrued leave.

Extending Employer-Paid Insurance Upon Retirement. Employees may be eligible to extend employer-paid insurance upon retirement by using accrued annual, sick leave or years of service credit. To take advantage of this benefit, the eligible employee must move directly from active public employment into his/her respective retirement system. If the employee chooses to defer retirement, sick and annual leave or years of service credit cannot be deferred for use later. Elected public officials are not eligible for this benefit. This benefit terminates when the policyholder dies; it cannot

be used by surviving dependents, who may continue coverage by paying the monthly premium.

Using Accrued Sick and Annual Leave to Extend Coverage. Employees of State Agencies, County Boards of Education, or local agencies enrolled in the PEIA PPB Plan or any of the managed care plans, may be able to use any accrued, sick and/or annual leave to extend employer-paid insurance coverage upon retirement. This extended coverage must be for full months. The amount of this benefit depends on the policyholder's effective date of coverage. Employees hired on or after July 1, 2001, are not eligible for this benefit.

Before July 1, 1988: If a policyholder has been continuously covered by the PEIA Plan since before July 1, 1988, then the additional coverage is calculated as follows:

2 days of accrued leave = 100% of the premium for one month of single coverage;

3 days of accrued leave = 100% of the premium for one month of family coverage.

After July 1, 1988: If an employee enrolled in the PEIA after July 1, 1988, or if a lapse in coverage occurred after July 1, 1988, then the additional coverage is calculated as follows:

2 days of accrued leave = 50% of the premium for one month of single coverage

3 days of accrued leave = 50% of the premium for one month of family coverage.

If the policyholder dies, the accrued and annual leave benefit terminates, even if the surviving dependent continues coverage.

The policyholder may also have the option to use accrued leave to increase retirement benefits from the retirement system. The policyholder must choose between additional retirement benefits and extended employer-paid insurance coverage. Accrued leave may not be divided to increase the retirement benefit and to extend employer-paid insurance coverage.

Extending Coverage for Higher Education Faculty. Full-time faculty members employed on an annual contract basis for a period other than 12 months may extend employer-paid insurance coverage based on years of teaching service. The benefit is calculated as follows:

3 1/3 years of teaching service = 1 year of single coverage

5 years of teaching service = 1 year of family coverage

If a policyholder and spouse are both public employees eligible for extended employer-paid insurance coverage, their accrued leave may be combined to extend employer-paid family coverage. If the policyholder and spouse retire concurrently, they may combine their accrued leave to purchase months of extended employer-paid coverage. If one spouse should die prior to the expiration of all months of extended employer-paid coverage, PEIA will consider any months of extended employer-paid coverage already used to have been those contributed by the deceased employee. Of the remaining months of extended employer-paid coverage, any that are attributable to the surviving employee may be used by the surviving employee. In no instance, however, shall any employee be permitted to use months of extended employer-paid coverage earned by a deceased employee.

Premium Assistance Program. Retired employees whose total annual income is less than 250% of the current federal poverty level may receive assistance in paying a portion of their PEIA monthly health premium and drug copayments through a grant provided by the PEIA. For copayments, see Appendix H. Applicants must be enrolled in the PEIA PPB Plan. Managed care members are not eligible for this program. Retired employees using accrued sick and/or annual leave to pay their premiums are not eligible for the premium assistance portion of this program until their accrued leave or years of service credit is exhausted. However, they are eligible for copayment assistance. Applications are mailed to all retired employees each spring.

Life Insurance Premiums. Life insurance premiums for all employees are set by PEIA's life insurance carrier. Basic life insurance premiums are included in the health premiums of the PEIA PPB Plan and the managed care plans offered by PEIA. Optional life insurance premiums are paid by the employee and are based on age and amount of coverage.

Managed Care Plans. Enrollees in the managed care plans offered by the PEIA pay premiums determined by the managed care plans. Premiums are published in the *Shopper's Guide* prior to each Open Enrollment. The published premiums are set for a Plan Year unless the West Virginia Insurance Commissioner requires a mid-year change to ensure a plan's solvency. For State Agencies, County Boards of Education and Colleges and Universities, the employer will contribute the same amount toward an employee's coverage as if the employee were enrolled in the PEIA PPB Plan. The employee will contribute an amount equal to the premium established by the managed care organizations and approved by the State of West Virginia Insurance Commissioner, less the amount contributed and approved by the PEIA Finance Board. Local government agencies will be billed the full premium by PEIA and will determine their own levels of employer/employee premium sharing.

The managed care plans being offered by employers are part of the PEIA benefits package and policyholders may enroll for any plan for which they meet the eligibility guidelines. An employee's plan choice is binding for one Plan Year unless the employee moves outside the enrollment area of the chosen plan.

Failure to Pay Premiums. Failure of an employer or policyholder to pay the monthly premium by the 25th of the month will result in cancellation of the policyholder's participation in the Plan retroactive to the last day of the month for which the premium was received.

Checks returned to PEIA by the bank for insufficient funds, closed account, etc., will be returned to the employer or policyholder, as appropriate, for replacement by either a postal money order or cashier's check. If a money order or cashier's check is not remitted to PEIA within 30 days of payroll notification, insurance coverage provided by the PEIA will be terminated for failure to pay premium retroactive to the last day of the month for which a premium was received.

Monthly Reports. By the 15th day of each month, the PEIA shall forward to each employer a report showing all of their employees enrolled in the Plan, each employee's coverage type and the cost of coverage. This report shall reflect the eligibility records of the PEIA as of the date of this report.

The employer is responsible for verifying the accuracy of the monthly report and reporting any discrepancies to the PEIA by the 25th day of each month.

If an employee should appear on the report for that month but does not, the employee's name should be written on the monthly report along with the employee's effective date of coverage, Social Security number, coverage code, premium due (if any), and any optional life and dependent life coverage.

The employer must mark through any name which should not appear on the invoice, such as a terminated or ineligible employee. For a policyholder who is changing coverage type, the employer need only change the coverage code(s) and amount due. Forms reflecting these changes, if not already forwarded, are to be sent immediately to the PEIA.

If a name has been stricken from the billing, the employer must indicate in the margin of the report whether the employee has been terminated or transferred to another PEIA account. If terminated, the termination date is to be inserted by the employer. If transferred to another PEIA account, the name of the new employer should be inserted.

When all changes have been made, the current premium date should be recalculated and the correct amount forwarded by the 25th of the month.

Administrative Expense and Enrollment Fee. The PEIA will determine annually the amount necessary to pay the administrative costs of the Plan, and each participating employer will pay to the PEIA the amount determined per year, per employee. Employers will be billed annually, on July 1, for all employees, and will be billed on an individual basis for new employees enrolled after July 1. Administrative fees are not prorated for employees. Additionally, an enrollment fee is charged to non-state agencies each time they join the Plan.

Refunds. The method of payment of refunds by the PEIA is dependent upon: 1) whether the refund is due to a policyholder or an employer; and 2) if due to a policyholder, whether the policyholder is an active employee or retired.

Active Employee. If an overpayment occurs on a monthly billing due to an incorrect amount being deducted or paid, a refund is due to the employee. To correct this overpayment, the employer shall make a refund directly to the employee, and take a credit on the next month's PEIA billing to reflect the previous overpayment.

Retiree/Surviving Dependent/COBRA. If an overpayment occurs due to an incorrect premium being deducted or paid, or due to an erroneous coverage code, a request for refund should be made to PEIA.

Employer. When there is an overpayment on the employer contribution, a credit must be taken by the employer on the next monthly billing.

Administrative Expense Fee. Same procedure as for "Employer".

Optional & Dependent Life Insurance. Same procedure as for "Active Employee."

Refund Timeframes. If the error was on the part of the employer or policyholder, a request for refund with an incurred date within the current fiscal year shall be refunded during that current fiscal year from current fiscal year funds. A request for refund with an incurred date in an immediately previous fiscal year and received up to and including July 31 of the current fiscal year shall be made and considered as refund out of the immediately past fiscal year funds. A request for refund due with an incurred date in an immediate previous fiscal year or earlier and received after July 31st of the current fiscal year shall be ineligible for a refund.

Where a refund is requested due to the termination of an employee's coverage and the failure of the employer to timely submit the termination information to PEIA, the PEIA is not obligated to refund more than two (2) months premium. If such employee has incurred health care claims between the date intended for termination by the employer and the date the employer notifies PEIA of the termination, no refund is due.

Where the error occurred on the part of the Public Employees Insurance Agency, refunds shall be made without regard to time lapsed.

Medicare Refunds. If PEIA has paid as the primary insurer on claims that Medicare should have paid as the primary insurer, then the TPA-C will take back the claims paid and recover PEIA funds from the provider. As these overpayments are identified, the Eligibility Unit at PEIA will be notified of the effective date of the Medicare coverage. This information will be used to retroactively credit for up to 36 months the policyholder for any premium difference that may be due as a result of the Medicare status and to request claim adjustments.

Contracts

The operation of the PEIA requires the assistance of numerous vendors. Such vendors include the third-party administrators for medical claims, prescription drug claims and utilization review, managed care organizations offering coverage to PEIA members, the agency's actuaries, the cafeteria plan administrator, the life insurance administrator, auditors and consultants.

Awarding Contracts. W.Va. Code § 5-16-3(c) and §5-16-8 (a) authorize the Director to enter into contracts necessary to carry out the day-to-day operations of the Agency. Pursuant to W.Va. Code §5-16-9(c), such contracts are not subject to the purchasing rules of the West Virginia Department of Administration.

Insurance Contracts. Before entering into any contract for insurance coverage, including plan or plans for group hospital and surgical insurance coverage, group major medical insurance coverage, group prescription drug insurance coverage, and group life and accidental death insurance coverage, the Director shall invite competitive bids from all qualified and licensed insurance companies or carriers who may wish to offer plans for the insurance coverage desired. The Director shall award the bid on a competitive basis taking into account, among other things, the vendors' experience and facilities. The PEIA shall not pay a finder's fee or commission for such contracts, and any such fee paid by a prospective vendor must be related to actual services rendered or performed by the agent or agents.

TPAs. Awards of contracts for the PEIA's medical claims processing, prescription drug processing and utilization management services and other professional services shall be made by the Director in the same procedural manner as awards for insurance contracts.

Professional and Consulting Services. Awards of professional and professional consulting services contracts shall be made by the Director on a competitive basis or sole source basis. The determination not to competitively bid these contracts may be made when the contract is for less than $10,000, the selected vendor has specific knowledge or experience that is not available from other prospective bidders, or, in the sole discretion of the Director, he/she determines that putting the contract out for competitive bid would not be in the best interest of the Agency. The Director shall state

within the contract the reason or reasons why the contract was awarded as a sole source contract.

Inter-Agency Agreements. From time-to-time, it is necessary for the PEIA to enter into agreements with other State agencies to further the goals of the PEIA and/or the State of West Virginia. Such agreements do not require a competitive bid and are entered into at the sole discretion of the Director.

Renewing, Extending and Amending Contracts. All contracts and agreements entered into by the PEIA will contain provisions outlining conditions for renewing, extending, amending and terminating the contract or agreement. All such renewals, extensions and amendments may be entered into by the PEIA at the sole discretion of the Director, and must be reduced to writing.

Payments

Payment of Claims Expenses. The adjudication of medical claims is made by the PEIA's Third-Party Administrator for Medical Claims (TPA-C) and the adjudication of prescription drug claims is done by the PEIA's Third-Party Administrator for Prescription Drugs (TPA-P).

The TPA-C will make claim checks payable directly to in-state providers and the TPA-P will make claim checks payable directly to the participating Network Pharmacy. For policyholders who paid for the services or prescriptions, and who are seeking reimbursement, see Filing Claims Section IV (medical) and Section V (prescription drugs). The payment of Life and AD&D claims is addressed in Section VI.

Both the TPA-C and TPA-P will use the following procedures in the payment of adjudicated claims:

- TPAs shall prepare, as requested by PEIA, a funding request for the total checks prepared for issuance by TPAs for the payment of claims, and shall deliver such voucher to the PEIA within twenty-four (24) hours after the request. Upon obtaining necessary approvals from the State Auditor and State Treasurer, the PEIA shall wire transfer to the PEIA Dedicated Daily Cash Investment Account's funds to pay all claims listed on the vouchers. Upon receipt of such funds by the bank, TPAs shall promptly mail the checks funded or electronically transfer the amount.

- TPAs shall include a statement on each check stating that such check shall be void if not cashed within one hundred eighty (180) days after issuance.

- Interest earned on the PEIA accounts shall belong to the PEIA. The PEIA shall be responsible for all bank charges associated with the PEIA accounts.

- TPAs shall maintain reasonable flexibility in their claims adjudication and payment process to enable the PEIA to make special requests for priority actions. For example, TPAs shall accommodate requests from the PEIA to process and pay or to hold all or a portion of outstanding claims for a particular insured or provider, for certain types of providers (e.g., hospitals), or for providers by geographic location (e.g., in-state versus out-of-state).

- TPAs shall be responsible for the administration of the respective PEIA Dedicated Daily Cash Investment Account and PEIA Dedicated Checking Accounts, and for the full and complete reconciliation of all deposits made and checks issued on the accounts, for as long as the accounts remain open, which shall be for at least one hundred eighty (180) days after the date of issuance of the last check. TPAs shall furnish the PEIA with monthly bank reconciliations for the PEIA Dedicated Cash Investment Account and PEIA Dedicated Checking Account within thirty (30) days after the end of each month.

Payment of Administrative Expenses.

Professional, Contractual and Operating Expenses. All professional, contractual and operating expenses of the PEIA shall be submitted to the PEIA on a detailed invoice. Invoices will be verified by the PEIA Fiscal Officer and approved by the Chief Financial Officer. Approved invoices will be forwarded to the State Auditor for payment.

Third-Party Administration Expenses. Payment of the monthly administrative fee to PEIA's Third-Party Administrators will be in accordance with the terms of their respective contracts. When payments are based, either in whole or in part, on enrollment figures, the PEIA's Eligibility Section will confirm the enrollment figures. Payments to TPAs shall be reviewed and approved by the Chief Financial Officer.

Payments to Managed Care Organizations. Payments to managed care organizations providing medical coverage to PEIA members will be made in accordance with their respective contracts. The PEIA Fiscal Officer, or other designee, will verify the enrollment data for purposes of determining the correct monthly payment.

Audits

Hospital. Audits of hospital claims will be performed by the TPA-C. Audits will be performed for all out-patient service claims that, in the aggregate, exceed $5,000 and, for selected DRGS for in-patient claims, and for other in-patient claims that are $25,000 or more. The TPA-C will review an insured's medical file and compare the file documents with the submitted claims. When discrepancies are discovered, the TPA-C will take the necessary corrective action, to include requesting a refund from the facility or deducting the over-payment from the provider's check. The TPA-C will prepare and deliver a report to the Director each month on the activities of the hospital audit program.

Providers. PEIA will periodically conduct audits of provider claims. By submitting claims to PEIA, the provider is deemed to have agreed to cooperate with such audits and to provide access to records by PEIA.

Insured. Audits of claims paid to the insured will be performed by the TPA-C for charges paid of $2,500 or more. When discrepancies are discovered, the TPA-C will take the necessary corrective action, to include requesting a refund from the insured, or deducting the overpayment from any checks to the insured.

Pharmacy. Each year, the TPA-P will conduct an audit of at least 5% of pharmacies participating with the PEIA. Pharmacies will be chosen at random for the audit. The audit will include a comparison of claims with the records of the pharmacy to verify, among other things, that the claims are consistent with the prescriptions and authorized refills and that the PEIA is not being charged in excess of the pharmacy's ordinary and customary price for prescription drugs.

Employer. The PEIA's Premium Accounts Section audits the monthly reports and premium payments from participating agencies. Discrepancies in the monthly reports or payments are reported to the participating agency, and any amounts owed to the PEIA must be remitted with the next monthly billing.

TPAs. The PEIA employs, or requires a TPA to employ through contractual agreement, an independent accounting firm to audit the records of its third-party administrator for medical and prescription drug claims. The audit includes a SAS-70 Type II and an operational audit of claims processing. These audits will be conducted on a yearly basis and will include not less than six (6) months' claims data.

Agency. The PEIA will employ an independent accounting firm to perform an audit of the PEIA's financial statements. The audit will be performed on a yearly basis and in accordance with the requirements developed by the Financial, Accounting and Reporting Section (FARS) of the West Virginia Department of Administration.

Legislative. Pursuant to W. Va. Code § 4-2-1, et seq., the Legislative Auditor is required periodically to conduct a post audit of the records of the PEIA. The PEIA's Chief Financial Officer shall be responsible for coordinating and facilitating such audits with the Legislative Auditor.

Patient Audit Program. The patient audit program provides for payment to an insured of up to fifty percent (50%) of any overpayments from the PEIA PPB Plan or Prescription Drug Program which are actually recovered by PEIA through the program. The program is intended to help detect and correct overcharges or overpayments resulting from clerical error, miscalculation, fraud and charges for services not received.

Upon request, the PEIA will supply a patient audit report form outlining the steps to follow when filing for this program. The insured must initiate the patient audit report for any overpayments prior to the request or receipt of any recovered amounts by TPA-C or TPA-P. If the TPA-C or TPA-P detects or corrects an error before the insured has filed the patient audit report, the insured may not collect.

A billing error qualifies for the audit program if, after a thorough investigation, the TPA-C or TPA-P receives a refund from the provider. The PEIA must have paid the incorrect amount and then received a refund before payment is allowed under this program. The insured will be paid 50% of the amount recovered as an overpayment.

Reported errors must be at least $50 to qualify for this program and must be submitted within 60 days of the date on the Explanation of Benefits statement. Awards under this program have a maximum of $1,000 annually per policyholder.

MCO members are not eligible for the patient audit program.

Quarterly Reports.

Pursuant to W. Va. Code § 5-16-26, by the 13th day of January, April, July and October of each year, the Director shall prepare a financial report for the approval of the Finance Board. Once approved, the report will be presented to the Joint Committee on Government and Finance. The report will include:

- A summary of the cost of the Plan of health care for claims incurred in the previous calendar quarter;

- A summary of funds accrued to the Plan by legislative appropriation, employer and employee premiums and otherwise in the preceding calendar quarter for payment of health care claims;

- An explanation of cost containment measures, increased premium rates, any other Plan changes adopted by the Director in the preceding calendar quarter; estimated cost savings and enhanced revenues resulting therefrom, and a certification that the Director made a good faith effort to develop and implement all reasonable health care cost containment alternatives;

- Expected claims costs for the next calendar year;

- Such other information as the Director deems appropriate; and

- Any other financial or other information as may be requested by the Committee.

Employer's Notification Responsibility.

All participating employers must give written notice to each member within their agency prior to institution of any changes in benefits to insureds. W.Va. Code § 5-16-8.

IV

SECTION 125 PLAN

ARTICLE I - INTRODUCTION

1.1 Purpose of Plan. The purpose of this Plan is to permit Participants to choose between cash and certain nontaxable health and welfare benefits provided by the Employer. In accordance with this purpose, the Plan provides Premium Conversion Benefits, which are non-taxable benefits provided automatically to Participants through payroll deductions upon the satisfaction of eligibility requirements (unless such benefits are declined for cash), and provides Mountaineer Flexible Benefits, which are non-taxable benefits provided to Participants only upon their election and agreement to payroll deductions.

1.2 Authorization. West Virginia Code Section 5-16-14 authorizes Director of the State of West Virginia Public Employees Insurance Agency to develop and implement deductible and employee premium programs which qualify for favorable income tax treatment under Section 125 of the Internal Revenue Code of 1986, as amended.

1.3 Cafeteria Plan Status. The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Code, and is to be interpreted in a manner consistent with the requirements of Section 125.

1.4 Effective Date. The Plan is amended and restated effective January 1, 1996.

ARTICLE II – DEFINITIONS

For all purposes herein, the following definitions and terms shall apply:

2.1 "Administrator" means PEIA and such other TPA as may be appointed from time to time by PEIA to supervise the administration of the Plan.

2.2 "Basic and Optional Life Insurance Program" means the group term life insurance plan offered by PEIA through a contractual arrangement with an insurance carrier of term life insurance under which benefits are excluded from the Employee's gross income pursuant to Section 79 of the Code.

2.3 "Benefit Election Form" means the form promulgated by the Administrator by which an eligible Employee makes his benefit election(s) as described in Section 4.1 of the Plan and in accordance with Article IV.

2.4 "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any Section or Subsection of the Code includes reference to

any comparable or succeeding provision of any legislation, which amends, supplements or replaces such Section or Subsection.

2.5 "Compensation" means the total compensation for services paid or made available by the Employer to an Employee including elective contributions or deferrals which would be included in the Employee's compensation except for the operation of Code Sections 125, 403(b), or 457.

2.6 "Contributions" means Employee contributions as described in Article IV used to purchase Premium Conversion Benefits and Mountaineer Flexible Benefits.

2.7 "Dental Benefit Plan" means the dental care plan, or plans, offered by PEIA under which benefits are excluded from the Employee's gross income pursuant to Section 105 of the Code.

2.8 "Dependent" means any person, which falls within the definition of dependent provided in Section 125 of the Code.

2.9 "Dependent Care Expenses" has the meaning specified in Article II of the Dependent Care Reimbursement Plan.

2.10 "Dependent Care Reimbursement Plan" means the State of West Virginia Public Employees Insurance Agency Dependent Care Reimbursement Plan.

2.11 "Director" means the Director of PEIA.

2.12 "Effective Date" means, with respect to this amendment and restatement, January 1, 1996.

2.13 "Eligible Employee" means any Employee who is eligible to participate in the Medical Benefit Plan.

2.14 "Employee" means any common law employee of the Employer.

2.15 "Employer" means the State of West Virginia, its boards, agencies, commissions, departments, institutions or spending units, or a county board of education which elects to participate in the Plan.

2.16 "Health Care Expenses" has the meaning specified in Article II of the Medical Reimbursement Plan.

2.17 "Highly Compensated Individual" means a Participant which is (a) an officer, (b) a shareholder owning more than 5 percent of the voting power or value of all classes of stock of the Employer, (c) highly compensated, or (d) a spouse or dependent (within the meaning of Section 152 of the Code) of an individual described in (a), (b), (c) above.

2.18 "Key Employee" means any person who is a key employee as defined in Section 416(i)(1) of the Code.

2.19 "Long-Term Disability Plan" means the long-term disability plan offered by PEIA under which benefits are excluded from the Employee's gross income pursuant to Section 106 of the Code.

2.20 "Medical Benefit Plan" means the Employer's respective medical insurance plan(s) and any contract or contracts with health maintenance organizations or group plans in effect from time to time which provide for health care benefits.

2.21 "Medical Reimbursement Plan" means the State of West Virginia Public Employees Insurance Agency Medical Reimbursement Plan.

2.22 "Mountaineer Flexible Benefits" means, collectively, the Vision Benefit Plan, Dental Benefit Plan, Long-Term and Short-Term Disability Plan and the Dependent Care Reimbursement and Medical Reimbursement Plan, and related plans.

2.23 "Open Enrollment" means the period of time prior to or during a Plan Year which PEIA has designated and communicated to Eligible Employees as the period within which they may make elections to allocate Contributions under the Section 125 Plan. The Open Enrollment period may be changed from year to year by PEIA.

2.24 "Participant" means each Eligible Employee who elects to participate in the Plan in accordance with Article III.

2.25 "PEIA" means the State of West Virginia Public Employees Insurance Agency and any successor thereto.

2.26 "Period of Coverage" for the Premium Conversion Benefits means the period of time during the Plan Year in which a Participant is eligible to participate in the Plan under the terms of the Plan and pursuant to the laws of the State of West Virginia. In no event shall the Period of Coverage commence prior to, nor terminate after, the commencement and ending dates of the Plan Year.

For the Mountaineer Flexible Benefits, the Period of Coverage shall be the PEIA Plan year. The Period of Coverage, shall generally be twelve (12) months, except for Plan Years during which an Employee is a Participant for less than the entire Plan Year. A Period of Coverage shall not be for a duration which would enable a Participant to defer the receipt of Compensation or to obtain coverage under the Plan only for periods during which a Participant expects to incur Health Care Expenses or Dependent Care Expenses or require medical insurance coverage.

2.27 "Plan" means the Sate of West Virginia Public Employee Insurance Agency Section 125 Plan as set forth herein, together with any and all amendments and supplements hereto.

2.28 "Plan Year" means the twelve-month benefit period.

2.29 "Premium Conversion Benefits" means the Medical Benefit Plan and Basic and Optional Life Insurance Program.

2.30 "Spouse" means an Employee's legally married husband or wife.

2.31 "TPA" means the third-party administrator retained by PEIA to administer the Plan.

2.32 "Vision Benefit Plan" means the vision plan offered by PEIA under which benefits are excluded from the Employee's gross income pursuant to Section 105 of the Code.

The masculine gender, whenever used herein, shall include the feminine, and the Singular shall include the plural and vice versa, unless the context clearly indicates otherwise.

ARTICLE III – PARTICIPATION

3.1 Commencement of Participation. All Eligible Employees may participate in and enter the Plan.

(a) With respect to Premium Conversion Benefits, each Eligible Employee shall automatically become a Participant in this Plan for a Period of Coverage on the first day of the first month following enrollment in the Medical Benefits Plan, unless the employee properly files with the Administrator a Benefit Election Form to decline participating in the Plan in accordance with Section 4.5.

(b) With respect to the Mountaineer Flexible Benefits, participation begins when the Eligible Employee elects, pursuant to Section 4.5, to allocate the Contributions available under this Plan to pay for such benefits during an Open Enrollment period. An Eligible Employee is hired after Open Enrollment is not eligible to participate in the Plan until the next Open Enrollment.

(c) The effect of participation, in this Plan is that the Participant's Compensation will be reduced, pursuant to this Plan, by an amount equal to the amounts required as employee contributions for the benefits elected by the Participant.

(d) Except as provided in Sections 3.2 and 4.8, an election to participate in the Plan with respect to a particular Plan Year shall remain in effect for the remainder of that Plan Year.

3.2 Cessation of Participation. Except as provided in Article VIII, a Participant shall cease to be Participant as of the earlier of (a) the date on which the Plan terminates, (b) the date on which the employee ceases to be an Eligible Employee, or (c) the date on which he/she has elected to cancel the applicable benefit coverage(s) under Article IV.

3.3 Reinstatement of Former Participant. A Former Participant who is rehired shall become a Participant again in accordance with Section 3.1. However, in the case of a Participant who separates from service with the Employer during a Period of Coverage and elects to revoke existing benefit elections and terminates the receipt of benefits for the remaining portion of the Period of Coverage, upon return to service, such a Former Participant shall be prohibited from making new benefit elections for the remaining portion of the Period of Coverage.

3.4 Relation to Other Eligibility Requirements. Each of the optional benefits incorporated in this Plan, such as the Mountaineer Flexible Benefits and Premium Conversion Benefits, may have its own eligibility requirements for participation, which may differ from those set forth in this Plan. The eligibility requirements set forth in this Plan relate only to participation in this Plan and shall have no effect on such other eligibility requirements.

ARTICLE IV – BENEFIT OPTIONS

4.1 Benefit Elections. A Participant may elect under this Plan to receive full Compensation for any Period of Coverage in cash or have a portion of his/her Compensation contributed to the Plan by the Employer toward the cost of one or more of the following optional benefits:

(1) Benefits available to the Participant as Premium Conversion Benefits, including, but not limited to, benefits available under the Medical Benefit Plan and Basic and Optional Life Insurance Program;

(2) Benefits available to the Participant as Mountaineer Flexible Benefits, including, but not limited to, the Vision Benefit Plan, Dental Benefit Plan and Long-Term Disability Plan, but excluding the Dependent Care Reimbursement and the Medical Reimbursement Plans;

(3) Benefits available to the Participant under the Dependent Care Reimbursement and the Medical Reimbursement Plans.

4.2 Salary Reduction. By participating in the Plan, each Participant agrees to have his/her annual Compensation reduced by the cost of the benefit(s) selected by him or her under the Plan.

4.3 Description of Benefits Other Than Cash. While the election to receive one or more of the optional benefits described in Section 4.1 may be made under this Plan, the benefit will be provided not by this Plan but by the Employer's Dependent Care Reimbursement Plan, the Medical Reimbursement Plan, any Premium Conversion Benefit plans, and Mountaineer Flexible Benefit plans. The types and amounts of benefits available under each option, and the other terms and conditions of coverage and benefits under such options shall be established and set forth in each of the above plans described in Section 4.1 as provided in their respective Plan Documents, and in the group insurance contracts and prepaid health plan contracts that constitute (or are incorporated by reference) those plans. The benefit descriptions in such plans and contracts, as in effect from time to time, are hereby incorporated by reference into this Plan.

4.4 Election of Optional Benefits in Lieu of Cash. A Participant may elect under this Plan to receive one or more of the optional benefits described in Section 4.1 in accordance with the procedure described in Section 4.5. If a Participant elects any such benefit described in Sections 4.1(1) or 4.1(2), the Participant's Compensation will be reduced by the amount of the Participant's share of the cost of the selected benefit as determined by the Employer, and an amount equal to the reduction will be contributed by the Employer under the respective plans described in Sections 4.1(1) and 4.1(2) to cover the Participant's share of the cost of such optional benefit. Such amount shall be adjusted automatically in the event of a change in such cost. The balance of the cost of such benefit, if any, shall be paid by the Employer with non-elective Employer contributions. If a Participant's net pay is not sufficient to fully fund the salary reduction for benefits offered under Sections 4.1(1) and 4.1(2), the contribution can be made up in the future when the Participant has earned salary sufficient to fund such benefit election.

If a Participant elects an optional benefit described in Section 4.1(3), the Participant's case Compensation will be reduced, and an amount equal to the reduction will be credited by the Employer to a reimbursement account in accordance with the Dependent Care Reimbursement Plan and/or the Medical Reimbursement Plan, as the case may be. If a Participant's net pay is not sufficient to fund the salary reduction for benefits offered under Section 4.1(3) for any payroll period, the Participant's ability to contribute for such payroll period shall be determined in accordance with the Dependent Care Reimbursement Plan and/or Medical Reimbursement Plan, as the case may be.

4.5 Election Procedure. With respect to the cash benefit described in Section 4.1, the Participant must file a Benefit Election Form with the Administrator to receive this taxable cash benefit, and thereby refuse to receive the qualified tax free benefits known as the Premium Conversion Benefits.

Each Participant who desires optional benefit coverage(s) under Sections 4.1(2) or (3), shall so specify on the appropriate Benefit Election Form, as provided by the Employer, and shall agree to a corresponding reduction in Compensation. The amount of the reduction in the Participant's Compensation for the Period of Coverage for each optional benefit described in Sections 4.1(2) and (3), shall be the amount elected by the Participant, subject to the limitations set forth in the separate Plan Documents governing such benefits.

Each Benefit Election Form described in this Section 4.5 must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the Period of Coverage.

4.6 New Participants. An Employee who is hired after the Effective Date and who becomes a Participant in accordance with Section 3.1 or 3.3 hereof shall be provided a Benefit Election Form, as soon as practicable after his date of hire.

An Employee may elect or decline participation in the optional benefit coverage(s) in accordance with Section 4.5 hereof. If a Benefit Election Form must be completed and returned to the Administrator, such form must be returned on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's compensation reduction agreements will apply.

4.7 Failure to Elect. Except as otherwise provided under Section 4.5, a Participant who has elected to be a Participant in the Premium Conversion Benefit described in Section 4.1(1) shall automatically and simultaneously become a Participant in this Plan for such Period of Coverage, without having to complete and return a Benefit Election Form. The Participant shall also be deemed to have agreed to a reduction in Compensation for such Period of Coverage equal to the Participant's share of the cost from time to time during such Period of Coverage of each such optional benefit the Participant is deemed to have elected for such Period of Coverage. If a Participant fails to return a completed Benefit Election Form to the Administrator on or before the specified due date for any subsequent Period of Coverage, the Participant shall be deemed to have elected to continue the same Premium Conversion Benefit elections as in the prior Period of Coverage.

With regard to the Mountaineer Flexible Benefits, the Dependent Care Reimbursement benefits and the Medical Reimbursement benefits described in Sections 4.1(2) or (3) respectively, a Participant failing to return a completed

Benefit Election Form to the Administrator on or before the specified due date for any Period of Coverage shall be deemed to have elected cash compensation in lieu of such optional benefits, regardless of the election in effect during any preceding Period of Coverage.

4.8 Changes by Administrator. If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year the non-discrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, Highly Compensated Individuals, principal shareholders, or owners with or without the consent of such individuals, it may be necessary for the Administrator to change the Plan.

4.9 Irrevocability of Election by the Participant During the Period of Coverage. Elections made under the Plan (or deemed to be made) with respect to the Optional Benefits described in Section 4.1 shall be irrevocable by the Participant during the Period of Coverage, subject to a change in family status. A Participant may revoke a benefit election for the balance of a Period of Coverage and file a new election only if both the revocation and the new election are on account of and consistent with a change in family status as defined below.

A change in family status for this purpose includes marriage or divorce of the Employee, death of the Employee's Spouse or dependent, birth or adoption of a child of the Employee, termination or commencement of employment of a Spouse, the switching from part-time to full-time employment status or from full-time to part-time status by the Employee or the Employee's Spouse and the taking of an unpaid leave of absence by the Employee or the Employee's Spouse and such other events that the Administrator determines will permit a change or revocation of an election during a Period of Coverage under regulations and rulings of the Internal Revenue Service. A Participant may also revoke a benefit election and in lieu thereof receive, on a prospective basis, coverage under another benefit plan with similar coverage if coverage is significantly curtailed or ceases during a Period of Coverage or if the premium amount of a benefit plan significantly increases. Election changes are also permitted where there has been a significant change in health coverage of the Employee or Spouse attributable to the Spouse's employment. Any new election under this Section 4.9 must be filed by the participant with the Administrator within 62 days of the qualifying event, and shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after an election form is completed and returned to the Administrator.

4.10 Automatic Termination of Election. Elections made under this Plan (or deemed to be made) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under the respective plans described in Section 4.1 may continue if and to the extent provided by such plans.

4.11 Maximum Employer Contributions. The maximum amount of Employer contributions under the Plan for any Participant shall be the sum of (a) the maximum amounts which the Participant may receive in the form of dependent care reimbursement under the Dependent Care Reimbursement Plan and as health care reimbursements under the Medical Reimbursement Plan, as set forth in such plans, and (b) the costs from time to time of the most expensive Premium Conversion Benefits and Mountaineer Flexible Benefits available to the Participant (including the portion of such costs payable with non-elective Employer Contributions).

4.12 Effective Periods for Elections. Only Compensation earned after an Employee elects participation in the Plan maybe used to purchase optional benefits described in Section 4.1 for a Participant. Participants may not carry over any overused contributions or benefits from one Period of Coverage to a subsequent Period of Coverage.

4.13 Nondiscrimination. Notwithstanding any provisions of insurance coverage provided for under this Plan and any other provisions of this Plan, this Plan shall not discriminate as to eligibility to participate, contributions or benefits in favor of Highly Compensated Individuals or Key Employees.

ARTICLE V – ADMINISTRATION OF PLAN

5.1 Plan Administrator. The Administrator shall have the sole responsibility for the administration of this Plan which responsibility is specifically described in this Plan. The Administrator shall have the authority to appoint such other person or committee from time to time to supervise the administration of the Plan. The designated representatives of the Administrator shall have only those specific powers, duties, responsibilities and obligations as are specifically given them under this Plan.

The Employer shall have the sole responsibility for making the contributions provided for under Article IV hereof. PEIA shall have the sole authority to amend or terminate, in whole or in part, this Plan at any time with the approval of PEIA's Director.

The Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. Furthermore, the Administrator may rely upon any such direction, information or action of another Employee of the Employer as being proper under this Plan, and is not required under this Plan to inquire into the propriety of any such direction, information or action. It is intended under this Plan that the Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities

and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Administrator nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

All usual and reasonable expenses of the Administrator that are not properly chargeable to or payable by the Plan (including payment out of forfeitures pursuant to Section 5.4) shall be paid by the Employer, and any expenses not paid by the Employer shall not be the responsibility of the Administrator personally. The Administrator or any other designated representative of the Employer who is an Employee of the Employer shall not receive any compensation with respect to services hereunder except as such person may be entitled to benefits under this Plan.

5.2 Records and Reports. The Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participant and the balances, if any, which are maintained under this Plan. The Administrator shall be responsible for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 125 plans.

5.3 Other Powers and Duties of the Administrator. The Administrator shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not limited to, the following:

(a) To prescribe such procedures as the Administrator deems necessary or proper to be followed by Participants in the filing of applications for benefits;

(b) To construe and interpret the Plan, its construction and interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To prepare and distribute, in such manner as the Administrator determines to be appropriate, information explaining the Plan;

(e) To receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(f) To furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate;

(g) To receive, review and keep on file (as it deems convenient and proper) reports of benefit payments by the Employer and reports of disbursements for expenses directed by the Administrator;

(h) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and,

(i) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry our any of it responsibilities under the Plan, any such allocations, delegation, or designation to be in writing.

The TPA shall have no power to add to, subtract from, or modify any of the terms of Plan, or to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan.

Notwithstanding anything herein to the contrary, any claim which arises under the plans described in Section 4.1 shall not be subject to review under this Plan, and the Administrator's authority under this Section 5.4 shall not extend to any matter the determination of which an Administrator under the respective plan is empowered to make.

5.4 Examination of Records. The Administrator shall make available to each Participant for examination (at reasonable times during normal business hours) such of the records under the Plan as pertain to such Participant. The Administrator shall be responsible for complying with all notice, reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 125 Plans.

5.5 Reliance on Tables, etc. In administering the Plan, the Administrator shall be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of the administrators of the plans described in Section 4.1 or by accountants, counsel (legal or otherwise), or other experts employed or engaged by the Administrator.

5.6 Rules and Decisions. The Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Administrator, whether discretionary or otherwise, shall be exercised in a uniform and consistent manner so that all persons similarly situated will receive substantially the same treatment. When making a determination or calculation, the Administrator shall be entitled to rely upon information by a Participant, the Employer, or the legal counsel of the Employer.

5.7 Procedures. The Administrator may act at a meeting or in writing without a meeting. The Administrator may adopt such bylaws and regulations as it deems necessary for the conduct of its affairs.

5.8 Authorization of Benefit Payments. The Administrator shall issue directions to the Employer concerning all benefits which are to be paid from the Employer's general assets pursuant to the provisions of the Plan, and warrants that all such directions are in accordance with the Plan.

5.9 Application and Forms for Benefits. The Administrator may require a Participant to complete and file with the Administrator an application for a benefit and all other forms approved by the Administrator, and to furnish all pertinent information requested by the Administrator. The Administrator may rely upon all such information so furnished it, including the Participant's current mailing address.

5.10 Facility of Payment. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a benefit or installment thereof hereunder is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such person or to the person's legal representative or to a relative of such person for such person's benefit, or the Administrator may direct the Employer to apply the payment for the benefit of such person in such manner as the Administrator considers advisable. Any payment of a benefit or installment thereof in accordance with the provisions of this Section 5.11 shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

5.11 Indemnification of Administrator. The Employer agrees to indemnify and to defend to the fullest extent permitted by law, any individual serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against any and all liabilities, damages, costs and expenses (including reasonable attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or failure to act in connection with the Plan, if such act or failure to act is made in good faith pursuant to the provisions of the Plan.

5.12 Claims Procedure.

(a) A claim for benefits under the Plan shall first be filed with the TPA. Notice of the decision shall be furnished to the claimant by the TPA within a reasonable period of time after receipt of the claim by the TPA. IF a Participant does not receive notice of denial of a claim for benefits under the Plan within 90 days of the filing of such claim, then the claim shall be deemed denied.

(b) A claimant may review all pertinent documents and may request a review by the TPA of any claim. Any such request must be filed in writing with the TPA within 90 days after the earlier of (i) receipt by the claimant of

written notice of the decision on the claim or (ii) 90 days after the initial filing of such claim. Such written request for review shall contain all additional information which the claimant wishes the TPA to consider. Notice of the decision on review shall be furnished in writing to the claimant within 90 days (unless special circumstances require an extension of up to 90 additional days) following the receipt of the request for review. The TPA's written decision shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan or of the Plan Documents on which the decision is based.

(c) If such claim is denied by the TPA, a claimant may appeal in writing to PEIA. Such appeal must be filed with PEIA within 30 days of receipt of the TPA's decision denying such claim. All information relating to the denial, including a copy of the denial letter from the TPA, must be supplied to PEIA by the claimant. PEIA shall, after reviewing the facts, make a final determination and notify the claimant of its decision. Such decision shall be final and binding.

5.13 Claims and Review Procedure for Insured Benefits. To the extent that benefits hereunder are provided by an insurance company, the provisions of Section 5.12 shall not apply to claims for such benefits, and claims shall be filed with and subject to review by such insurance company.

ARTICLE VI – AMENDMENT AND TERMINATION OF PLAN

6.1 Amendment and Termination. PEIA hopes and expects to continue this Plan indefinitely and every effort has been made to arrange its provisions so that it will meet future conditions insofar as they can be foreseen. However, in order to protect against unforeseen circumstances, PEIA reserves the right to make any amendment it deems necessary or desirable, or to terminate this Plan at any time by an instrument in writing executed by the Director of PEIA.

However, no such amendment or termination of the Plan shall adversely affect the rights of any Participant hereunder (a) with respect to any balance remaining in his Dependent Care Reimbursement Plan or Medical Reimbursement Plan at the time of such amendment or termination; or (b) with respect to any claims incurred prior to such amendment or termination for the optional benefits described in Section 4.1 hereof.

ARTICLE VII – MISCELLANEOUS PROVISIONS

7.1 Information to be Furnished. Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

7.2 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or Administrator, except as provided herein. No Employer or Employee upon termination of employment or otherwise shall have additional rights or benefits under the Plan, except as provided from time to time under this Plan, and then only the extent of benefits payable under the Plan to such Employee or beneficiary. All payments of benefits as provided for in this Plan shall be made solely out of the assets of the Employer and the Administrator shall not be liable therefor in any manner.

7.3 Governing Law. This Plan shall be construed, administered and enforced according to the laws of the State of West Virginia.

7.4 Selection of Beneficiaries. In the case of any insurance policy which permits or requires the naming of a beneficiary, it shall be the responsibility of the Employee to see to it that this is done. The Employer shall not be liable for any loss or cost which may result from such failure. The Employer's responsibility shall be limited to joining in the execution of any documents as requested by an Employee or insurance carrier in order to carry out the purpose of this Plan.

7.5 Non-alienation of Benefits. Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable hereunder, shall be void. The Employer shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits hereunder.

7.6 Divestment of Benefits. Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to the benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.

7.7 Discontinuance of Contributions. In the event of a permanent discontinuance of contributions to the Plan, all Participants shall receive any and all benefits to which they were entitled as of the date the discontinuance of contributions occurred.

7.8 Non-guarantee of Employment. Neither the establishment or continuance of the Plan, nor any modification thereof, nor the establishment or continuance of any Medical Benefit Plan or any trust, nor the payment of any benefits, shall give any participating Employee, or other person whomsoever the right to be retained in the service of any Employer or PEIA, and all Participants and other Employees shall remain subject to discharge to the same extent as if the Plan had never been adopted.

7.9 Binding Effect. Subject to the other provisions of this Article VII, this Plan shall be binding upon PEIA and each Employer, their successors and assigns, and upon anyone participating in, or claiming benefits under, the Plan, including each Participant and each of the beneficiaries, heirs, executors, administrators, personal representatives, successors and assigns.

7.10 Severability. If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective, unless such action would then render the Plan inoperable relative to its original intent.

7.11 Construction of the Plan. The Director may construe any ambiguous provisions of the Plan, correct any defect, supply any omission, or reconcile any inconsistency, in such manner and to such extent as the Director in his discretion may determine; any such action of the Director shall be binding and conclusive upon all Participants.

7.12 Benefits Solely From Assets. The benefits provided hereunder will be paid solely from the assets of the Employer. The benefits provided by the Plan are given in exchange for the Participant's salary reduction agreement. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset for the Employer from which any payment under the Plan may be made.

ARTICLE VIII – CONTINUATION COVERAGE

8.1 Right to Elect Continuation Coverage. To the extent required by COBRA, a Participant, the Participant's Spouse, ex-spouse, and the Participant's dependent child can elect continuation coverage of such optional benefits available under the Employer's Medical Benefit Plan and Medical Reimbursement Plan, Dental Benefit Plan, and vision.

V

MEDICAL BENEFITS PLAN

Introduction

The Medical Benefits Plan described in this section refers to medical benefits offered as part of the PEIA Preferred Provider Benefit (PPB) Plan. The PEIA PPB Plan replaced the PEIA Indemnity Plan effective July 1, 1999. For a discussion of medical benefits provided through one of PEIA's managed care offerings, refer to Section VII of this Plan. For a discussion of prescription drug benefits offered as part of the PEIA PPB Plan, please refer to Section VI of this Plan.

The Medical Benefits Plan pays for a wide range of health care services for PEIA insureds. These benefits include hospital services, medical services, surgery, durable medical equipment and supplies. To be covered, the service must be medically necessary or be a specified preventive care or wellness service.

Deductibles, Coinsurance, Copayments and Plan Maximums

The PEIA PPB Plan is designed to provide as much care as possible within the State of West Virginia. The PEIA Preferred Provider Organization (PPO) is made up of West Virginia providers who accept PEIA's reimbursements and providers in the Acordia/PEIA Network to provide services to PEIA for out-of-state care. For a detailed description of the network, see **PEIA PPO** in this Section. The deductibles and coinsurance amounts paid by insureds vary based on where care is received and the provider's participation in the PEIA PPO.

Under the cost-sharing benefit design of the PEIA PPB Plan, some services are paid at 100% with no copayment or deductible; some are subject to a copayment only; some are subject to the coinsurance and deductible, and some are subject to the copayment, coinsurance, and deductible. The following section describes the applicable cost-share involved with each type of service.

Deductibles. A deductible is the amount that an insured must pay toward approved medical expenses before the Medical Benefits Plan begins to pay. Services applied to the deductible must have been received in the same Plan Year in order for it to count toward the deductible for that Plan Year (i.e., expenses incurred in one Plan Year cannot be used to meet a deductible for a subsequent Plan Year).

Deductibles for the Medical Benefits Plan are based on the employee's annual salary, tier of coverage (Employee Only, Employee and Child(ren), Family, or Family with Employee Spouse), employment status, and whether you get your services within the PEIA network or outside the network. Medical expenses for an individual may apply to both the individual's deductible and the family deductible; however, an individual may

not otherwise use the medical expenses of another individual to meet the individual deductible. Once the family deductible has been met, then the deductible requirement will be satisfied for the Plan Year for each and every member of the family.

There is also a separate deductible for services received outside of the PEIA PPO. The out-of-network deductible is twice the amount of the in-network deductible. Any medical charges applied toward the out-of-network deductible for services received outside of the PEIA PPO can also be applied to the in-network deductible. However, the in-network deductible cannot be applied to the out-of-network deductible; it must be satisfied separately.

Deductibles for Family with Employee Spouse coverage are based on the average of the two employees' salaries. Add the annual salaries together and divide by two to get the basis of the premium. This provision does not apply to local government agency employees or retired employees. The deductible for local government agencies and retired employees in PPB Plan A is the same as that of the active employee salary tier for employees with a salary range of $36,001 to $42,000.

A current listing of deductibles for the Medical Benefits Plan is contained in Appendix C. Deductibles for the Prescription Drug Plan are addressed in Section VI and are separate from the Medical Plan.

Coinsurance. Once the annual deductible has been met (and copayment, when applicable), the Medical Benefits Plan will pay a percentage of the allowed amount for the covered service. The allowed amount is the maximum level of payment that the PEIA has authorized for a covered service. The coinsurance amount (20% or 40%) is determined according to where the insured lives, where the services are received and whether the provider participates in the PEIA Network. For services provided within the State of West Virginia or in a bordering county of a surrounding state using PPO providers, the Plan pays 80% of the allowed expense and the insured pays the remaining 20%. These amounts increase to 40% when an insured who lives in West Virginia or a bordering county accesses care from non-PPO providers outside of the State and beyond the bordering counties or from non-PPO providers in bordering counties. Coinsurance levels due from insureds can be reduced by obtaining prior approval whenever they receive services either outside of the State or from non-PPO providers. For a detailed explanation of this process, **see Prior Approval** in this Section.

A current schedule of coinsurance for services covered under the Medical Benefits Plan is contained in Appendix C. For information concerning the PEIA PPO Network, **see PEIA PPO in this Section.**

Copayments. A copayment is a flat dollar amount for which the insured is responsible upon receipt of medical services. Certain services are subject to a copayment under the Medical Benefits Plan, including all physician's office visits, except well child care visits. When seeking preventive care at a physician's office, the

visit will be subject to a $10 copayment. Office visits to treat an illness or injury or for specialty care are subject to a $15 copayment. Insureds do not have to meet the annual deductible in order for the office visit copayments to apply. However, these copayment amounts do not count toward the out-of-pocket maximum.

Certain other services covered under the Medical Benefits Plan are subject to a copayment in addition to the standard coinsurance level after the annual deductible has been met. The coinsurance amounts paid for these services do count toward the out-of-pocket maximum.

A current schedule of copayments for services covered under the Medical Benefits Plan is contained in Appendix C.

Out-of-Pocket Maximums. An out-of-pocket maximum is the most money, in coinsurance, (excluding copayments), that an insured has to pay for covered services in one Plan Year. After the out-of-pocket maximum has been met by an insured, the Medical Benefits Plan will pay the 20% coinsurance amount in addition to the 80% already paid by the Plan for the remainder of the Plan Year. Amounts paid toward annual deductibles, for copayments, for precertification penalties, for prescription drugs and for services not covered under the Plan do not apply to the out-of-pocket maximum. The out-of-pocket maximum includes only medical coinsurance.

The out-of-pocket maximum is based on employment status, annual salary, where services are received, and whether the provider participates in the PEIA PPO. The out-of-pocket maximum is the same for single and family plans; it is a per-contract amount that does not change regardless of the number of dependents covered under the contract.

There are separate out-of-pocket maximums for in-network and out-of-network expenses. For insureds living within the State of West Virginia or a bordering county, any medical charges, which result from care received from a West Virginia provider or from an Acordia/PEIA Network Provider with prior approval will be applied to the in-network out-of-pocket maximum. Insureds living beyond the bordering counties of the state may apply any medical charges incurred from care received through a participating network provider to the in-network out-of-pocket maximum. All other charges for covered services are applied to the out-of-network out-of-pocket maximum, unless previously approved by the TPA-C.

Medical charges applied to the in-network out-of-pocket maximum cannot be used to satisfy the out-of-network out-of-pocket maximum. However, expenses for out-of-network services can be applied to the in-network out-of-pocket maximum. A current list of out-of-pocket maximums is contained in Appendix D.

Benefit Maximums.

Annual Maximums. For certain types of covered services, the Medical Benefits Plan will pay up to a set amount per Plan Year. Those services and the specific amounts are contained in Appendix D.

The PEIA may authorize payments, if indicated in Appendix D, in excess of the annual maximum when the service is medically necessary as recommended by its Third-Party Administrator for Utilization Management (TPA-UM). In order for the service to be covered, approval for exceeding the annual maximums must be received from the TPA-UM prior to obtaining the service. Approval can be obtained in the same manner as a precertification request as described in this Section.

Lifetime Maximums. The Medical Benefits Plan will pay a maximum of $1,000,000 in benefits per insured. The Director of the PEIA, has sole discretion, to authorize payment in excess of the lifetime maximum. The insured must request an exemption from the lifetime maximum, in writing, prior to exceeding the lifetime maximum level. Requests should be sent to the Director.

Providers

Eligibility. In order to be eligible for payment as a covered service under the Medical Benefits Plan, the service must be rendered by a health care professional who is licensed and qualified under the laws of the jurisdiction in which the care is received and who is providing treatment within the scope of his/her professional license. If the service is provided by a medical facility such as a hospital or treatment center, the facility must be Medicare or JACHO approved.

Reimbursement Rates. Reimbursement rates for all providers are established by the PEIA and are not subject to review by the West Virginia Health Care Authority. These rates represent the maximum amount the PEIA will pay for a covered service. PEIA will notify providers of changes to the reimbursement rates within thirty days, when possible.

West Virginia Physicians and Other Health Care Professionals. West Virginia physicians and other health care professionals are paid according the Resource-Based Relative Value Scale (RBRVS) and policy provisions. Services included under RBRVS are processed to allow charges up to the RBRVS fee allowance. Services billed that are not covered by RBRVS will be subject to a set discount, maximum allowance or discount from charges.

West Virginia Facilities. Most West Virginia hospitals are paid for inpatient admissions in accordance with the Prospective Payment System (PPS) methodology. Outpatient RBRVS services performed at a facility are paid according to the RBRVS

payment schedule. Facility admissions and services that are not covered under the PPS or RBRVS methodology will be paid on a discount-from-charges basis.

Out-of-State Physicians and Other Health Care Professionals. Physicians and other health care professionals participating in the Acordia/PEIA Network are paid according to their contractual agreements. Non-participating physicians and providers may be paid a negotiated rate, paid in full or paid a discounted rate based upon reasonable and customary charges. In some circumstances, the insured may be paid directly when the provider is a nonparticipating provider.

Out-of-State Facilities. Facilities participating in the Acordia/PEIA Network are paid according to their contractual agreements. For non-participating facilities, inpatient and outpatient non-RBRVS services may be paid on a negotiated rate, paid in full or paid a discounted rate based on reasonable and customary charges. In some circumstances, the insured may be paid directly when the provider is a nonparticipating provider.

Durable Medical Equipment (DME) and Supplies from West Virginia Providers. DME and supplies are paid in accordance with the DME fee schedule as determined by PEIA.

Home Health Care from West Virginia Providers. Home Health Care is paid in accordance with the Home Health Care Fee Schedule as determined by PEIA.

Other Services. All other covered services not subject to RBRVS, PPS or an established fee schedule are paid on a discount-from-charge or discount-from-payment basis.

PEIA PPO. The PEIA Preferred Provider Organization (PPO) is made up of all West Virginia providers who accept PEIA's insureds as patients. This includes providers located within the State of West Virginia, as well as in the bordering counties of the surrounding states, who participate in the Acordia/PEIA Provider Network. Care for covered services received from a provider in the PEIA PPO by a PEIA insured will be covered at the highest level of benefit and the services received do not require prior approval.

Residents of West Virginia and Bordering Counties. In order to ensure that the highest level of benefit is paid for out-of-state care (beyond the bordering counties to West Virginia), a PEIA insured who lives within the State of West Virginia or in one of the bordering counties must obtain prior approval for all services received, except in the case of an emergency. West Virginia residents and insureds living in bordering counties will be subject to a higher coinsurance when they receive out-of-state care (beyond the bordering county) that has not been previously approved, even if the provider is a member of the Acordia/PEIA Network. For a detailed explanation of this requirement, see Prior Approval in this Section.

Out-of-State Residents. PEIA insureds who live beyond the bordering counties of West Virginia may seek care from a Acordia/PEIA Network participating provider at any time without prior approval for covered services. Services that have not been previously approved will be covered at the highest level of benefit for out-of-state residents only.

Emergency Out-of-State Care. If any PEIA insured who is a resident of West Virginia or a bordering county must seek emergency medical care in another state, it is not necessary to obtain prior approval, and the service will be covered at the higher benefit level.

Medicare Primary Insureds. PEIA insureds who have Medicare as their primary plan are not subject to PPB Plan network requirements. It is not a requirement that they seek services from network providers and prior approval is not required.

Non-PPO Providers. Any PEIA insured may seek prior approval for a service to be provided outside of the State of West Virginia from a non-PPO provider. If the request is approved, the service will be covered at the higher benefit level (80%). Services received outside of the State from non-PPO providers without prior approval will be subject to a lower benefit level (60%) for all PEIA insureds.

Covered Services

Medically Necessary Services. To be covered by this Medical Benefits Plan, the service must be medically necessary or be one of the listed preventive health or wellness services. Services rendered by a medical provider who is not authorized by this Medical Benefits Plan to provide the service or supplies will not be covered. A service is considered to be medically necessary if it is:

- consistent with the diagnosis and treatment of the injury or illness;
- in keeping with generally accepted medical practice standards;
- not solely for the convenience of the patient, family or health care provider;
- not for custodial, comfort or maintenance purposes;
- rendered in the most cost-efficient setting and level appropriate for the condition; and,
- not otherwise excluded from coverage under the Medical Benefits Plan.

The fact that an authorized health care provider has determined that a service is medically necessary does not necessarily make it a covered service. The PEIA reserves the right to make final determination on the medical necessity of the service based on the diagnosis and supporting medical data.

Specific Covered Services. The following is a list of services that are specifically covered under the Medical Benefits Plan. The appropriate level of coinsurance, copayment, and deductible apply to all services as described in this Section.

Acupuncture. Services of a licensed acupuncturist for treatment of medical conditions are included in the Outpatient Therapy Benefit (see below) and are covered at 20% coinsurance after the in-network deductible. Contact the TPA – C for specific benefit limitations. Combined coverage for these therapies is limited to a maximum plan cost of $1,000 per person per plan year. Office visits are covered with a $15 copayment and treatments are covered at 80% after the in-network deductible is met.

Allergy Services. The PEIA covers the physical examination, including skin testing, diagnosis, and treatment of allergic conditions. Allergy serums and extracts provided by the physician are also covered.

Ambulance Services.

- Local Ground Transportation: Services are covered for emergency patient transportation by a licensed ambulance service. The transportation must be to the nearest appropriate hospital for inpatient care, or medical emergency care, or transportation from a hospital to the nearest facility able to provide services not available at the transferring hospital or facility.

- Non-Local Ground Transportation: Transportation of the patient between a hospital which does not offer the required service to the nearest hospital which is able to provide those services is covered.

- Air Ambulance Transportation: Expenses for air ambulance services are covered if the services are medically necessary and the services provide transportation to the nearest hospital able to provide the treatment.

- Transportation from hospital to home is not covered, unless approved by the TPA-UM.

Birth Control. The following drugs and procedures are covered expenses for policyholders and their eligible spouses:

- Tubal ligation;

- Vasectomy;

- Birth control pills: Birth control pills must be purchased at a drug store or through the mail order program and are covered under the Prescription Drug Plan;

- IUD and insertion;

- Birth control implants: covered expenses include the cost of the system and the charges for insertion and removal of the capsules one time every five years;

- Depo-provera injections: covered once every three (3) months. Office visits are not covered when the injection is the primary purpose of the visit.

The Plan does not cover:

- Reversal of a vasectomy or sterilization;

- Birth control pills for contraception purposes for dependent children. They are covered expenses under the Prescription Drug Plan if previously authorized and determined to be medically necessary for purposes other than contraception; or

- Birth control implant covered expenses do not include charges for reinsertion of capsules for the one-year period after the removal if the capsules must be removed due to medical conditions.

Cancer Treatments. Treatments for cancer are covered expenses unless the treatment is experimental in nature. Bone marrow transplant treatment for cancer requires precertification by the Third-Party Administrator for Utilization Management (TPA-UM) (see Organ Transplants in this Section).

Cardiac Rehabilitation. Cardiac rehabilitation expenses are covered when incurred due to one of the following conditions:

- Acute myocardial infarction (heart attack),

- Coronary by-pass surgery, or

- Stabilized angina pectoris.

Cardiac rehabilitation for any other condition is not a covered expense.

Covered treatments may be provided at a clinic, a cardiac rehabilitation clinic, or the outpatient department of a hospital and are limited to three (3) sessions per week for 12 weeks or 36 sessions in a twelve-month period. Treatment must commence within three months of the cardiac event.

Cardiac rehabilitation must be precertified in advance by the provider through the TPA-UM.

Chelation Therapy. Covered services include removal of unwanted metal ions from the body for the treatment of the following conditions:

- Hemochromatosis,
- Thalassemia (major),
- Cystinuria,
- Heavy metal poisoning from such substances as arsenic, copper, gold, iron, lead, or mercury,
- Wilson's Disease, and
- Control of ventricular arrhythmias, etc., associated with digitalis toxicity.

Chelation therapy treatment for the conditions listed above is not considered investigational. Chelation therapy is considered investigational, and is not covered for all other conditions including reversal or prevention of coronary artery disease.

Chemotherapy. This treatment is covered when ordered by a physician and may be received on either an inpatient or outpatient basis. Most cancer treatments are case managed by the TPA-UM.

Chiropractor. Covered chiropractic services include office treatment for neuro-muscular-skeletal conditions, x-rays, and massage therapy when provided by a massage therapist or neuromuscular therapist and billed by the chiropractor. These services are included in the Outpatient Therapy Benefit (see below). Payments for the combined therapies are limited to a maximum of $1,000 per Plan Year, per insured. Office visits and x-rays billed by a chiropractor do not apply to the $1,000 maximum.

Christian Science Benefit. Charges for inpatient or outpatient treatment are covered if:

- The treatment is for a demonstrable illness or injury;
- The Christian Science Sanitarium where the treatment is received is maintained and accredited by the Mother Church at the time of the service;

- The treatment is performed by a practitioner or nurse who is accredited by the Mother Church and who is listed in the Christian Science Journal's most recent issue at the time of the treatment; and,

- The individual receiving the treatment is not, at the same time, receiving medical treatment for the same condition.

Covered expenses do not include treatment for the purpose of rest or study or communication charges.

The maximum benefit payable is $1,000 per calendar year, per insured. Inpatient services are covered in excess of the $1,000 if medically necessary and precertified by the TPA-UM.

Colorectal Cancer Screening. Screenings for colorectal cancer as shown in the chart below are covered at 100% in-network with no deductible or coinsurance required. The related office visit expenses are subject to the applicable preventive care office visit copayment.

Preventive Care PPB Plan Benefits for PEIA

Benefit	Coverage as of July 1, 2000
Colorectal Cancer Screening*	100% coverage in-network; out of network coverage is 60% after out-of-network deductible is met. This benefit is covered as follows: 82270 Fecal-occult blood test – 1 in 12 months/age 50 and over 45330 Flexible Sigmoidoscopy – 1 in 48 months/age 50 and over 45378 Colonoscopy – 1 in 24 months/high risk** patients or 1 in 10 years/age 50 and over 74280 X-ray, barium enema – 1 in 4 years/age 50 and over 74280 X-ray, barium enema – 1 in 24 months/high risk patients**

*Office visits associated with these services are subject to the applicable copayments, coinsurance, and deductibles.

**High risk is defined as a patient who faces high risk for colorectal cancer because of:

- Family history;
- Prior experience of cancer or precursor neo-plastic polyps;
- History of chronic digestive disease condition (inflammatory bowel disease, Crohn's disease, ulcerative colitis; and
- Presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors.

(High risk status is not required if age 50 or older.)

Diabetes Education Program. Educational programs for diabetics are covered expenses when the program has been reviewed and determined to meet national standards for diabetes education programs. The TPA-C should be contacted to see if the program being considered is approved.

Durable Medical Equipment (DME). Durable medical equipment is a covered expense. Precertification is required for all DME purchases of $1,000 or more, or rentals of more than three months. If precertification is not obtained, a 30% penalty will be applied even if it is later determined that the DME was medically necessary. The insured's provider must submit a letter of medical necessity or call the TPA-UM stating the length of time the equipment will be needed, its cost, and the reason the equipment is needed. The PEIA covers the item, in accordance with the fee schedule for DME and supplies, if purchased, and rental up to the purchase price, if it is rented.

Durable medical equipment coverage does not include:

- Equipment primarily for comfort and convenience (such as remote controls and intercoms);
- Exercise equipment (such as stationary bicycles or weights);
- Educational equipment (including computers and vocabulary assistance devices);
- Environmental control equipment (including air conditioners or vacuum cleaners); or
- Portable whirlpool pumps (tub spas).

A further listing of some of the non-covered equipment is provided in Appendix E. If the insured has a question whether the DME is covered under the Plan, they should contact the TPA-C.

Ear Care. Hearing tests are covered as wellness benefits for children under age 13. For individuals over the age of 12, hearing tests are covered if they are for a medical condition, including hearing loss unless it is hearing loss as a result of the normal aging process. Hearing tests as part of routine physical examinations are not covered for individuals over age 12.

Other covered ear care expenses include patching of perforated eardrum and otoplasty to correct birth defects.

Hearing aids, hearing implants, ear plugs, and ear molds are not covered expenses.

Emergency Medical Services (including supplies). Services received when the condition has been certified as an emergency are subject to a $25 copayment and 20% coinsurance in-network once the deductible has been met.

Emergency Room Treatment (non-emergency). Services received in an emergency room when the condition is determined to be a non-emergency are subject to a $50 copayment and 20% coinsurance in-network after the annual deductible has been met.

Eye Care. Diagnosis and treatment of a disease, medical condition, or injury to the eye are covered expenses. Covered expenses include, but are not necessarily limited to, treatment for the following diagnoses:

- Neoplasm of the eye,
- Diabetic retinopathy and cataract,
- Disorders of the globe,
- Retinal detachments, defects, and other disorders,
- Chorioretinal inflammations, scars, and other disorders of the choroid,
- Disorders of the iris and ciliary body,
- Glaucoma,
- Cataracts,
- Keratitis,
- Disorders of the conjunctiva,
- Inflammation of the eyelids and other eyelid disorders,
- Disorders of the lacrimal system,
- Disorders of the orbit,
- Disorders of the optic nerve and visual pathing; and,
- Disorders of binocular eye movements.

Claims for diagnoses which require additional review (preauthorization is recommended) by the TPA-C include:

- Visual disturbances,
- Blindness and reduced vision,
- Dyslexia, and
- Vision Therapy.

The first pair of contact lenses or eyeglasses after cataract or retinal detachment surgery is covered unless the surgery included a lens implant. Vision therapy services indicated by a medical diagnosis are also covered. Preauthorization is recommended and this benefit is subject to the $1,000 outpatient therapy benefit limitation.

Services not covered include routine or preventive eye care, refractions, eye exams, disorders of refractions and accommodation, radial keratomy, and other surgeries intended solely to restore or correct vision.

Foot Care. Expenses covered include medically necessary foot care performed by a health care provider practicing within the scope of his/her license. This would include such services as:

- Diagnostics services (such as X-rays and lab work),
- Orthotics (precertification is required),
- Treatment of bunions, neuromas, hammertoe, hallux valgus, calcaneal spurs or exstosis,
- Removal of nail matrix or root,
- Treatment of mycotic infections; and,
- Diabetic foot care.

Expenses not covered include:

- Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), hypertrophy (growth of tissue under the skin);
- Cutting, trimming, or partial removal of toenails;
- Treatment of flat feet, fallen arches, or weak feet; and
- Strapping or taping of the feet.

Gynecological and Breast Exams. Annual screening pap smear and mammogram is covered. Office visits and general physicals associated with these exams are also covered and are subject to a $10 copayment with no deductible. Annual screening pap smears and mammograms are covered at 100% and are not subject to deductible, coinsurance or copayments.

High Risk Birth Score Program. Infants identified at birth as being at risk for health problems are provided with six office visits in addition to the standard well-baby care. There will be no deductible or copayment required for these visits. The extra visits are to be scheduled when the baby is 2, 4, 8, 12, 16, and 24 weeks of age.

Home Health Care. Covered home health services include care in the patient's home from nurses, IV and infusion therapists, physical, speech, occupational, or respiratory therapists along with medical equipment and supplies. To be covered, services must be provided by licensed Home Health Agencies and prescribed by the patient's treating physician in place of inpatient care. Home health care must be precertified by the TPA-UM, and requires case management.

Home health care services are not covered for:

- Custodial or intermediate care, including services related to performance of activities of daily living;
- Personal convenience services (such as shopping or housekeeping); and
- Care given by a relative living in the same household.

Hospice. Hospice services provided by a nurse-coordinated or unit-based hospice program are covered. An insured requiring hospice care must have his/her physician order the service and receive precertification from the TPA-UM; and the service is subject to case management. This service is not covered if the insured is receiving medical treatment other than for pain management.

Hospital Inpatient Expenses. Hospital admissions due to illness, injury, mental health or substance abuse, detoxification, medical rehabilitation, or extended care in a skilled nursing facility are covered. Hospital charges related to pregnancy of a policyholder or spouse are also covered.

The TPA-UM must be notified 5 business days in advance by the admitting physician, or admitting facility, for review and/or case management prior to any planned hospital admission, unless the admission is for the treatment of a medical emergency or related to an accident in which case the hospitalization must be reported to the TPA-UM within 48 hours of the admission. If the TPA-UM is not notified, a 30% penalty will apply even if the admission is later determined to be medically necessary.

Covered expenses include:

- Room and board (semi-private);
- Cardiac and ICU care; and
- Additional Services and supplies used for diagnosis or treatment while the insured is in the hospital.

The following services are not covered:

- Admissions which are not recommended or scheduled by a provider authorized to schedule admissions;
- Room and board which is not approved as medically necessary by the TPA-UM;
- Hospital stays which are not medically necessary or which are primarily for education or training;
- Charges for a diagnosis or procedure which is not covered by the PEIA;
- The difference between semi-private and private room charges;
- Charges for conveniences, such as TVs, telephones, hairdresser or barber services, and shaving supplies;
- Charges by a federal hospital for injuries, illness, or disability resulting from war;
- Charges due to a work-related injury or illness, unless denied by Workers' Compensation; and
- Days for which the patient has a therapeutic leave of absence pass.

Hypertension (High Blood Pressure) Screening. Hypertension screening services including a detailed office visit, blood pressure check, and chemistry profile are covered based on this schedule:

- One time between the ages of 20 and 30,
- Once every 3 years between the ages of 31 and 39, and
- Once every 2 years after age 40.

More frequent screenings are not covered expenses.

Immunizations. All non-experimental immunizations are covered. Childhood immunizations for children through age 16 are payable at 100% and are not subject to a deductible, coinsurance or copayment (see Pediatric Care in this Section). All other immunizations will be paid at the normal rate of a $10 copayment for the office visit with immunization for in-network services at 100% for certain approved immunizations and 80 % for others, and 60% for out-of-network services after the out-of-network deductible has been met. Routine office visits at the time of immunization are also covered at 100% for children through age 16 without a deductible, coinsurance or copayment. In-network office visits for insureds age 17 and over are covered at the copayment level of $10.00 if the office visit is one of the periodic physicals as recommended in the guidelines for pediatric and adult preventive care but are subject to the $15.00 copayment if it is not one of the scheduled preventive care services.

Infertility and Sterility. Treatment of a medical condition resulting in infertility is covered. Services intended to enhance fertility or to treat infertility or sterility, including prescription drugs, are not covered. The following procedures and related expenses are not covered:

- In vitro fertilization,
- GIFT (gamete intrafallopian transfer),
- Embryo transport,
- Surrogate parenting,
- Donor semen, and
- All other methods of artificial insemination.

Massage Therapy. Massage therapy is included in the Outpatient Therapy Benefit (see below). Payments for the combined therapies are limited to a maximum of $1,000 per Plan Year, per insured.

Massage therapy may be provided either through a chiropractor's office or an independent massage therapist. In either case, the massage therapist must be licensed or certified in the state in which the services are performed or be certified through the National Massage Therapy Association. Where a massage therapist is not employed by or associated with a chiropractor, the treatment must be ordered by a physician who certifies medical necessity, provides a treatment plan (including duration and frequency), and states the patient's prognosis.

When services are billed by an independent massage therapist or through a chiropractor's office, further information must be provided to the TPA-UM if:

- The therapy begins more than 90 days after the onset of the condition;
- The frequency of the therapy is more than 5 times a week in the first week and more than 3 times a week in the following weeks;
- The duration of the therapy is greater than 90 days;
- The TPA-UM determines medical necessity.

Mastectomy. Any insured who is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with such benefits is entitled to receive the following procedures:

- Reconstruction of the breast on which the mastectomy was performed;
- Reconstruction surgery of the other breast to present a symmetrical appearance; and
- Prostheses and coverage for physical complications at all stages of the mastectomy procedure including lymphedas.

Maternity Care. Benefits are payable only for the policyholder or the policyholder's spouse. Covered benefits include services normally provided in maternity cases including care during pregnancy, delivery, and postpartum or follow-up care. Birthing centers and certified nurse midwife services are covered.

Professional Services. An uncomplicated pregnancy and delivery is paid at 100% under a global fee arrangement (a set amount the PEIA has established to cover obstetrical care, including delivery) after the annual deductible has been met and usually includes patient histories, physical examinations, recording of weight, blood pressure and fetal heart tones, routine chemical urinalysis, and regular visits until delivery. Facility services for maternity care are covered at 80% after the deductible is met.

One obstetrical profile is covered at 100% of the allowed amount after the deductible has been met, and usually includes:

- Hemoglobin/hematocrit,
- Blood types, RH factor, RH immunization,
- Urine culture,

- Rubella titer, and

- Chemistry profile.

One routine obstetrical sonogram or ultrasound is also covered at 100% of the allowed amount after the deductible has been met. Additional sonograms and ultrasounds are not covered unless they are medically necessary. When additional sonograms are determined to be medically necessary, they are covered at 80% after the deductible has been met.

Other medically necessary maternity services are considered outside the global fee allowance.

Pre-Payment Benefit. If the insured is eligible for maternity benefits under the Medical Benefits Plan, she can arrange to have a $500 maternity care pre-payment made to the attending provider by submitting the required pre-payment form and either an assignment of benefits form or a statement from the provider that the required deposit has already been paid. No portion of the $500 pre-payment will be applied to the deductible. Pre-payment benefits are not available to hospitals.

At delivery, the benefit normally paid to the physician will be reduced to account for the $500 pre-payment. The entire cost of the benefit (including the $500 pre-payment) cannot exceed the global fee allowance for delivery.

If the insured changes doctors during the pregnancy, the $500 pre-payment and benefits paid separately to each physician cannot exceed the global fee allowance. If the person is no longer covered under the Plan at the time of delivery, the amount of the pre-payment, minus any incurred charges must be repaid.

Medical Care. The PEIA pays for care by a health care provider while the insured is in the hospital and for office visits when the insured is not hospitalized.

Inpatient: Medical visits are covered once per day while the insured is in the hospital, up to the number of days of hospitalization. If the insured is treated by more than one provider for unrelated conditions, each provider's visits may be paid.

Outpatient: Visits to the provider for the diagnosis and treatment of medical conditions are covered.

Concurrent or Parallel Care: If the patient requires the service of two or more physicians for the treatment of unrelated conditions, benefits will be payable up to the PEIA Fee Schedule rate to more than one physician.

Consultations are covered when requested by the attending physician.

Medical Supplies. Supplies for ostomy and colostomy are covered if a letter from the attending physician confirming medical necessity is provided.

Routine medical supplies such as tape, gauze, swabs, elastic bandages, diapers, thermometers, and aspirin are not covered expenses under any circumstances.

Mental Health and Substance Abuse. If an insured needs these services on an inpatient or partial hospitalization basis, the TPA-UM must be contacted to review the circumstances and to begin case management support.

Outpatient coverage is limited to no more than 20 visits a year for short-term individual or group mental health or chemical dependency treatment. If the covered person or his/her physician feel more than 20 visits are needed, the TPA-UM should be contacted after the 16th visit. While this is not a requirement, it will allow the TPA-UM time to evaluate the treatment plans and provide appropriate recommendations, prior to exhausting the 20 visits.

Outpatient or Inpatient Care: Covered mental health and substance abuse expenses include:

- Individual, family, or group outpatient mental health and chemical dependency evaluation and referral services;
- Diagnostic, crisis intervention, and therapeutic services;
- Inpatient or partial hospitalization;
- Biofeedback for control of involuntary nervous system problems; and
- Psychological testing and neuropsychological assessment when specified tests are medically necessary.

These services are not covered:

- Chemical dependency treatment when the patient leaves care against medical advice;
- Mental health services for treatment of mental illnesses which will not substantially improve beyond the current level;
- Nursing home services for custodial or intermediate level care;
- Educational or cognitive services; and,

- Marital counseling.

Nutritional Supplements. When these supplements are required to sustain life, they will be covered. Nutritional supplements are not an allowed expense when they are used for weight management, to balance the normal diet, or in any other way by an individual who does not require them to stay alive. In most cases, conditions requiring nutritional supplements require case management. Preauthorization is recommended.

Occupational Therapy. Occupational therapy is covered when it is ordered by a physician. This benefit is included under the Outpatient Therapy Benefit (see below) and coverage for the combined therapies is limited to $1,000 per Plan Year for each insured, unless additional therapy is recommended by the TPA-UM as medically necessary. Precertification is required if additional therapy is to be covered.

Oral Conditions. These services for mouth, teeth, and gum care are covered expenses:

- Accident-related dental services including extraction, oral examinations, repair to damaged teeth, replacement with prosthetic (false) teeth or replacement of existing prostheses;

- Medically necessary oral surgery, including orthognathic and ridge reconstruction;

- Diagnosis of myofacial pain; and

- Medically necessary surgical extraction of bony or tissue impacted teeth (except those removed for orthodontic purposes).

The TPA-UM must be notified 5 business days in advance for review of inpatient oral surgery.

These services are not covered: Cleanings; fluoride treatments; splints; gingival surgery; orthodontics; periodontics; treatment for temporomandibular joint dysfunction (TMJ); biting or chewing injuries; complete or partial sets of prosthetic teeth or dental implants unless the loss is accident related; and all other dental services not specifically included in this plan.

To be covered, the accident-related injury must occur while the patient is insured by PEIA and services must be provided within six months of the injury. An exception is made for a child when repair cannot be made until the child is older. In this case, a plan for correction when the child is older must be presented to the TPA-C within six months of the accident.

Organ Transplants. The PEIA, through its TPA-C, has access to a national organ transplant network (Network). A listing of participating facilities of this Plan is available through the TPA-UM or TPA-C.

An insured who requires an organ transplant must contact the TPA-UM prior to receiving any transplant related services. Organ transplants and related services are subject to pre-certification in accordance with PEIA's utilization management program.

Once an insured's annual deductible and out-of-pocket maximum have been met, the PEIA will pay one hundred percent of the cost of in-Network services for pre-transplant services, the transplant and one year of follow-up services; however, if the services span two Plan Years, two deductibles and out-of-pocket maximums will apply. Copayments are also applicable and are not waived once the out-of-pocket maximum is met.

The TPA-UM will assist the insured and his/her physician with obtaining information about Network facilities, offer support and assistance in evaluating treatment options, and assist in the coordination for the transplant. In addition, the TPA-UM may authorize up to $5,000 reimbursement for patient travel, lodging and meals. A portion of this allowance may also be applied to reimburse one member of the patient's family or a friend providing support for their travel, lodging and meals. In order to qualify for this reimbursement, the transplant must take place at a Network facility and receipts are required. Further conditions, as appropriate, may be established by the TPA-UM according to the specifics of each case.

For insureds who choose a non-Network facility for transplant services, there will be an additional $10,000 deductible applied to the cost of the hospital admission above PEIA's annual deductible and out-of-pocket maximum. This $10,000 deductible may be waived if the TPA-UM approves the non-Network facility in advance as medically necessary.

The PEIA will pay 100% of the allowed charges for prescription drugs after the insured has met the annual prescription drug deductible when the patient requires immunosuppressant drugs. This benefit is covered under the Prescription Drug Plan.

Where the donor does not have Health Insurance coverage and PEIA insures the recipient, PEIA will recognize the donor's medical expenses as part of the recipient's claim. PEIA will also recognize the donor's medical expenses as part of the recipient's claim if the donor has coverage, but his carrier refuses to recognize his expenses for a claim.

In determining donor benefits, PEIA will cover the donor's charges on the recipient's medical claim history. Donor's room and board is limited to the day of donation. The donor's surgical charge will be paid separately as a second operative procedure charged to the recipient.

Where PEIA insures the donor, PEIA will recognize the donor's medical expenses under his own medical claim history to the extent that the recipient's insurance, if any, does not cover the donor's medical expenses; but PEIA will not include the recipient's expenses.

Where both the donor and recipient have health coverage and PEIA insures the recipient, PEIA will recognize under the recipient's claim the donor's medical expenses to the extent that the donor's medical insurance is not sufficient to cover his medical expenses.

In some instances, PEIA may insure both the donor and recipient either through the same or a different policyholder. In no instance will PEIA pay an amount greater than that reimbursement which would be owing to the donor or the recipient individually.

Outpatient Diagnostics and Therapeutics. Diagnostics include tests and examinations needed to identify the medical problem that is causing symptoms. Therapeutics are treatments indicated to correct or lessen the medical problem. These expenses are covered if they are:

- An evaluation to establish the cause and nature of an illness and provide a logical basis for treatment,
- Actual treatment,
- Outpatient pre-admission testing, or
- X-ray examination or laboratory examination needed due to injury or sickness.

The following outpatient procedures/services must be pre-certified at least 5 business days in advance:

- Allergy Services or Testing
- Cardiac Rehabilitation,
- Christian Science Treatment
- Colonoscopy (diagnostic only),
- Dexa Scans,
- Durable Medical Equipment (DME) if the cost is $1,000 or more or rental more than 3 months.

- Home Health Services,
- Hospice Care,
- Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA),
- Neuromuscular Stimulators and Bone Growth Stimulators,
- Orthotics (if $1,000 or more),
- Multidisciplinary Pain Management Services,
- PET (Positron Emission Topography) Scan, and
- Sclerotherapy,

Outpatient Therapy Benefit. The following outpatient therapy services have been combined into a single benefit: outpatient physical therapy, occupational, massage, speech and vision therapy, and chiropractic care. The combined benefit for all of these services is $1,000 per person per year. Additional services may be covered if approved in advance by the TPA-UM.

Pain Management. The PEIA covers acute and chronic pain management. Chronic pain management requires a treatment plan approved by the TPA-UM.

Pap Smear. An annual pap smear and the associated office visit to screen for cervical abnormalities are covered. The screening pap smear is covered at 100% and is not subject to a deductible, copayment or coinsurance. Additional diagnostic pap smears are also covered and are paid at 80% after the deductible is met. An office visit incurred at the time of the pap smear is subject to the normal copayment of $10.00 to preventive care and $15.00 for non-preventive care visits.

Pediatric Care. PEIA covers all medically necessary and preventive services by a licensed physician, as recommended by the American Academy of Pediatrics, including:

- A routine schedule for active immunization of normal infants and children from birth through age 16 covered at 100% with no deductible, copayment, or coinsurance; and,
- Routine office visits for preventive care, and well-child visits as recommended by the American Academy of Pediatrics from birth through age 16 covered at 100% and no deductible, copayment or coinsurance is required.

Physical Therapy. This benefit is included in the Outpatient Therapy Benefit (see above) and coverage for the combined therapies is limited to $1,000 per person per Plan Year. According to current state law, a physical therapist may practice only when the patient is referred by a licensed physician, surgeon, dentist, osteopathic physician or surgeon. In order to be covered, physical therapy services must be performed by a provider practicing in accordance with the rules of the state board responsible for licensure of physical therapists and with state law.

Prescription Drugs. Most prescription drugs are covered under the Prescription Drug Plan (see the following chart for details).

CASE MANAGED DRUGS

Drug Name	Who Case Manages Intracorp or Express Scripts (ESI)	Who Pays Claims Acordia or Express Scripts (ESI)	Copay Information 20%, $5, $15, $25
Avonex	Not required	Express Scripts	$15
Betaseron	Not required	Express Scripts	$15
Botox	Not required	Acordia	20%
Copaxone	Not required	Express Scripts	$15
Epogen	Express Scripts - if purchased at pharmacy Intracorp – if patient in case management Not required – if received with other treatment	Express Scripts – if purchased at pharmacy Acordia – if case managed by Intracorp or if received with other treatment	Express Scripts - $15 Acordia – 20%
Enbrel	Express Scripts	Express Scripts	$15
Gamma Gard	Intracorp	Acordia	20%
Growth Hormones Humatrope, Saizen, Norditropin Serostim Protopin, Nutropin, Genotropin	Express Scripts	Express Scripts	$15
Hyalgan	Not required	Acordia	20%
HIV/AID-Related Drugs	Intracorp	Express Scripts	None
Leukine	Express Scripts Intracorp – if patient in case management Not required – if received with other treatment	Express Scripts – if purchased at pharmacy Acordia – if case managed by Intracorp or if received with other treatment	Express Scripts - $15 Acordia – 20%
Lupron, Lupron Depot	Express Scripts	Express Scripts	$25
Neumega	Express Scripts Intracorp – if patient in case management Not required – if received with other treatment	Express Scripts Acordia – if case managed by Intracorp	Express Scripts - $15 Acordia – 20%
Neupogen	Express Scripts Intracorp – if patient in case management Not required – if received with other treatment	Express Scripts Acordia – if case managed by Intracorp or received with other treatment	Express Scripts - $15 Acordia – 20%

Procrit	Express Scripts Intracorp – if patient in case management Not required – if received with other treatment	Express Scripts Acordia – if case managed by Intracorp or if received with other treatment	Express Scripts - $15 Acordia – 20%
Remicade	Not required	Acordia	20%
Sandoglobulin	Intracorp	Acordia	20%
Sandostatin	Intracorp	Acordia	20%
Synvisc	Not required	Acordia	20%
Transplant-related drugs	Intracorp	Express Scripts	None

Prostate Cancer Screening. One prostate examination and the related office visit will be covered each year for men at the age of 50 and older. The PSA test is covered at 100% with no deductible, copayment or coinsurance. The related office visit is subject to the preventive care copayment of $10.00

Prostheses and Implants. Covered expenses include:

- Artificial eyes, limbs, larynx, and other prosthetic devices,
- Lens implants after cataract surgery,
- Breast prosthesis,
- Pacemakers, and other implants medically necessary due to illness or injury; and,
- Post-mastectomy bras and stump stockings (usually 2 per year are covered).

The removal of silicone breast implants is considered a medical necessity and will be covered in all cases. If the silicone implant was originally placed due to a mastectomy, the PEIA will also cover replacement of the silicone implant with a non-silicone implant or reconstructive surgery. If the silicone implant was originally placed for cosmetic reasons in a normal, healthy breast, the replacement of the implant is not a covered expense.

Radiation Therapy. Treatment by radiation, on either an inpatient or outpatient basis, is covered when prescribed by a physician. The TPA-UM must be notified for case management when inpatient radiation therapy is being recommended as a treatment for cancer or a similar disease.

Skilled Nursing Facility Services. The PEIA covers care in a skilled nursing facility. This is a facility that provides care similar to that given in a hospital to meet the medical needs of a seriously ill patient. This benefit is limited to 100 days per member per year.

When medically necessary, the following items provided in a skilled nursing facility are covered expenses:

- Prescription drugs,
- Physician visits,
- Diagnostic X-rays and lab work,
- Oxygen, and
- Therapy services.

Services provided in a skilled nursing facility at the custodial or intermediate care level are not covered. Care at this level may include some minor medical services but is primarily for support in the tasks of daily living. Skilled nursing care for patients with a primary diagnosis of Alzheimer's Disease is not covered.

Speech Therapy. When speech therapy is ordered by a physician, it will be covered under the Outpatient Therapy Benefit (see above). The benefit for the combined therapies is limited to $1,000 per member per year. Additional therapy may be covered if it is recommended as medically necessary by the TPA-UM. Speech therapy for voice modulation, language training, elimination of a lisp, or similar training is not covered.

Surgery. To assure an insured has the right type of care and full benefits under the Medical Benefits Plan, all inpatient surgeries must be reviewed in advance by the TPA-UM. Covered expenses generally include:

- Inpatient, outpatient, or office surgery;
- Cosmetic and reconstructive surgery needed to correct a birth defect or for treatment due to an accident or illness;
- Second and third surgical opinions;
- Medically necessary gastric stapling or bypass;
- Medically necessary oral surgery; and
- Medically necessary assistant surgeon fees.

These surgical expenses are not covered:

- Cosmetic or reconstructive surgery other than to correct a birth defect or the effects of an accident or illness; and
- Surgery to relieve a patient of emotional stress or a psychological disorder.

Other special provisions.

- If two or more surgical procedures are performed on the same day, the allowance for the second through fifth procedure is covered at 50% of the allowed amount. The sixth procedure requires special review by the TPA-UM.
- Certain outpatient surgeries require precertification by the TPA-UM. These include knee arthroscopy, cataract extraction, tonsillectomy, colonoscopy, septoplasty, and laparoscopy other than for sterilization.

- If an assistant surgeon is medically necessary, the allowance for the second surgeon is 16% of the allowed amount for the first procedure, and 8% after that.

- If a second surgical opinion is required by the TPA-UM, it will be covered at 100% of the PEIA fee schedule allowance after the annual deductible is met. If it is voluntary, it will be paid at the normal rate. Third surgical opinions are paid at the normal rate.

Therapies. Specific therapies (i.e., speech therapy, occupational therapy, etc.) are addressed under their own heading in this section. Inpatient rehabilitation therapies must be reviewed in advance by the TPA-UM.

These therapies and supplies are not covered:

- Devices used in sports-related activities,

- Educational or cognitive medical rehabilitation,

- Therapy for a patient showing no progress,

- Daily living skills training,

- Stimulation therapy,

- Orientation therapy, and

- Aqua therapy.

Tobacco Cessation Program. PEIA PPB Plan provides benefits for insureds who wish to quit smoking or using smokeless tobacco products. You may enroll in the tobacco cessation program by calling the Quit Line. The Quit Line will provide counseling and support, including written materials to each program enrollee. PEIA covers both prescription and non-prescription tobacco cessation products for those who have

enrolled in the tobacco cessation program. Non-prescription drugs will be covered only if prescribed by a physician.

From time to time, PEIA may offer special limited-time benefits under this program. Contact the Quit Line for details.

For pregnant insureds (employees and spouses only), PEIA will provide 100% coverage for the tobacco cessation benefit during any pregnancy in the member's lifetime.

Payment Level. PEIA will pay for an office visit, if it is required to obtain a prescription for tobacco cessation drugs. The patient will pay the $10 preventive care office copayment. The drugs will be covered for 12 weeks.

- Nicotine withdrawal therapy is covered with a $5 generic copayment for a month's supply.

- Zyban is covered with a $15 preferred brand copayment for a month's supply.

Vision Therapy. Vision therapy is included in the Outpatient Therapy Benefit (see above) and is limited to a maximum of $1,000 per person per year for the combined benefit. Vision therapy is covered when it is ordered by a physician for correcting a covered medical condition. Preauthorization is recommended, but precertification is required beyond the $1,000 Outpatient Therapy Benefit amount.

Wellness. To encourage sound preventive care, these services are covered by the Plan:

- Immunizations and vaccinations, such as flu shots, are covered for insureds over age 16;

- Well child care, including routine check-ups, for children through age 16;

- High-risk birth score program. Infants determined to be at risk are eligible for six additional check-ups;

- Hypertension screening, including a detailed office visit, a blood pressure check, and a chemistry profile;

- Periodic physicals every two years, or more often if recommended by a physician based on the patient's special needs;

- Tobacco Cessation Program, including prescription and non-prescription drugs and counseling services;

- Annual prostate examination for men over 50, including the office visit;

- Annual pap smears;

- Annual mammograms (the associated office visit is covered if the service is performed at the same time as the pap smear); and

- Colorectal Cancer Screenings.

Exclusions. In addition to exclusions listed in the Specific Benefits Section, the following services are not covered by the PEIA regardless of medical necessity. As it would be practically impossible to list all possible exclusions, this is not intended to be a complete listing. If the service is not one of the services listed in the Specific Benefits Section, the insured should contact the TPA-C to determine if the service is covered.

1. Augmentative communication devices.

2. Aqua therapy.

3. Birth control drugs, devices, and services for dependent children.

4. Chemical dependency treatments when a patient leaves the hospital or facility against medical advice.

5. Coma stimulation.

6. Cosmetic or reconstructive surgery when not required as the result of accidental injury or disease, or unless the surgery is performed to correct birth defects.

7. Custodial care, intermediate care, domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living.

8. Dental services including routine dental care, x-rays, treatment of cysts or abscesses associated with teeth, or any other dentistry and dental procedures.

9. Duplicate testing, interpretation or handling fees.

10. Educational equipment including augmentative communication devices.

11. Environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors.

12. Exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines.

13. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts.

14. Experimental, investigational or unproven services, unless pre-approved by the TPA-UM.

15. Foot care (routine) including: removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), hypertrophy (growth of tissue under the skin); Cutting, trimming, or partial removal of toenails; treatment of flat feet, fallen arches, or weak feet; and Strapping or taping of the feet.

16. Hearing aids, wigs or wig styling, vibrators or bathroom scales.

17. Homeopathic medicine.

18. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days; including unauthorized days prior to scheduled surgery.

19. Hygienic equipment such as bed baths, commodes, and toilet seats.

20. Hypnosis.

21. Incidental surgery performed during medically necessary surgery.

22. Infertility services or sterility services including in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, all methods of artificial insemination, and donor semen.

23. Mailing and handling charges.

24. Marriage counseling.

25. Medical equipment, appliances or supplies of the following types: equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs; recliners; contour chairs; or adjustable beds.

26. Nutritional supplements, food liquidizers or food processors.

27. Medical rehabilitation which is primarily educational or cognitive in nature.

28. Mental health services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning.

29. Optical services such as routine eye examinations, refractions, eye glasses, contact lenses and fittings.

30. Personal comfort and convenience items or services (whether on an inpatient or outpatient basis) such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician.

31. Physical conditioning. Expenses related to physical conditioning programs such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation.

32. Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered by the PEIA, when such services are: related to employment; to obtain or maintain insurance; needed for marriage or adoption proceedings; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; to obtain or maintain a license or official document of any type or for participation in athletics.

33. Pregnancy-related conditions for dependent children.

34. Professional medical equipment such as blood pressure kits or stethoscopes.

35. Radial keratotomy and other surgery to correct vision.

36. Reversal of sterilization and associated services and expenses.

37. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities.

38. Services rendered by a provider with the same legal residence as an insured, or who is a member of the insured's family. This includes spouse, brother, sister, parent, or child.

39. Services rendered outside the scope of a provider's license.

40. Sex transformation operations and associated services and expenses.

41. Supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags.

42. TMJ. Treatment of temporomandibular joint (TMJ) disorders: including intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for temporomandibular joint dysfunction not caused by documented organic disease or acute physical trauma.

43. The difference between private and semi-private room charges.

44. Therapy and related services for a patient showing no progress.

45. Transportation other than medically necessary ambulance services, or as approved by the TPA-UM.

46. War-related injuries. Treatment in a state or federal hospital for military or service-related injuries or disabilities.

47. Weight loss. Health services and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight control programs, weight control drugs, screening for weight control programs, and services of a similar nature.

48. Whirlpool pumps or equipment.

49. Work-related injury or illness.

Pre-existing Condition Limitations. Any employee and/or dependent enrolling in the PEIA Plan on or after July 1, 1988, will be subject to pre-existing condition limitations. For the purposes of this Plan, a pre-existing condition is defined as an injury, sickness or any condition relating to that injury, sickness or condition for which an insured is diagnosed, receives treatment, or incurs expenses within three months prior to the effective date of their coverage under the Medical Benefits Plan. Pregnancy or any condition meeting the definition of handicap as provided for in W. Va. Code § 5-16-17 is not considered a pre-existing condition.

Expenses for a pre-existing condition will not be covered by the PEIA for the first twelve months of an insured's participation in the Medical Benefits Plan. In determining whether the pre-existing condition limitation applies to an insured, the insured will be given credit for the time such person was covered under any previous employer-based health benefits plan, any comparable individual health benefit plan, or any self-insured plan if the previous coverage terminated no more than 62 days in advance of the insured's enrollment in the PEIA Plan. Any applicable waiting period met in the previous plan will be counted toward the twelve month waiting period. To simplify administration, this pre-existing limitation will be waived if the insured had coverage under another health plan which terminated no more than 62 days prior to the effective date of the PEIA PPB Plan coverage.

Utilization Management Program

The PEIA's utilization management program includes requirements governing hospital pre-admission review, post-admission review of emergency admissions, weekend admissions, optional second surgical opinions, mandatory outpatient procedures review, and medical case management. The intent of this program is to control claims cost by insuring the medical necessity and appropriateness of certain high-cost and over-utilized benefits.

Precertification Review. For providers participating in the PEIA Plan, precertification is the responsibility of the provider for both inpatient and outpatient services requiring precertification. Any admission to a hospital, skilled nursing facility, mental health facility, substance abuse facility, rehabilitation facility or other inpatient facility must be precertified with the PEIA's TPA-UM. Admissions for partial hospitalizations and day programs also require prior approval. In addition, precertification is also required for organ transplant services and for the following outpatient services:

- Cardiac Rehabilitation;
- Colonoscopy (diagnostic only);
- Dexa Scans;
- Durable Medical Equipment ($1,000 or more and rentals at more than three months);
- Magnetic Resonance Angiography (MRA);
- Magnetic Resonance Imaging (MRI);
- Orthotics;
- Multidisciplinary Pain Management Programs;
- PET Scan;
- Sclerotherapy;

The TPA-UM will verify the medical necessity of the admission or procedure and determine the appropriate length of stay.

For purposes of precertification, the following notice requirements will apply:

- For planned admissions and outpatient services requiring precertification, notification is required to the TPA-UM at least five (5) business days in advance to ensure that the TPA-UM has a sufficient time to review the case.

- For admissions related to the birth of a child, the TPA-UM must be notified within 48 hours of the admission, unless the procedure to be performed is a planned Cesarean section, in which case the TPA-UM must be notified five (5) business days prior to the admission.

- Emergency admissions must be reported to the TPA-UM within forty-eight (48) hours of the admission.

The insured is responsible to notify his/her provider or the admitting facility that he/she is a member of the PEIA, and that the PEIA has certain pre-certification requirements. For purposes of pre-certification, the insured's provider or the admitting facility must contact the TPA-UM. In circumstances when notice to the TPA-UM must be made within forty-eight (48) hours of admission, a family member or personal representative must notify the TPA-UM if the provider is a non-participating provider. Participating providers will make the notification to the TPA-UM.

The TPA-UM may be notified of the admission by telephone or by letter. In either circumstance, the notice must be received by the TPA-UM in accordance with the time frames listed above. The request should be made no more than thirty days prior to the admission.

If the TPA-UM is notified by telephone during office hours, the decision to certify the admission may be made at that time, unless additional information is needed to make the decision. Once all information is received, the TPA-UM will make its decision within two (2) working days.

Whether approved or denied, the TPA-UM will send a letter to the insured, the physician, and the facility advising them of the approval or denial of the pre-certification request. This letter will be sent no later than one (1) working day after the decision by the TPA-UM has been made.

When a proposed admission is approved, the TPA-UM will notify the provider of the number of days approved for the insured. The participating provider must contact the TPA-UM to request additional days. It is the responsibility of the insured to request additional days if the provider is a non-participating provider. When determining whether additional days should be allowed, the TPA-UM will review the health care services delivered during the admission to determine if additional days at the facility are medically necessary. The TPA-UM will notify the insured and provider by telephone and will follow up with a confirming letter within one working day of making its decision.

If the insured is transferred to another facility, admission to the second facility requires precertification in accordance with this Section.

Failure to precertify an admission in accordance with the above timeframes will result in a reduction of benefits under the Medical Benefits Plan of thirty percent (30%). This thirty percent penalty will be the obligation of the insured for non-participating providers and of the provider when the provider is participating. If the insured or provider feels that the TPA-UM inappropriately denied an admission or the extension of an admission, or that extenuating circumstances existed that prevented the insured from notifying the TPA-UM within the timeframes set forth in this Section, the insured or provider may appeal the decision in accordance with the procedures set forth herein.

Preauthorization. Preauthorization is a program which allows insureds to determine whether or not the charges for a procedure that has been recommended are covered under the Medical Benefit Plan. Obtaining preauthorization from the TPA-UM assures that the medical claim will be paid upon submission. Requests for preauthorization should be submitted to the TPA-C and should include the following information: insured's name, address, telephone number, Social Security number, information available about the procedure that has been recommended, and the name and address of the provider who has recommended the service. If a request for preauthorization is denied, the insured will be responsible for payment of the service if performed.

Preauthorization is recommended for the following services:

- Chelation Therapy
- Massage Therapy
- Vision Therapy
- Accident-related Dental Services

Prior Approval of Out-of-State Services. When PEIA insureds receive care from providers who do not participate in the PEIA PPO, the TPA-C must prior approve these services. Prior approval may be obtained by contacting the TPA-C.

To receive the highest level of benefit, prior approval is required for all non-emergency out-of-state (beyond the bordering counties to West Virginia) medical care that is provided to a PEIA insured who resides within the State of West Virginia or in a bordering county. Care provided outside of the state beyond bordering counties with prior approval from Acordia is covered at the 80% level for insureds living within West Virginia or in a bordering county. PEIA insureds who reside beyond the bordering counties of West Virginia may seek medical care from any provider who participates in the Acordia/PEIA Network without prior approval. Any PEIA member receiving services from a non-PPO provider without prior approval will be subject to a higher coinsurance (40%). Out-of-state care provided without prior approval from the TPA-C is only

covered at the 60% level, unless the person receiving the care also lives more than one county beyond the borders of West Virginia. For a detailed explanation, see Out-of-State Provider Networks in this Section.

Medical Case Management. The TPA-UM provides medical case management services in cases involving expensive, serious, or long-term illness or injury and in maternity cases. This program assists the insured and/or provider in identifying available resources and containing the cost of long-term care. The insured or participating provider, must notify the TPA-UM five (5) business days, where possible, prior to receiving any of the following covered services:

- Home health care, including but not limited to skilled nursing visits, I.V. therapy in the home; physical, speech or occupational therapy done in the home, hospice care and medication provided or administered by a home heath agency;

- Skilled nursing facility services;

- Durable medical equipment if $500 or more or rental of 3 or more months;

- Rehabilitation services;

- Physical, occupational or speech therapy in excess of the amount allowed under the Medical Benefits Plan; and

- Mental health visits (outpatient) in excess of the amount allowed under the Medical Benefits Plan.

- Insureds (employee and employee spouse) who are pregnant must contact the TPA-UM within the first trimester of pregnancy or as soon as pregnancy is confirmed.

Nurse Advice Line. The TPA-C provides a 24-hour nurse advice line designed to improve insureds' access to medical care. The line is staffed by a registered nurse during and after normal business hours. The nurse is available to answer questions insureds may have about current symptoms and other general medical questions. The nurse cannot help with questions about claims or benefits, or authorize admissions.

Transition of Care Program. To assist insureds that have been receiving treatment for serious medical conditions from non-PPO providers prior to their effective date of coverage in the PEIA PPB Plan, PEIA has a Transition of Care (TOC) program. Insureds who qualify for TOC can continue to receive medical treatment from a non-PPO provider during a transition period and be covered at the in-network benefit level.

Following this transition period or after treatment is complete, medical care must be provided by a network provider to be eligible for the higher in-network level of benefits.

Not all conditions will qualify for the TOC program. Medical conditions **likely to qualify** include:

- Acute heart attack that occurred recently;
- Acute trauma such as a bone fracture;
- Cancer diagnosed recently requiring surgery, chemotherapy or radiation therapy;
- Pregnancy;
- Psychiatric treatments or substance abuse programs that qualify;
- Surgical procedures performed recently with complications; and
- Total joint replacement requiring physical therapy.

Medical conditions which are ***not likely*** to qualify for TOC benefits include:

- allergies,
- arthritis,
- asthma,
- diabetes, and/or
- hypertension.

In most cases, a network provider can successfully treat these chronic conditions. If there is not a network provider available to treat a specific illness or condition, PEIA will work with the insured to provide that care. Conditions limited or excluded from coverage are not eligible for TOC benefits. A separate application for each TOC provider must be completed and submitted. Insureds do not need to apply for TOC benefits if the treating physician participates in the PPB PPO. Applications can be obtained by contacting the TPA- C.

Claims

In-State Claims. As one of West Virginia's state health care programs, the PEIA uses an electronic claims clearing house for claims submitted by West Virginia providers.

Providers may submit claims electronically using ASAP-AP software (if submitting to the claims clearing house) or other software if compatible with the TPA-C's system, or manually by use of a HCFA 1500 form (professional providers) or UB-92 form (facilities). Actual claims processing is performed by the TPA-C.

The PEIA pays directly to providers. An insured who pays for a covered service and wishes reimbursement may contact the TPA-C or the PEIA and obtain a PEIA claim form. This form, along with a copy of the receipt for services and itemized bill,

must be forwarded to the TPA-C for processing. Cash register receipts and canceled checks are not sufficient proof of payment. A HCFA 1500 or UB-92 signed by the provider and indicating the amount paid by the insured will also be acceptable.

Insureds will be provided a medical/prescription drug identification card that must be presented to the provider at the time of service. This card will identify insureds with the PEIA PPB Plan and will allow insureds access to Out-of-State Provider Network benefits. The identification cards will be issued within 30 days of the date of enrollment. Additional cards may be acquired by contacting the TPA-P. If the insured is enrolled in a managed care plan, that plan will issue the medical identification card.

If the insured has other insurance that is primary, including Medicare, an Explanation of Benefits (EOB) form from the primary insurer must be submitted with the claims. The EOB form is usually submitted with the claim by the provider. The TPA-C will not process the claim until the EOB from the primary insurer is received.

Providers and insureds (if the insured paid the claim and is seeking reimbursement) must file claims within six months of the date of service. If Medicare is the primary insurer, the provider and insured will have six months from the date of the explanation of benefits (EOB) to file claims. Failure to file a claim in a timely manner will result in the denial of the claim by the PEIA, and the PEIA will have no further obligation to pay the claim.

Out-of-State Claims. Claims for services from out-of-state providers may be processed differently than in-state claims, depending on whether the provider participates in the Out-of-State Provider Network.

Out-of-State Provider Networks. Under the current TPA-C contract and the PEIA/Acordia Network, PEIA insureds have access to the Beech Street and Medical Mutual of Ohio (MMOH) SuperMed Plus Provider Networks. These networks allow a PEIA insured access to provider discounts on a national basis. Before obtaining the service, the insured should determine whether the provider is a member of the PEIA/Acordia Network, which includes the Alliance, Beech Street and MMOH SuperMed Plus Networks. Insureds who receive services through these networks will not be subject to balance billing. The insured must pay any copayment, coinsurance and/or deductible due under the Medical Benefits Plan. A more detailed description of these networks is contained in Appendix F.

Out-of-State Waiver Program. When an insured receives services out of state from a provider that does not participate in the Acordia/PEIA Network, they may be subject to balance billing. In such circumstances, the insured may apply to PEIA requesting that the PEIA pay amounts exceeding the allowable charges under the Plan. The insured may request an Out-of-State Waiver form from the PEIA, complete the form and return it to the PEIA. The Director, has sole discretion, to grant the out-of-state waiver under the following circumstances:

1. The PEIA is the primary payer;

2. The insured is billed for amounts that exceed the PEIA allowable charge;

3. It was necessary for the insured to receive the service for one of the following reasons:

   * an emergency arises and out-of-state care can be reached more quickly,
   * the insured lives or is traveling out of state, or
   * the medically necessary service is not available in West Virginia, or
   * is not available within a reasonable travel time in West Virginia; and

4. If the insured has secondary insurance, an EOB from the secondary insurance must be submitted with the request.

If granted, the PEIA will pay the balance owed for covered services to the out-of-state provider, subject to an additional $500 annual deductible that will be applied against any amount over the allowable charge. This deductible, determined on a Plan Year, can be accumulated by an individual or a family. Under the PEIA PPB Plan, waivers will not be approved for amounts applied to the out-of-network deductible or coinsurance, copayments, or non-covered services, or for penalties.

Claims Incurred Outside of the U.S. Insureds who incur medical or pharmaceutical expenses outside the United States may be eligible to receive reimbursement from the PEIA. The insured must forward a completed copy of the appropriate PEIA claim form along with the itemized bill to the TPA-C or TPA-P. The TPA will process the claim and determine the applicable exchange rate.

Court-Ordered Dependents. The legal custodian of a child covered under the non-custodial parent's plan as a result of a court order may submit claims for reimbursement directly to the TPA-C and TPA-P. The legal custodian must submit a certified copy of the divorce order requiring that coverage be provided by the non-custodial parent. The custodial parent must obtain a Court Ordered Dependent Claim Form and submit this form with an itemized bill. Reimbursement for claims will be processed and paid to the custodial parent if the claim indicates payment by the custodial parent. If the provider is paid, the custodial parent will receive the EOB.

Assignment of Benefits. In accordance with W. Va. Code § 16-29D-4, any West Virginia provider who elects to see a PEIA insured must accept assignment of benefits. The provider may collect any copayment, coinsurance, or deductible that would be due under the Medical Benefits Plan at the time of service, if the provider knows the current allowed amount. Any provider who renders emergency medical service necessary to treat a life threatening situation of a PEIA insured is not bound to accept assignment of benefits; however, once the patient is stabilized, any further services by the provider are subject to this provision. Providers who contract directly with the PEIA must accept assignment at all times.

Cost Controls

Coordination of Benefits (COB). In an effort to control health care costs, the PEIA has a coordination of benefits (COB) provision. Under this provision, when a PEIA insured also has coverage under another policy or policies, the rules described in Appendix G will determine how the PEIA will pay benefits.

Subrogation. If the PEIA pays an insured's medical expenses for an illness, injury, disease or disability for which another person is legally liable, the PEIA has the right of subrogation. This right of subrogation allows the PEIA to be reimbursed for the expenses it has already paid, if the responsible person pays the insured, or pays a provider on the insured's behalf. The PEIA can only collect amounts that are related to that illness, injury, disease or disability.

The PEIA has the right to seek repayment of expenses from, among others, the party that caused the sickness, injury, disease, or disability, his or her liability carrier or the insured's own auto insurance carrier in cases of uninsured, underinsured medical payment coverage. Subrogation applies, but it is not limited to, the following circumstances:

- Payments made directly by the person who is liable for the insured's sickness, injury, disease, or disability, or any insurance company which pays on behalf of that person, or any other payments on his/her behalf;

- Any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured medical payment policy on the insured's behalf; and

- Any payments from any source designed or intended to compensate the insured for medical treatment of the sickness, injury, disease, or disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.

This right of subrogation constitutes a lien against any settlement or judgment obtained by or on behalf of an insured for recovery of such benefits.

When an insured incurs medical expenses for which the PEIA has a right of subrogation, the insured must:

- Notify the PEIA in writing of any injury, sickness, disease, or disability for which the PEIA has paid medical expenses on the insured's behalf that may be attributable to the wrongful or negligent acts of another person;

- Notify the PEIA in writing if the insured retains services of an attorney, and of any demand made or lawsuit filed on the insured's behalf, and on any offer, proposed settlement, accepted settlement, judgment, or arbitration award;

- the PEIA has the right to seek repayment of expenses from, among others, the party that caused the sickness, injury, disease or disability, his or her liability carrier or the insured's own auto insurance carrier in cases of uninsured, underinsured or medical payment coverage; and

- Promptly reimburse the PEIA for benefits paid on the insured's behalf attributable to the sickness, injury, disease, or disability, once the insured has obtained money through settlement, judgment, award, or other payment.

Failure to comply with any of these requirements may result in:

- PEIA's withholding payment of further benefits or recovery of payment from the provider, and

- The insured being obligated to pay attorney's fees and/or other expenses incurred by the PEIA in obtaining the required information or reimbursement.

These provisions shall not limit the PEIA with respect to any other remedy provided by law. This right of subrogation shall apply without regard to the location of the event which led to or caused the applicable sickness, injury, disease or disability.

As with any claim, the claims resulting from an accident or other incident which may involve subrogation, must be submitted within the PEIA's filing requirement. It is not necessary that any settlement, judgment, award, or other payment from a third-party have been reached or received before filing a claim with the PEIA.

Balance Billing. When PEIA is the primary payer, physicians, facilities, and other health care providers (with the exception of pharmacists and oral surgeons performing services on an outpatient basis) located within the State of West Virginia must accept as payment in full the maximum allowed amount established by the PEIA for covered services. This provision is not subject to waiver by the insured. Such providers are prohibited from billing members for any charges other than deductibles, coinsurance, copayments, and for services not covered by the Plan. Where the services are provided outside of the State of West Virginia or where PEIA is the secondary payer, the above balance billing prohibition does not apply. In addition, the insured will not be balance billed if the service is provided by a participating Acordia/PEIA Network Provider.

Recovery of Overpayment, Incorrect Payments, or Payments Made for Which a Third-Party is Responsible. The PEIA has the right of recovery from any insured, provider or any other person or entity for benefits paid which are subsequently

determined to be excessive, for non-covered services, are paid by PEIA when another party is responsible for the claim, or are otherwise improperly or incorrectly made. Failure of an insured or provider to cooperate fully with the PEIA to secure recovery of any such overpayments or incorrect payments from the insured or an entity to whom such overpayment have been made will result in either the amount of the overpayment being deducted from other benefits which are, or may become, payable to or on behalf of the insured, or from benefits payable to the provider or the PEIA withholding benefits entirely. By agreeing to provide care, services, or products to a PEIA enrollee a provider agrees that it will cooperate with PEIA auditing of claims records.

This provision shall not limit the PEIA with respect to any other remedy provided by law.

Fraud or Misrepresentation. Insureds who intentionally provide false or misleading information to the PEIA or its TPAs are subject to termination of coverage. In addition, PEIA may proceed with civil action to recover any moneys expended and may report such activities to the appropriate law enforcement agency.

Providers who knowingly provide false or misleading information to the PEIA or its TPAs will be reported to the appropriate law enforcement agency and/or licensing board. In addition, the PEIA may proceed with a civil action to recover any moneys owed it.

In accordance with W. Va. Code § 5-16-11(a), the PEIA may withhold any payments due an insured or provider, or may directly offset any payments owed an insured or provider for whom it has evidence that the insured or provider has received an overpayment or unauthorized payment through fraud or misleading information.

Before the PEIA withholds or retains moneys as an off-set, and before the PEIA elects to terminate coverage of an insured based on the insured's providing false or misleading information, the PEIA must provide the insured or provider with an administrative hearing before the Director.

Appeals

An insured or a provider has the right to appeal the denial of a claim or the denial of a request for service (e.g., precertification, extension of a hospital stay, non-covered service). Before starting the appeal process, the provider or insured should contact the appropriate TPA to determine if the denial was an administrative error.

The first stage of the appeal is to the TPA that denied the claim or service. The provider or insured must file a written request for appeal within sixty (60) days of notice of the denial. The written request should contain the following information:

1. Name of the insured and/or provider, address and telephone number;
2. Description of claim or service that was denied;

3. Date denial was received;
4. Reason given for the denial;
    1. Reason why the claim or service should not have been denied;
    2. The Explanation of Benefits if the claim has been processed; and
    3. Any additional information that supports the insured's or provider's position.

Once received by the TPA, the TPA will render a written decision on the appeal within thirty days. This thirty-day period may be extended if it is necessary for the TPA to obtain additional information before rendering a decision.

If the appeal is denied by the TPA, the provider or insured may appeal the matter to the Director of the PEIA. This appeal must be filed with the Director within sixty (60) days after receipt of notice of the denial of the first level appeal by the TPA. The second level appeal must be in writing and contain the same information provided to the TPA. The Director will render a written decision within 30 days, unless further information is need in order to render a decision.

VI

PRESCRIPTION DRUG PLAN

Introduction

The PEIA Prescription Drug Plan works in coordination with the Medical Benefits Plan to assist in the payment of health care costs for PEIA insureds. The PEIA Prescription Drug Plan is available to all Participants in the PEIA PPB Plan.

Both the claims-processing and utilization-review functions of the Prescription Drug Plan are administered by the TPA-P.

Deductibles, Copayments and Plan Maximums

Deductibles. Before the PEIA pays for the cost of covered prescription drugs, the insured must have met an annual deductible. This deductible is $75 per person and $125 per family for each Plan Year. Covered prescription drug purchases will be counted toward the annual deductible in the Plan Year of purchase, not the Plan Year they are billed to the PEIA. Only allowed expenses will be counted toward the deductible. Expenses that should be billed through the Medical Benefits Plan, including certain prescription drugs such as Hyalgan, Synvisc, immunizations and immune globulins will not be counted toward the Prescription Drug Plan deductible.

Copayments. Once an insured's annual deductible has been met, the Prescription Drug Plan will pay a portion of the cost of the insured's covered prescription drugs. The amount exceeding the deductible that the insured is responsible to pay is known as the copayment amount. PEIA's portion of the covered prescription cost is dependent on the type of drug and whether it is dispensed by a Network Pharmacy, a non-Network Pharmacy, or through the TPA-P's mail order service. A chart showing the current copayments under the Prescription Drug Plan is contained in Appendix H.

If a prescription is filled at a non-Network Pharmacy, the insured is responsible for the entire cost of the medication at the time of purchase and the claim can later be submitted to the TPA-P for payment. The insured will be reimbursed PEIA's allowed amount for the drug, which is based on the Average Wholesale Price (AWP) less the PEIA discount, minus the dispensing fee and a $3.00 processing fee. The insured will be responsible for any difference in the submitted amount and the allowed amount.

Copayments (Retiree Drug Copay Assistance)

Retired employees, whose total annual income is less than ~~200%~~ 250% of the current federal poverty level, may receive assistance in paying a portion of their drug copayments. Applicants must be enrolled in the PEIA PPB Plan. Managed care

members are not eligible for this program. Applications are mailed to all retired PPB Plan members annually. (See Appendix H.)

Prescription Out-of-Pocket Maximum. PEIA has added an out-of-pocket maximum on drugs. The maximum is $1,750 for an individual and $3,500 for a family. Once you have met the out-of-pocket maximum, PEIA will cover the entire cost of your prescriptions for the balance of the plan year. The out-of-pocket maximum only includes actual copays, not deductibles or other charges, and is separate from your medical plan out-of-pocket maximum.

Brand vs. Generic

If an insured's doctor prescribes any generic drug, the copayment at a network drug store is $5.00 for up to a 34-day supply. If the medication is a brand-name and is included on the Preferred Drug List (PDL), the copayment at a Network Pharmacy is $15.00. However, if the insured chooses a Non-Preferred brand-name drug, or if the physician prescribes the Non-Preferred brand-name drug, the copayment is $30.00. If an A-B rated generic drug is available, but the insured or the physician feel the brand-name drug is necessary, the insured will pay the $5.00 generic copayment plus the difference in cost between the brand and the generic. If medical necessity of the multi-source brand-name product is documented by the physician, a prior authorization will be approved. However, the medication will be covered as a Non-Preferred brand-name drug.

Providers

Pharmacy Network. In order to control costs and ensure quality service, the PEIA utilizes the services of a pharmacy network. Services from a Network Pharmacy include:

- a controlled price on the cost of prescriptions;
- electronic claims filing; and,
- the insured's only having to pay the copayment at the time of the dispensing of the medication, providing that their prescription drug deductible has been met.

PEIA Network pharmacies should display a sign indicating that they are part of the Network. An insured who has a question whether a pharmacy is in the PEIA Network may either contact the specific pharmacy or the TPA-P. The network includes most pharmacies in West Virginia and large chain pharmacies out of state. The PEIA will include Plan incentives to encourage the use of the Network by PEIA insureds.

Non-Network Providers. The PEIA will pay for prescriptions filled at a non-Network Pharmacy, however, a higher out-of-pocket expense will apply (see Appendix H). The insured must pay the full price of the non-Network claim at the time of the

dispensing of the medication and seek reimbursement from PEIA for the covered amount (see **Filing Claims** in this section). The insured will be reimbursed PEIA's allowed amount for the drug, which is based on the Average Wholesale Price (AWP) less the PEIA discount, minus the dispensing fee and a $3.00 processing fee.

A non-Network Pharmacy may not be familiar with prescription drugs covered under the PEIA Prescription Drug Plan. The non-Network Pharmacy or the insured may contact the TPA-P to determine whether the prescription drug will be a covered expense by the PEIA. Determining whether the prescription is covered under the PEIA Prescription Drug Plan is the ultimate responsibility of the insured, and the PEIA will not reimburse the insured for any prescription drugs not covered, even if the insured mistakenly thought the prescription was a covered expense.

Mail Order Service or Retail Maintenance Pharmacies

Through the current TPA-P, PEIA insureds have access to a prescription mail order service or retail maintenance pharmacies. Drugs prescribed by a physician that are included on the Maintenance Medications List can be filled by mail or at a participating retail maintenance pharmacy in a supply of up to 90 days for the price of two copayments (see **Maintenance Medications** this section). The insured must submit a prescription from the physician written for a 90-day supply along with a completed Mail Service Pharmacy Order Form and payment to the TPA-P. The insured should notify the TPA-P of any changes in prescription information by submitting a new form. Refills of maintenance medications can be placed over the phone by contacting the TPA-P's customer service department. Any prescriptions submitted to the TPA-P that are not available by mail order will be returned to the insured.

Covered Prescriptions

Specific Prescriptions. The following prescription drugs and medical items are covered under the Prescription Drug Plan when prescribed by a provider authorized by law to prescribe the medication:

- Aerochamber spacers,
- Compound medication of which at least one ingredient is a legend drug,
- Disposable needles/syringes,
- Glucometer Dex sensor cartridges,
- Glucometer Elite test strips,
- Glucose elevating agents,

- Inspirease spacers,

- Insulin,

- Lancets,

- Legend contraceptives, oral or other, except those listed below will be covered for policyholder and spouse only, Injectable contraceptives may be dispensed in up to a 90-day supply.

- Legend drugs. Exceptions: See Exclusion list in this Section, and

- Tretinoin topical (e.g. Retin-A) for individuals through the age of 26 years.

Preferred Drug List. The current TPA-P for PEIA offers a listing of brand-name and generic medications that have been proven to be safe, effective treatments and are available at a reduced cost. The copayments for drugs listed on the Preferred Drug List (PDL) are $5.00 for generic and $15.00 for brand-name drugs.

The PDL includes drugs to treat the following conditions:

- Allergies/Asthma – antihistamines, beta agonist and corticosteroid inhalers, corticosteroid nasal sprays;

- Antineoplastic and Immunosupressants – alkylating agents, antimetabolites, androgens, and hormones.

- Anxiety – anxiolytics;

- Arthritis – non-steroidal anti-inflammatory drugs (NSAIDs);

- Biotechnology – interferons and growth hormones;

- Cardiovascular – ACE inhibitors, angiotensin II receptor blockers, alpha-1 blockers, beta blockers and calcium channel blockers for high blood pressure; HMG Co-A reductase inhibitors for high blood cholesterol;

- Central Nervous System – narcotic analgesics, anxiolytics, sedative/hypnotics, anticonvulsants, antivertigo antiemetics, antiparkonism agents, antipsychotic drugs, CNS stimulants.

- Depression – antidepressants;

- Dermatological/Topical – corticosteroids, anesthetics and acne;

- Diabetes – insulin, blood glucose strips, sulfonylureas;

- Gastrointestinal conditions – H_2 antagonists, proton pump inhibitors to treat ulcers and reflux;

- Glaucoma – alpha agonist, beta blockers, carbonic anhydrase inhibitors, prostaglandin;

- Infections – antibiotics, antifungals, and antivirals to treat common infections like bronchitis, ear infections, toenail and fingernail infections, herpes;

- Migraine – selective serotonin -1 receptor agonists;

- Topical – anesthetics, corticosteroids, anti-acne drugs, keratolytics, anti-psoriarsis and anti-eczema drugs, drugs affecting the ear, nose, throat and mouth.

- Urological – anticholinegics, antispasmodics and benign prostatic hyperplasia therapy;

- Vitamins – prenatal and multi-vitamins; and

- Women's health conditions – hormone replacement (menopause), oral contraceptives, selective estrogen receptor modulators (osteoporosis prevention).

A PDL is distributed to all insureds and is also available by contacting the TPA-P or on-line at www.wvpeia.com.

Prior Authorization. Your prescription drug program provides coverage for **some** drugs only if they are prescribed for certain uses and amounts, so those drugs require prior authorization for coverage. If your medication must be authorized, your pharmacist or physician can initiate the review process for you. The prior authorization process is typically resolved over the phone; if done by letter it can take up to one business day. If your medication is not approved for plan coverage, you will have to pay the full cost of the drug.

PEIA will cover, and your pharmacist can dispense, up to a five-day supply of a medication requiring prior authorization for the applicable copayment. This policy applies when your doctor is either unavailable or temporarily unable to complete the prior authorization process promptly. If the prior authorization is ultimately approved, your pharmacist will be able to dispense the remainder of the approved amount with no further copayment for that month's supply if you have already paid the full copayment.

The medications listed below require prior authorization:

- CNS stimulants for adults*
- Erythroid stimulants (Epogen, Procrit)
- Fluconazole (Diflucan)
- Growth hormones
- Itraconazole (Sporanox)
- Legend oral contraceptives for dependents (covered for treatment of medical conditions only)
- Leuprolide (Lupron, Lupron Depot)
- Oxycodone hydrochloride (Oxycontin) beginning 10/2/02
- Terbinafine (Lamisil)
- Tramadol (Ultram)
- Tretinoin cream (e.g. Retin-A) for individuals 27 years of age or older

* For pharmacy benefits, PEIA defines "adults" as 19 years of age or older.

This list is subject to change during the plan year if circumstances arise which require adjustment. Changes will be communicated to members through the PEIA *News*, the newsletter PEIA publishes nine times each year. The changes will be included in PEIA's Plan Document, which is filed with the Secretary of State's office, and will be incorporated into the next edition of the Summary Plan Description.

Drugs with Special Limitations

Step Therapy. Step Therapy promotes appropriate utilization of first line drugs and/or therapeutic categories. Step Therapy requires that participants receive one or more first-line drug(s), as defined by program criteria before prescriptions are covered for second-line drugs in defined cases where a step approach to drug therapy is clinically justified. Patients currently taking a second-line drug will be able to continue therapy without interruption.

To promote use of cost-effective first-line therapy, PEIA will implement step therapy in the following therapeutic classes:

- Non-Steroidal Anti-inflammatory Drugs (brand-name NSAID, e.g. Celebrex, Vioxx),

- Proton Pump Inhibitors (e.g. Prilosec, Prevacid, Nexium),
- H2 Antagonists (e.g. Axid),
- Disease-modifying Antirheumatic Drugs (e.g. Enbrel, Kineret), and
- Prozac Weekly.

This list is subject to change during the plan year, if circumstances arise which require adjustment. Changes will be communicated to members through the PEIA *News*, the newsletter PEIA publishes nine times each year. The changes will be included in PEIA's Plan Document, which is filed with the Secretary of State's office, and will be incorporated into the next edition of the Summary Plan Description.

Quantity Limits

Under the PEIA PPB Plan Prescription Drug Program, certain drugs have preset coverage limitations (quantity limits). Quantity limits ensure that the quantity of units supplied in each prescription remains consistent with clinical dosing guidelines and PEIA's benefit design. Quantity limits encourage safe, effective and economic use of the drugs and ensure that members receive quality care. Select medications from the quantity limit list are provided below. If you are taking one of the medications listed below and you need to get more of the medication than the plan allows, ask your pharmacist or doctor to call Express Scripts to discuss your refill options.

Anzemet, Kytril, Zofran. Coverage Limitations:

- Anzemet is limited to 1 tablet per prescription
- Kytril is limited to 2 tablets per prescription
- Zofran 24 mg. is limited to 1 tablet per prescription
- Zofran 4 mg. and 8 mg. are limited to 12 tablets per prescription
- Zofran Solution is limited to 3 bottles per prescription

Brand name medically necessary prescriptions. If the medication your doctor prescribes is a multi-source drug (that is, more than one manufacturer markets the drug), and there is an FDA-approved – or "A-B rated" – generic on the market, then PEIA will pay only for the generic version. Medical justification is required for prior authorization. If prior authorization is granted, these drugs will be covered as non-preferred brand-name drugs.

Diflucan 150 mg. Coverage is limited to two tablets per prescription.

Migraine Medications. Coverage is limited to quantities listed on the chart below:

Generic Name	Brand Name	Quantity Limit Per Dispensing	Total Quantity Limit within a 28-Day Period
Almotriptan tablets 6.25 mg, 12.5 mg	Axert® - Pharmacia	6	18 tablets
Dihydroergotamine nasal spray	Migranal® - Novartis	4	2 kits = 8 unit dose sprays
Naratriptan tablets 1 mg, 2.5 mg	Amerge® Glaxo Wellcome	9	18 tablets
Rizatriptan tablets 5 mg, 10 mg, orally disintegrating tablets	Maxalt – MLT® - Merck	6	24 tablets
Rizatriptan tablets 5 mg., 10 mg.	Maxalt® - Merck	6	24 tablets
Sumatriptan injection syringes	Imitrex® Glaxo Wellcome	1 Kit (2 syringes)	8 kits = 16 injections
Sumatriptan injection vials	Imitrex® Glaxco Wellcome	2 Vials	16 Vials
Sumatriptan nasal spray 20 mg	Imitrex® Glaxo Wellcome	6 spray devices	3 boxes = 18 unit dose spray devices
Sumatriptan nasal spray 5 mg.	Imitrex® Glaxo Wellcome	6 spray devices	6 boxes = 36 unit dose spray devices
Sumatriptan tablets 25 mg, 50 mg, 100 mg	Imitrex® Glaxo Wellcome	9 tablets	18 tablets
Zolmitriptan tablets 2.5 mg and 5 mg, orally disintegrating	Zomig-ZMT® Astra Zeneca	6 tablets for 2.5 mg 3 tablets for 5 mg	18 tablets
Zolmitriptan tablets 2.5 mg, 5 mg	Zomig® - AstraZeneca	6 tablets for 2.5 mg 3 tablets for 5 mg	18 tablets

New drugs approved by the FDA that have not yet been reviewed by Express Scripts' Pharmacy and Therapeutics Committee will have a non-preferred status.

Non-sedating antihistamines (Allegra, Claritin, Zyrtec). PEIA will cover 34 days of therapy in a 180-day period. Therapy beyond 34 days requires prior authorization from Express Scripts.

Toradol. Coverage is limited to one course of treatment (5 days) per 90-day period.

Tamiflu and Relenza. Coverage is limited to one course of treatment within 180 days. Additional quantities require prior authorization from Express Scripts.

Exclusions. The following prescriptions are excluded from the Prescription Drug Plan:

- Anoretics (any drug used for the purpose of weight loss). Exceptions: Amphetamines are covered for individuals through the age of 19;
- Anti-wrinkle agents (e.g., Renova);
- Birth control drugs for dependent children;
- RU-486
- Butorphanol nasal spray (Stadol);
- Charges for the administration or injection of any drug;
- Codeine/APAP/Caffeine/Butalbital (Fioricet with Codeine);
- Codeine/ASA/Caffeine/Butalbital (Fiorinal with Codeine);
- Contraceptive devices and implants;
- Dermatologicals, hair growth stimulants;
- Drugs labeled "Caution—limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
- Drugs requiring a prescription by state law, but not by federal law (state controlled) are not covered;
- Fertility drugs;
- Homeopathic medications;
- Hyalgan
- Immunization agents, blood or blood plasma, biologicals;
- Impotence medications;
- Levonorgestrel (Norplant);

- Medication which is to be taken by or administered to an individual, in whole or in part, while a patient in a hospital, rest home, sanitarium, extended care facility, or convalescent hospital;

- Medication for which the cost is recoverable under any Worker's Compensation or occupational disease law, or from any state or government agency or medication furnished by any other drug or medical service for which no charge is made to the member.

- Non-legend drugs other than those listed above, except when included in a compound with a legend drug;

- Pentazocine/Acetaminophen (Talacen);

- Prescription drug charges not filed within 6 months of the purchase date, if PEIA is the primary user, or within 6 months of the processing date on the Explanation of Benefits (EOB) from the other plan if PEIA is secondary;

- Replacement medication for lost or stolen drugs;

- Requests for more than a 34-day supply of an acute medication or more than a 90-day supply of maintenance medication;

- Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms, except when enrolled in the tobacco cessation program;

- Synvisc;

- Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those listed above;

- Vacation supplies, unless leaving the country;

- Vaccines.

In addition, the following drugs are not covered under the Prescription Drug Plan but are covered under the Medical Benefits Plan when approved by the TPA-UM:

- Biological sera;

- Blood or blood products;

- Contraceptive devices and implants;

- Hyalgan;
- Immunizations;
- Synvisc; and
- Vaccines

Dispensing Limits

Acute Medications. Reimbursement for medication taken for short periods to treat acute medical conditions will be limited to a 34-day supply when the prescription is filled, and each time it is refilled. If a larger supply is purchased, the insured will be responsible for the charge in excess of the cost of the 34-day supply.

Maintenance Medications. A maintenance drug is taken for a long-term condition such as high blood pressure or diabetes. A 3-month (90-day) supply of a maintenance medication can be purchased at a retail pharmacy for the price of three copayments. Maintenance medications can be purchased in a 90-day supply through the TPA-P's mail order service or participating retail maintenance pharmacies at the price of only two copayments. Any maintenance medication dispensed at less than a 90-day supply will be subject to the same copayment that would apply for an acute medication.

Maintenance Drug List.

- Alendronate Sodium (Fosamax)
- Antiarthritics
- Anticoagulants
- Anticonvulsants
- Antineoplastics
- Antiparkinsonism Agents
- Antispasmodics: Urinary Tract
- Benign Prostatic Hypertrophy/Micturation
- Bronchodilators
- Calcitonin (Miacalcin)

- Cardiovascular Agents
- Copaxone
- Corticosteroids, Bronchial
- Cromolyn Sodium
- Diabetic Therapies
- Digestants
- Disposable Needles and Syringes
- Diuretics
- Enzymes, Systemic
- Estrogens and Progestins
- Gastrointestinal, Colitis
- Glaucoma Agents
- Gout Medications
- Hormones, Misc.
- Immunosupressive Agents
- Interferon Beta (i.e., Avonex, Betaseron)
- Lancets
- Legend Vitamins (including Legend Hematinics, Vitamin K)
- Leukotriene Receptor Antagonists (asthma agents)
- Lipotropics (cholesterol lowering agents)
- Mucolytics (pulmonary agents)
- Oral Contraceptives
- Legend Potassium
- Raloxifene (Evista)

- Risedronate (Actonel)
- Thyroid Medications
- Tuberculosis Medications
- Xanthines (asthma agents)

Prescription Drug Formulary

The PEIA maintains an open drug formulary to allow members access to most medications available. It follows a three-tier copayment schedule: a generic copayment, a brand-preferred copayment, and a brand non-preferred copayment. The TPA-P will publish and distribute a list of preferred medications, known as the Preferred Drug List (PDL). These medications are clinically appropriate alternatives while also being the most cost effective. Insureds are not limited to PDL medications, but may take advantage of the discounts available on the drugs that are included in the listing. The PDL will be sent to all insureds.

Bayer Glucometer® Program

Diabetic PEIA PPB insureds have access to a free glucometer program made possible through PEIA and Bayer. Bayer provides the Glucometer® Dex® and the Glucometer Elite® XL and the Glucometer Elite® at no charge to insureds.

The Plan also covers Glucometer Elite® test strips and Glucometer® Dex® sensor cartridges. PEIA insureds must have a current prescription for a glucometer on file at their participating pharmacy to receive their free Bayer Glucometer. This program is for insureds who have the PEIA PPB plan as their primary insurance carrier. If another insurance is primary, including Medicare, then the Bayer Glucometer expenses must be submitted to the primary insurance carrier. After the primary insurance has processed the charges, submit a paper claim to the TPA-P along with a copy of the Explanation of Benefits from the primary insurer.

Tobacco Cessation Program

PEIA has a tobacco cessation program that includes coverage for Zyban and nicotine withdrawal drugs. The drugs are covered under your prescription drug program after a call is made to the PEIA Quit Line: 1-877-966-8784. The program also includes phone coaching services and printed information.

Coverage

After the Quit Line is contacted, PEIA will cover prescription and over-the-counter (OTC) tobacco cessation products only if they are dispensed with a prescription. Coverage is limited to the one twelve-week cycle per plan year, two cycles

per lifetime. Zyban is available for the Brand-preferred copayment of $15 for up to a 34-day supply. Nicotine withdrawal therapy is available for the generic copayment of $5 for up to a 34-day supply.

From time to time, PEIA may offer special discounts on nicotine withdrawal therapy. Call the Quitline at 877-966-8784 for details.

Who is Eligible?

PEIA PPB Plan insureds will be screened for eligibility and readiness. Pregnant women will be offered 100% coverage during any pregnancy.

Utilization Review

The TPA-P shall be responsible for the utilization review function of the Prescription Drug Plan. The purpose of utilization review is to ensure that medications prescribed for insureds are medically appropriate. When possible, the TPA-P will inform the dispensing pharmacy of a contraindicated drug before the drug is dispensed. While the TPA-P shall review prescriptions for over-utilization and contraindicated prescriptions, neither the PEIA nor the TPA-P assumes any responsibility for the medical care or treatment of an insured. The insured should consult with his/her treating provider and the dispensing pharmacist concerning the medication that has been prescribed.

The utilization review program will focus on the following issues of prescription drug utilization:

- Over-utilization;
- Under-utilization;
- Duplicate claims;
- Excessive daily dose;
- Insufficient daily dose;
- Therapeutic duplication;
- Drug-to-drug interaction;
- Drug/age contraindication; and
- Drug/pregnancy contraindication

By participation in the Prescription Drug Program, the insured has authorized the PEIA and the TPA-P to provide and receive information related to an insured's prescription from providers and pharmacies.

Filing Claims

The TPA-P is responsible for processing all prescription drug claims. In order to be paid under the Prescription Drug Program, the claim must be received by the TPA-P within six months of the date that the prescription was filled.

Network Pharmacies. Claims for prescriptions dispensed by a Network Pharmacy will be submitted electronically to the TPA-P. Claims will be approved prior to dispensing. The insured will be responsible for any copayment or deductible amount at the time the prescription is dispensed.

Non-Network Pharmacies. Claims from non-Network pharmacies must be filed using the PEIA Prescription Drug Claim Form. This form, which can be obtained from the PEIA or the TPA-P, must be filled out by the dispensing pharmacist and forwarded either by the pharmacist or the insured to the TPA-P. When using a non-Network Pharmacy, the insured is responsible for paying the full amount at the time the prescription is dispensed, unless the insured and the pharmacy reach a different agreement.

Filing Claims for Court-Ordered Dependents. Prescription drug claims for court-ordered dependents will be processed using the Social Security number of the policyholder currently on file with PEIA.

Claims Incurred Outside the U.S. Claims for prescriptions filled outside the U.S. will be processed in the same manner as such claims are handled under the Medical Benefits Plan, except that prescription drug claims must be sent to the TPA-P

and the PEIA prescription drug claim form must be completed. (see **Section V, Medical Benefits Plan, Claims**).

Appeals

Appeals of decisions made by the TPA-P will be processed in the same manner as appeals filed in the Medical Benefits Program, except that the first level of the appeal is to the TPA-P (see **Section V, Medical Benefits Plan, Appeals**).

Filing Claims

The TPA-P is responsible for processing all prescription drug claims. In order to be paid under the Prescription Drug Program, the claim must be received by the TPA-P within one year of the date that the prescription was filled.

Network Pharmacies. Claims for prescriptions dispensed by a Network Pharmacy will be submitted electronically to the TPA-P. Claims will be approved prior to dispensing. The insured will be responsible for any copayment or deductible amount at the time the prescription is dispensed.

Non-Network Pharmacies. Claims from non-Network pharmacies must be filed using the PEIA Prescription Drug Claim Form. This form, which can be obtained from the PEIA or the TPA-P, must be filled out by the dispensing pharmacist and forwarded either by the pharmacist or the insured to the TPA-P. When using a non-Network Pharmacy, the insured is responsible for paying the full amount at the time the prescription is dispensed, unless the insured and the pharmacy reach a different agreement.

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Appeals

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VII

MANAGED CARE PLANS

Introduction

The PEIA offers to certain policyholders and their dependents the option to participate in one of the managed care plans available through the PEIA.

PEIA will select and contract with qualified managed care plans to offer medical coverage to eligible PEIA insureds. While the managed care plans are non-governmental entities wholly separate and distinct from the PEIA, those members who select the managed care option are still regarded as Participants in the PEIA Plan.

Participation

Eligibility. All participating employers in the PEIA Plan must offer to their eligible employees the choice of selecting a PPB Plan or any PEIA-authorized managed care plan. Qualifications for participation in a PEIA-authorized MCO are the same as those requirements set forth in Section II of this Plan, except as specifically noted in this section. By selecting an MCO for medical coverage, the policyholder is agreeing that the insured and the insured's enrolled dependents will receive routine medical care in accordance with the guidelines established by the MCO. In addition to each plan's enrollment area, the Shopper's Guide contains a summary of each plan's benefit offerings, monthly premiums and copayment schedule.

All policyholders and their enrolled dependents are eligible to participate in a PEIA managed care option, unless the policyholder or an enrolled dependent is eligible to have Medicare as their primary insurer. If the policyholder or any covered dependent has Medicare as their primary insurer, the policyholder may not select an MCO. Should Medicare become the primary insurer for the policyholder or one of the covered dependents during a Plan Year, the policyholder and dependents must enroll in the PPB Plan.

Dependents must participate in the same plan as their sponsoring policyholder. Dependents living outside the enrollment area of the MCO in which they are enrolled must receive all routine medical services through their PCP.

A Non-Medicare insured who becomes a policyholder as a surviving dependent or through COBRA eligibility may select either the PPB Plan or a managed care plan during open enrollment, but may not change plans during the Plan Year as a result of their achieving policyholder status.

Prior to each open enrollment period, PEIA produces the Shopper's Guide, a reference document developed to assist policyholders in the selection of a medical benefit plan.

Enrollment.

Open Enrollment Period. Eligible policyholders may select a PEIA-authorized managed care plan during the annual open enrollment period. The open enrollment period is held each year for approximately 30 days. The PEIA will provide policyholders with advance notice of the dates of the annual open enrollment, a copy of the Shopper's Guide, and a transfer form to use to make changes in coverage.

A policyholder already enrolled in a medical plan who does not wish to change coverage will be automatically re-enrolled in that plan for the next Plan Year, unless other instructions are communicated during Open Enrollment. It is not necessary to complete another enrollment form.

A policyholder who selects a managed care plan must remain in the Plan for the full Plan Year, unless there is a qualifying event to permit the policyholder to change coverage.

Changes in Coverage Outside Open Enrollment Period. A policyholder enrolled in a managed care plan may make changes outside of the open enrollment period only as a result of one of the following qualifying events:

Changes in Marital Status Including:

- Marriage or divorce of the employee;
- Death of the employee's spouse or child;
- Death of the employee's spouse or dependent;
- Annulment;

Change in Number of Dependents, Including:

- Birth, death or adoption of the employee's child;
- A dependent loses eligibility due to age or student status.

Changes in Employment Status Including:

- Commencement or termination of employment of the employee's spouse or dependent;

- A change from full-time to part-time employment status, or vice versa, by the employee or his or her spouse;

- An unpaid leave of absence taken by the employee or spouse;

- A significant change in the health coverage of the employee or spouse attributable to the spouse's employment;

- Change in the residence or work site of the employer, spouse, or dependent;

- Employment change due to strike or lock-out; or

- The employee's spouse changes coverage during open enrollment of the spouse's employer's plan, and the spouse's employer's plan permits the same type mid-year changes, and the spouse's employer's plan year is different than the PEIA Plan Year.

Additions outside of an open enrollment period must be made in the calendar month of or the two calendar months following a qualifying event. Coverage will be effective on the first day of the month following enrollment, or in the case of newborns, on the date of birth. Any additions not made within these time frames may not be made until the next open enrollment. All deletions must be made within 60 days of the qualifying event.

Any dependent added to a managed care plan as a result of a qualifying event will not be subject to pre-existing condition limitations.

While the PEIA authorizes policyholders to make changes under the above-listed circumstances, those policyholders who participate in an IRS Section 125 Plan must consult their Section 125 Plan and IRS regulations to determine whether such change would be permitted by the IRS.

A physician's departure from a managed care plan does not qualify a managed care plan member to change plans. The member will be offered the opportunity to choose another participating physician from the Plan's network. If the withdrawing physician is the member's primary care physician (PCP), and the member does not choose another PCP, the member will be assigned a PCP by the Plan.

Commencement of Coverage. Coverage for members enrolled during an open enrollment period will begin on the first day of the new Plan Year. Commencement of coverage for members enrolled outside the open enrollment period will be the first day of the calendar month following the enrollment. Coverage for newborns enrolled during the month of or the two calendar months following birth will begin on the date of birth.

Termination of Coverage. A policyholder and dependents must remain in the plan selected by the policyholder for the full Plan Year, unless there is a qualifying event that would allow the policyholder to terminate coverage.

Transfer Between Agencies. A member of a managed care plan who transfers from one participating state agency to another during a Plan Year must remain in the managed care plan for the balance of the Plan Year. The member can only change plans during the Plan Year if the transfer moves him or her out of the enrollment area of the Plan so that accessing care is unreasonable.

In certain extraordinary circumstances, the Director may allow the policyholder to terminate coverage with an MCO outside of an open enrollment period and without having a qualifying event as described in this section. A policyholder may apply to the Director in writing describing why it would create an undue and unreasonable hardship for him/her to remain in the managed care plan through the Plan Year. The decision to allow the policyholder to terminate coverage under this provision is solely at the discretion of the Director. The fact that a policyholder's or their dependent's primary care physician, specialist, or preferred facility voluntarily left the managed care network will not be considered a justifiable reason to terminate the policyholder's coverage with the MCO.

As previously stated, if the policyholder's premium is paid with pre-tax dollars, there are certain IRS restrictions that apply to termination or changes in coverage. A policyholder participating in an IRS Section 125 Plan should consult that Plan to determine whether he/she may terminate or change coverage.

Copayments, Deductibles and Plan Maximums.

Copayments due under an MCO plan are payable by the member at the time the service is provided. MCO plans typically do not have medical deductibles.

Premiums

State agencies, colleges, universities and county boards of education pay the same "employer" premiums for the same tiers of coverage whether the policyholder participates in the PEIA PPB Plan or a managed care plan. Cost differences among the plans are borne by the employees who participate in the plans. Except with respect for retirees, non-state agencies (local government entities) determine what portion of the premium will be paid by the employer, and what, if any, will be paid by the employee. Premiums are paid to PEIA which, in turn, pays a capitation amount to the MCO for each enrolled policyholder. Premiums are published in the Shopper's Guide each year prior to Open Enrollment.

Capitation Rates

A capitation rate is the amount that the PEIA will pay to an MCO for providing medical care and prescription drug coverage to a PEIA member. The Director will set capitation rates for each coverage tier allowed in the PPB Plan.

Administration

In order to administer the managed care offering, the PEIA, MCOs, employers and policyholders all must recognize and fulfill certain responsibilities. The following is not intended to be an exclusive list of those responsibilities. Further responsibilities may be contained in the managed care contracts and on enrollment forms.

Responsibilities of PEIA. The PEIA is responsible for the following:

- Disseminating information regarding managed care options, restrictions and limitations so that policyholders may make informed choices;
- Processing new enrollments, changes in enrollment, terminations of enrollment and verifying eligibility to enroll in a managed care plan;
- Furnishing eligibility data to managed care plans;
- Billing and receiving premiums from employers, retirement plans and individual policyholders, as appropriate; and,
- Paying MCOs those capitation rates as agreed upon in the managed care contracts.

Responsibilities of MCOs. MCOs offering benefits to PEIA members are responsible for the following:

- Providing to PEIA members those benefits set forth in the evidence of coverage;
- Maintaining adequate provider contracts to insure that PEIA members have appropriate access to services as required by the West Virginia Department of Insurance;
- Providing eligible policyholders with information concerning their plan;
- Providing enrolled members with an identification card and evidence of coverage prior to the commencement of coverage;
- Resolving member grievances in a timely and fair manner; and

- Performing other duties as outlined in the managed care contract.

Responsibilities of Employers. Employers shall be responsible for following:

- Knowing the managed care offerings in their geographic area so they may direct employees to the correct source of information;

- Communicating eligibility and enrollment data to the PEIA as soon as the information becomes available; and

- Collecting and paying to the PEIA by the 25th day of each month the employer and employee share of the premium.

Responsibilities of Policyholders. Policyholders who select one of the managed care plans authorized through the PEIA are responsible for the following:

- Selecting a health plan selection for the Plan Year during open enrollment;

- Reviewing and understanding managed care options, limitations and restrictions prior to selecting a plan; and,

- Communicating eligibility/enrollment changes to the employer immediately as such information becomes available.

Benefits

The benefits package provided to PEIA must be an existing commercial benefit package offered to other clients and approved by the West Virginia Department of Insurance. Benefits, limitations and exclusions in an MCO plan must clearly be set out in the Plan description provided to members.

Solicitation

All solicitation material to be sent to PEIA insureds is subject to inspection and prior approval by the PEIA.

Communication

All communication materials to be mass-distributed to PEIA insureds are subject to inspection and prior approval by the PEIA.

Appeals

If you are a managed care plan member, and you think that an error has been made in processing your claim, the first step is to call your managed care plan to discuss the matter.

If your claim has been denied, or if you disagree with the determination made by your managed care plan, the second step is to appeal, in writing, within 60 days of the denial to your managed care plan. Instructions for filing that appeal are in your Evidence of Coverage provided by your managed care plan.

If you are not satisfied with the response from your managed care plan, you may appeal, in writing, to the Director of the PEIA. You or your covered dependents must request a review, in writing, within sixty (60) days of getting the decision from your managed care plan. Facts, issues, comments, letters, Explanation of Benefits (EOBs), and all pertinent information about the claim and review should be included. The appeal should be mailed to:

Director
Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, WV 25305-0710

When your request for review arrives, the PEIA will reconsider the entire case, taking into account any additional materials that have been provided. A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the insured or his or her authorized representative.

If you disagree with the decision of the PEIA Director, you have one final level of appeal to the West Virginia Insurance Commissioner. Instructions for this appeal are also provided in your Evidence of Coverage from your managed care plan.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD & D)

Introduction

The PEIA contracts with a life insurance carrier ("Carrier") to offer term life insurance and AD&D plans to active employees and term life insurance to retired employees through a group life insurance policy. The current carrier is listed in Appendix A. Active and retired employees can choose basic life insurance, optional life insurance, and optional dependent life insurance. Each of these coverages is described below.

Basic Life and AD&D Insurance

Active employees may select basic life insurance. For active employees, this benefit plan also includes coverage for accidental death and dismemberment. Retired employees are eligible only for the basic life coverage, but not AD&D coverage.

Basic life and AD&D insurance is decreasing term coverage. The amount of benefits depends on the age and employment status of the insured as set forth below.

Basic Life Insurance Benefits

Amount of Benefits. Upon receipt of proof of death of an enrolled employee, the Plan will provide the following Basic Life Insurance benefits:

Active Employees:

	Amount of Life Coverage	Amount of AD&D Coverage
Under age 65	$ 10,000	$ 10,000
Between ages 65 and 70	$ 6,500	$ 6,500
Age 70 and older	$ 5,000	$ 5,000

Retired Employees:

	Amount of Life Coverage	Amount of AD&D Coverage
At retirement	$ 5,000	$ 0
At age 67 and older	$ 2,500	$ 0

Disabled Employees (Disabled Prior to Age 60):

	Amount of Life Coverage	Amount of AD&D Coverage
Under age 65	$ 10,000	$ 0
Age 65 but Under Age 70	$ 5,000	$ 0
Age 70 or older	$ 2,500	$ 0

Optional Life and Accidental Death and Dismemberment (AD&D) Insurance

Active employees can elect optional life and an equal amount of AD&D coverage. Retired employees can elect optional life insurance, but not the AD&D coverage. The employee can choose from ten levels of decreasing term coverage for active and seven levels of decreasing term coverage for retired employees, depending on the age and employment status of the employee as follows:

Active Employee -- Optional Life and AD&D

Age	Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII	Plan VIII	Plan IX	Plan X
Under 65	$5,000	$10,000	$20,000	$30,000	$40,000	$50,000	$75,000	$100,000	$150,000	$200,000
65-69	$3,250	$ 6,500	$13,000	$19,500	$26,000	$32,500	$48,750	$ 65,000	$ 97,500	$130,000
70 & over	$2,250	$ 4,500	$ 9,000	$13,500	$18,000	$22,500	$33,750	$ 45,000	$ 67,500	$ 90,000

Retired Employee -- Optional Life with no AD&D

Age	Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII
Under 65	$ 5,000	$ 10,000	$ 20,000	$ 30,000	$ 40,000	$ 50,000	$75,000
65-69	$ 3,250	$ 6,500	$ 13,000	$ 19,500	$ 26,000	$ 32,500	$48,750
70 & over	$ 2,250	$ 4,500	$ 9,000	$ 13,500	$ 18,000	$ 22,500	$33,750

Increasing the Optional Life Insurance Benefit. An employee who wants to increase the Optional Life Insurance benefit will be required to submit a statement of insurability form. A medical examination, paid for by the employee, may be required.

Continuation of Coverage During Leave of Absence. An employee on an approved leave of absence may continue Optional Life Insurance by paying the required premiums if coverage under Basic Life Insurance Plan is continued through the period of the leave of absence.

Optional Dependent Life and AD&D

In addition to the Optional Life AD&D coverages, active employees may elect Optional Life with AD&D Insurance for their dependents. Retirees may elect Optional Life Insurance without AD&D coverage for their dependents.

- If a retiree elects option II, the retiree must provide evidence of insurability for each dependent to be insured.

- Retirees may elect Dependent Life Insurance only during the calendar month of or the two calendar months following their date of retirement. After this time, no initial elections or increases will be permitted.

	Plan I	Plan II
Spouse	$5,000 in Life Insurance $5,000 in AD&D Coverage	$10,000 in Life Insurance $10,000 in AD&D Coverage
Each Child	$2,000 in Life Insurance $2,000 in AD&D Coverage	$4,000 in Life Insurance $4,000 in AD&D Coverage

A statement of insurability will be required if Optional Dependent Life is elected at any time after the enrollment period.

Dependent life insurance benefits will be available for newborns who die before discharge from the hospital when they are added to the policy within the allotted time frames for enrollment of dependents, and if they meet the guidelines of an eligible dependent. They cannot be enrolled for an amount greater than the amount for which the policyholder has previously elected.

Enrollment

Enrollment in Basic, Optional or Dependent Life and AD&D coverage is accomplished by completing enrollment forms obtained from the employee's place of employment or through the retirement system. Enrollment will authorize the employer or retirement system to deduct the premiums for the coverages from the employee's salary or pension.

New Employees. The enrollment period for new employees is the calendar month in which the employee's employment begins and the following two calendar months. No statement of health will be required during this time, for any amount not exceeding $100,000. Coverage will become effective the first day of the month following enrollment, (or approval, if required).

In order for coverage to begin on the first day of the month following enrollment, the employee must be actively at work on the date the coverage would become effective. If the employee enrolls before he/she is actively at work, coverage will begin on the first day of the month following the employee's first day of active employment.

If the employee chooses to enroll in Basic, Optional, or Dependent Optional Life Insurance after the enrollment period, a statement of insurability will be required. Coverage will become effective the first day of the month following approval.

Basic Life coverage or an increase in the amount of Optional Life Insurance coverage will be effective on the date the policyholder becomes eligible provided the policyholder has completed:

a) a full day of Active Work on that date; or

b) a full day of Active Work on the last regularly scheduled work day and is able to work on the date he/she becomes eligible.

If the policyholder does not meet the requirements of (a) and (b) above, the coverage will become effective on the date the policyholder returns to Active Work.

Active Work and Actively at Work means: performing regular duties for a full work day for the Policyholder.

Retired Employees. The enrollment period for retired employees wishing to elect new, or continue or increase Optional Life Insurance is the calendar month of and the two calendar months following their retirement. A statement of insurability will be required for retirees wishing to elect new, increase their coverage, or who elect plan two. New or increased coverage will be effective the first day of the month following approval. The retired employee cannot elect to enroll in or increase Optional Life Insurance after this initial period. The retired employee cannot enroll for or continue AD&D insurance.

Benefits for Accidental Death and Dismemberment Insurance

For active employees, the amount of the AD&D coverage is equal to the amount of the basic and/or optional insurance coverage.

To qualify for an AD&D benefit payment, the death or dismemberment must be the result of an injury caused by external and purely accidental means. The accident must occur while the employee or dependent is insured, or the loss of life or body part must occur within 90 days after the accident. AD&D insurance is paid as follows:

100% – Accidental loss of life

100% – Accidental loss of both hands, both feet, the sight of both eyes, or one hand or one foot and the sight of one eye.

50% – The accidental loss of one hand, one foot, or the sight of one eye.

No more than the full amount of coverage will be paid for multiple injuries resulting from one accident.

No AD&D benefits will be paid for losses suffered due, directly or indirectly, to one of the following circumstances:

- Bodily or mental infirmity, or disease, whether it is a proximate or contributing cause of the loss, whether sane or not;
- An infection other than a burn-related infection or an infection of a cut or wound;
- Suicide or attempted suicide;
- Intentional self-inflicted injury;
- War or act of war;
- Taking part in a riot; and
- Committing or trying to commit a crime.
- Any other kind of disease.
- Hernia, unless caused by accidental means.
- Medical or surgical treatment (except surgical treatment required by the accident and performed within 90 days after the accident.)

Statement of Insurability

A statement of insurability will be required for any employee who does not elect Basic, Optional, or Dependent Optional Life Insurance during the enrollment period or who wishes to increase the coverage amount. The life insurance carrier may require a medical examination at the employee's expense, and will make the final determination of whether or not to issue coverage.

Designating and Changing Beneficiaries

Designation. The employee may indicate the individual, individuals, or entity to receive the proceeds of the benefits under the life insurance plan.

The employee may designate more than one person as the beneficiary, and may indicate the portion of the proceeds for each beneficiary by listing the beneficiary and the percentage of proceeds each beneficiary is to receive. If no percentage is listed, the proceeds and will be divided equally among all beneficiaries. If a beneficiary has died, the remaining beneficiaries will share the portion that would have been paid to the deceased beneficiary.

Failure to Designate a Beneficiary. If the employee fails to designate a beneficiary or if the beneficiary does not survive the employee, benefits will be paid to the first surviving class of beneficiaries:

- widow or widower;
- surviving children;
- surviving parents;
- surviving brothers and sisters; and
- the employee's estate.

Minor beneficiary. If the beneficiary is a minor for whom no legal guardian has been appointed, the Plan will request that a guardian be appointed so that the entire benefit can be paid. The benefit will not be paid until the appointment, or the life insurance carrier will place the money into an interest-bearing account, in the minor's name, to be held until the minor turns age 18.

Multiple Beneficiaries. If more than one (1) beneficiary is named, the form should indicate the proportion to be paid to each beneficiary. If the share that each beneficiary is to receive is not stated on the designation form, the beneficiaries will be paid equal shares.

If one or more of the named beneficiaries dies before the employee, the remaining beneficiaries will share equally the amount which would have been distributed to the deceased beneficiary or beneficiaries. If only one beneficiary survives the employee, that beneficiary will receive the entire benefit.

Beneficiary for Optional Dependent Life Insurance. The employee will always be the beneficiary of Optional Dependent Life Insurance benefits.

Changing a Beneficiary. The employee may change the beneficiary of the Basic or Optional Life Insurance and AD&D coverage by completing a Change of Beneficiary form obtained from the employee's benefits coordinator or the retirement system.

Premiums

Basic Life Insurance Coverages. All costs of Basic Life Insurance coverage for employees and totally disabled employees are paid by the employer, except for non-state agencies. The premium rates are set forth in Appendix B.

Optional Life Insurance. The employee is responsible for paying the full applicable premium for Optional Life Insurance. The premium rates are set forth in Appendix B.

Optional Dependent Life Insurance. The employee is responsible for payment of all applicable premiums for Optional Dependent Life Insurance. The premium rates are set forth in Appendix B.

All premium rates are subject to change as determined by the WV PEIA's Life Insurance Carrier.

Basic Life Insurance For Disabled Employees (Waiver of Premium). If an active employee with Basic Life Insurance becomes totally disabled before reaching age 60, the Basic Life Insurance may be continued at no cost to the employee through a waiver of premium while the employee remains totally disabled. To qualify for this waiver of premium, the employee must furnish proof of total disability within one year after the date of disability, and, the employee must have been covered under Basic Life Insurance when the disability began. The date of disability is the employee's last day of active work.

"Total Disability" exists when the employee is completely unable, due to sickness or injury or both, to engage in any gainful occupation which the employee is reasonably capable of performing by education, training or experience. The employee will not be considered totally disabled while capable of working at any gainful occupation.

Application for waiver of premium is made through the employee's benefits coordinator. Proof of continuing disability will be required three months before each anniversary of the initial date of disability. The employee may be asked by the life insurance carrier to submit to periodic medical exams. AD&D coverage does not continue under the waiver of premium.

If the waiver of premium application is approved, the Basic Life Insurance will remain at $10,000 with no premium cost to the employee. At age 65, the Basic Life Coverage will decrease to $5,000, and further reduce to $2,500 at age 67.

This coverage will end at the earliest of these events:

- the end of disability;
- the failure to provide proof of continued disability; or
- the failure to submit to a physical examination when required by the life insurance carrier.

Refund of Individual Policy Premiums. If the employee had converted his/her life insurance under the Group Policy to an individual policy while totally disabled, the employee must return the individual policy to the insurance company with the first proof of total disability for a refund of any premiums paid.

Medical Examinations. The insurance company has a right to have its medical representative examine the employee when necessary, but not more than one (1) time each year after the employee has been totally disabled for a period of two (2) years.

Optional Life Insurance for Disabled Employees (Direct Payment of Premiums). If an active employee who has Optional Life Insurance becomes totally disabled before reaching age 60, the same or lower level of Optional Life Insurance may be continued while the employee remains totally disabled if the employee pays the entire premium for the Optional Life Insurance directly to PEIA. To qualify for this benefit, the employee must furnish proof of total disability and, the employee must have been covered under Basic Life Insurance and Optional Life Insurance when the disability began. The date of the disability is the employee's last day of active work. The employee must meet the definition of "total disability" and qualify for "waiver of premium" of their Basic Life Insurance as more fully set out in the "Basic Life Insurance For Disabled Employees (Waiver of Premium) section immediately above. The employee must also qualify as totally disabled with the Public Employees Retirement System.

Conversion

Basic and Optional Life Insurance Coverage.

Termination of Employment. If an employee leaves employment, the life insurance protection will continue for thirty-one (31) days from the date of termination of employment. The Accidental Death and Dismemberment coverage will end on the date of termination of employment.

During the thirty-one (31) day period, the employee may elect to convert all or a part of the group life insurance coverage to an individual policy by making an application and paying the first premium during the thirty-one (31) day period. No medical examination or statement of health is required.

The employee may only choose a type of coverage available from the Carrier.

The amount which may be converted is an amount equal to or less than the prior level of coverage. The level of premium is based upon the age, occupation and type of policy selected. The policy will take effect at the end of the thirty-one (31) day period.

Conversion for Spouse or Dependent - If a dependent loses coverage due to attaining the age of nineteen (19) (or twenty-five (25) if a full-time student), the dependent may convert the Dependent Life Insurance into an individual policy. The application and payment of the first month's premium must be made within thirty-one (31) days after the termination of coverage.

If coverage on the spouse of the employee ends due to employee's loss of eligibility, the dependent may, within thirty-one (31) days after the insurance ends, apply to convert the coverage to an individual policy.

The spouse may elect term insurance for a period of not more that one (1) year before the conversion coverage. No medical exam is required. The converted policy will take effect

thirty-one (31) days after the coverage under the group policy ends as long as proper application is made and the first monthly payment is paid in that period.

If the employee coverage on the spouse ends because the group policy has terminated or is amended, the employee may apply to convert the coverage to an individual policy in the manner described above. However, he/she must have been insured under the group policy for at least three (3) consecutive years and the group policy must have been in force at least five (5) consecutive years. The sum of coverage is reduced by any other group policy for which he/she is eligible within the thirty-one (31) day conversion period.

If a dependent's coverage under the Optional Dependent Life Insurance ends because the employee's class of employment is no longer classified as eligible and the dependent dies within thirty-one (31) days of that event, the benefit will be paid in the amount for which the dependent was last insured.

If a dependent dies within thirty-one (31) days after the insurance ends because the group policy is discontinued or amended, a benefit will be paid in the amount for which the dependent was last insured under the group policy. The employee must have been insured under the group policy for at least three (3) consecutive years and the group policy must have been in force for at least five (5) consecutive years. This amount will be reduced by any amount for which a person became insured under any other group policy within thirty-one (31) days after the coverage under this plan ended.

No payments will be made under the provisions of the last 2 paragraphs above if: (I) at the time of the dependent's death, he/she is eligible for insurance as an employee under the Plan; or (2) at a child's death, he/she is married or has reached the age limit.

Totally Disabled Employees. When the life insurance coverage for a totally disabled employee ends, the totally disabled employee will have the same rights to convert the group life insurance to an individual policy as apply to an employee. This right of conversion applies only if the totally disabled employee does not become insured again under the group policy.

Termination of Group Coverage or No Longer Eligible to Participate. If the group policy terminates or the employee is no longer employed in an eligible class of employees, the employee may convert coverage to an individual policy within the thirty-one (31) day period after coverage ends. For this right of conversion to exist, the employee must have been insured under the group policy for at least three (3) consecutive years. The amount which may be converted is reduced by any sum for which the employee was otherwise eligible under any other group policy in the thirty-one (31) days during which the election to covert may be made.

If an employee dies within thirty-one (31) days of the end of coverage, and the coverage ended because the group policy terminated or the employee was employed in a class of employees which is no longer eligible to participate, the employee's beneficiary will

be paid a benefit if the employee had been insured under the group policy for at least three (3) consecutive years and the group policy had been in force at least five (5) consecutive years.

The amount of the benefit will be the amount of life insurance for which the employee was last insured less any sum for which the employee became insured under any other group policy within thirty-one (31) days of the date the coverage ended under the group policy.

The individual policies for all life insurance policies are issued by PEIA's life insurance carrier. The individual policy is not the same as provided through PEIA, and may be substantially different. The employee may obtain a Life Insurance Conversion Application Form by calling the PEIA. The completed form is provided by PEIA's life insurance carrier which will explain the coverage options and costs to the employee.

Filing Claims.

In General. Upon the death of the insured, the following steps are to be followed:

1. the insured's payroll location or retirement system should be notified by the family of the insured;

2. the payroll location or retirement system will initiate the process for the payment of the claim by completing the employer's statement on the notice of death form and sending it to PEIA;

3. PEIA will then notify the beneficiary by sending out a Proof of Death claim form and requesting a court-certified death certificate with a raised seal;

4. the beneficiary completes the Proof of Death claim form and returns these materials to:

   Public Employee's Insurance Agency
   Attn.: Life Insurance Specialist
   State Capitol Complex
   1900 Kanawha Boulevard
   Building 5, Room 1001
   Charleston, WV 25305-0710

5. upon receipt of these materials, PEIA completes the final preparation of the claim; and

6. PEIA forwards all materials to the Carrier for processing.

7. the proceeds will be paid to the beneficiary(ies).

Retired Employees. Retired employees using sick and/or annual leave to extend insurance coverage must contact their former employers to file life insurance claims. All other retired employees must file life insurance claims through their retirement system.

Accidental Death and Dismemberment Claims. Within ninety (90) days after the date of the loss for which a claim is being made, written notices of the event must be provided to the PEIA. Failure to provide notice within this ninety (90) day period will not invalidate or reduce the claim as long as it can be shown that is was not reasonably possible to provide notification within that time frame and that notice was provided as soon as reasonably possible.

Upon receipt of notice, the forms for filing a proof of claim will be provided by the PEIA. If the claimant does not receive the forms for filing a proof of claim from the PEIA within fifteen (15) days of providing notification, the claimant will be deemed to have complied with the proof of claim requirements. If the claimant submits written proof covering the occurrence and the character and extent of loss for which the claim is being made to the PEIA, this written statement must be received within ninety (90) days after the date of the loss unless it can be shown that is was not reasonably possible to furnish the proof within the required time, and that proof was provided as soon as reasonably possible.

Upon receipt of the proof of claim, the AD&D benefits will be paid to the employee, if living, or to the beneficiary.

Disputed Claims

All disputed claims for benefits under the Plan shall be submitted to PEIA, or its representative within 60 days of the receipt of the denial notice from Carrier. Written notice of the decision on each such claim shall be furnished within sixty (60) days of the decision of the Carrier to the claimant.

If the claim is wholly or partially denied, such written notice shall set forth an explanation of the specific findings and conclusions on which such denial is based. A claimant may review all pertinent documents and may request a review by the Carrier of such a decision denying the claim. Such a request shall be made in writing and filed with the Carrier, within 30 days after delivery to the claimant of written notice of decision. Such written request for review shall contain all additional information which the claimant wishes the Carrier to consider in rendering its decision, and the decision on review shall be made within ninety (90) days of the date all information is received by the Carrier.

Written notice of the decision of the Carrier, shall be furnished within sixty (60) days to the claimant and shall include specific reasons for such decision. For all purposes under the Plan, such decisions on claims (where no review is requested) and decisions on review (where review is requested) shall be final, binding, and conclusive on all interested persons as to participation and benefit eligibility and as to any other matter of fact or interpretation relating to the Plan.

Termination or Reduction of Coverage.

Employee. Coverage ends when the employee is no longer eligible or when the group coverage terminates, whichever happens first. In the case of a voluntary termination of employment, the employee's coverage terminates immediately upon termination. If the termination of employment is involuntary but not due to gross misconduct, the employee may continue to be covered for three (3) months after the end of the month in which the employee is taken off the payroll.

Dependents. A dependent's coverage will end at the earlier of the following events:

- The dependent is no longer an eligible dependent;
- The employee retires and elects not to enroll for optional dependent life insurance;
- The employee dies;
- The employee elects not to participate; or
- The coverage under the group policy ends.

IX

VISION, DENTAL, AND LONG AND SHORT TERM DISABILITY PLANS

Introduction

In accordance with W. Va. Code § 5-16-15, the PEIA offers a vision, dental and long term disability plan to eligible insureds. These plans are offered as part of Mountaineer Flexible Benefits administered by a TPA with insurance coverage provided by a third-party. Eligible insureds may elect to participate in any one of these plans separately or in combination.

Eligibility

All active employees and their dependents eligible to participate in the Medical Benefits Plan may elect to participate in any of these plans. In the case of County Boards of Education, the board must participate for the employee to be eligible. Non-state (local government) agencies are not eligible to participate. All issues concerning eligibility will be determined by the Director.

Enrollment

Active employees may enroll in these plans during the PEIA annual open enrollment, or if a new employee, during the calendar month of or the calendar month following their employment. If the active employee enrolls in any of these plans and uses pre-tax dollars to pay premiums, the employee may not voluntarily terminate participation until an open enrollment period, effective the first day of the next Plan Year, unless the employee has a qualifying event as defined by PEIA's Section 125 Plan.

Premiums

All administrative and actuarial costs of these plans shall be borne by the premium payments of the Participants, or in the case of employees of county boards of education, pursuant to any agreement between the employee and the agency. Premiums will be determined by the company providing the insurance coverage.

Employers will collect premiums from employees participating in the plans and forward the premiums to the PEIA. Employees on a leave of absence will send premium payments directly to the PEIA. The PEIA will determine the dates premium payments are due at the Agency and provide appropriate notice. The PEIA will collect all premium payments and forward them to the TPA.

Administration

The Vision, Dental, and Long- and Short-Term Disability Plans are administered for the PEIA by the TPA listed in Appendix A.

The Director shall establish separate accounts for the deposit of dental premiums, vision premiums, and short- and long-term disability premiums.

The TPA shall provide to the PEIA such reports as requested by the PEIA and as set forth in the contract between the TPA and the PEIA.

Benefits

Each insured who elects coverage from one of these plans will be given a summary of benefits by the carrier describing the benefits covered, the providers participating in the benefit (if applicable) and how to file claims.

X

MEDICAL REIMBURSEMENT PLAN

ARTICLE I - INTRODUCTION

1.1 Purpose of Plan. The purpose of the Plan is to enable Participants to elect to receive payments or reimbursements of Health Care Expenses that are excludable from the Participant's gross income under §105(b) of the Code and that would be deductible expenses under §162 of the Code.

1.2 Qualification of Plan. This Plan is intended to qualify as an accident and health plan under §105(e) of the Code, as is to be interpreted in a manner consistent with the requirements of §105 (e).

1.3 Effective Date. The Plan is amended and restated effective January 1, 1999.

ARTICLE II – DEFINITIONS

The definitions in this Plan shall have the same meanings as set forth in the State of West Virginia Public Employees Insurance Agency Section 125 Plan, unless otherwise indicated below.

2.1 "Benefit" means any amount(s) paid to a Participant in the Plan as reimbursement for Health Care Expenses incurred by a Participant during a Plan Year by the Participant, Spouse or Dependents.

2.2 "Effective Date" means this amendment and restatement is effective July 1, 2000.

2.3 "Grace Period" means the 90 day period after the end of each Period of Coverage during which a Participant may submit claims for reimbursement from the Medical Reimbursement Account for claims incurred during the immediately preceding Period of Coverage.

2.4 "Health Care Expense" means health care expenses that are (a) deductible under Section 213 of the Code; (b) incurred by the Participant, Spouse, or Dependents during the Period of Coverage in which Contributions were credited to the Participant's Medical Reimbursement Account; (c) not incurred prior to the date the Employee's participation in the Plan commended; and (c) not incurred prior to the date the Employee's participation in the Plan commenced; and (d) not reimbursed by the Medical Plan or any other source. Health Care Expenses shall not include an expense incurred for the payment of premiums under a health insurance plan. For purposes of this Plan, expenses are incurred when

the Participant or Beneficiary is furnished the health care or services giving rise to the claimed expense.

2.5 "Highly Compensated Individual" means a Participant who is (a) one of the 5 highest paid officers, (b) a shareholder owning more than 10 percent in value of the stock of the employer, or (c) among the highest paid 25 percent of all Participants as defined in §105(h)(5) of the Code.

2.6 "Open Enrollment" means the period of time prior to or during a Plan Year during which Eligible Employees may make elections to allocate Contributions under the Section 125 Plan. The Open Enrollment period shall be established from year to year by PEIA.

2.7 "Participant" means each Employee who elects to participate in the Plan in accordance with Article III.

2.8 "Period of Coverage" means the Plan Year. The Period of Coverage will generally be twelve (12) months, except the 1999 Plan Year, or for Periods of Coverage during which an Employee is a Participant for less than the entire Period of Coverage. A Period of Coverage shall not be for a duration, which would enable a Participant to defer the receipt of Compensation or to obtain coverage under the Plan only for periods during which a Participant expects to incur Health Care Expenses.

2.9 "Plan" means The State of West Virginia Public Employees Insurance Agency Medical Reimbursement Plan as set forth herein, together with any and all amendments and supplements hereto, which is designed to operate in conjunction with the Section 125 Plan.

2.10 "Plan Year" means the twelve-month period beginning July 1 and ending June 30.

2.11 "Required Premium" means the amount of medical reimbursement coverage elected by the Participant for the Period of Coverage divided by the number of pay periods in such Period of Coverage.

2.12 "Section 125 Plan" means The State of West Virginia Public Employees Insurance Agency Section 125 Plan as amended from time to time.

The singular shall include the plural and vice-versa, whenever used herein, unless the context clearly indicates otherwise.

ARTICLE III - PARTICIPATION

3.1 Eligibility to Participate. All Eligible Employees may participate in and enter the Plan.

3.2 Commencement of Participation. An Eligible Employee may elect to become a Participant in the Plan by completing a Benefit Election Form and filing it with the Employer. Such an individual will become a Participant upon the effective date of an election to participate in the Plan as set forth in Article IV. In order to participate in the Plan during a particular Period of Coverage, an Employee must complete and file a Benefit Election Form during an Open Enrollment period designated by the Employer, which shall end prior to the first day of such Period of Coverage. If an Eligible Employee is hired after Open Enrollment, the employee must enroll during the month of hire or the following month.

On the Benefit Election Form, the Employee shall designate the amount of Compensation to be contributed to the Medical Reimbursement Plan, and thereby agrees to have his/her Compensation reduced by such amount.

3.3 Cessation of Participation. Except as provided in Article VII, a Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates, (b) the date on which the employee ceases to be an Eligible Employee, or (c) the date on which the election under the Section 125 Plan to receive Health Care Expense reimbursements expires or is terminated under the Section 125 Plan.

3.4 Reinstatement of Former Participant. A Former Participant will become a Participant again upon meeting the eligibility requirements of Section 3.1 and electing again under the Section 125 Plan to receive Health Care reimbursement under this Plan. However, in the case of a Participant who separates from service with the Employer during a Period of Coverage and elects to revoke existing benefit elections and terminates the receipt of benefits for the remaining portion of the Period of Coverage, if such Participant should return to service within the same Period of Coverage, the Participant will be prohibited from making new benefit elections for remaining portion of said Period of Coverage.

3.5 Participation of Spouses or Dependents. To the extent required by law, coverage under this Plan shall be made available to the Spouse or a Dependent of a Participant or Former Participant in lieu of (or in addition to) the Participant. In that event, such Spouse or Dependent shall be treated as a Participant under this Plan, but only to such extent and for such period as the law requires. No Benefit Election Form shall be required for such a Spouse or Dependent, but Required Premiums must be paid to the Employer on a monthly basis (or within such other time limit as may be provided for by law), and coverage shall cease upon nonpayment of any such Required Premium.

3.6 Salary Reduction. By participating in the Plan, each Participant agrees to have his/her annual Compensation reduced by the amount of money the Participant has elected to contribute to the Medical Reimbursement Account under the Section 125 Plan. No Participant shall be entitled to reduce Compensation for Health Care Expenses by more than the maximum amount of Benefits specified in Section 4.3.

ARTICLE IV – ELECTION TO RECEIVE HEALTH CARE REIMBURSEMENTS

4.1 Election Procedure. A Participant may elect to receive reimbursements of his Health Care Expenses under this Plan by filing a Benefit Election Form in accordance with Article IV of the Section 125 Plan. An election to receive reimbursements of Health Care Expenses shall be irrevocable and remain in effect until the end of the Period of Coverage, subject to a change in family status, as provided in the Section 125 Plan.

4.2 Minimum Reimbursement Election. The minimum amount, which the Participant may elect to receive in any Period of Coverage in the form of reimbursement for Health Care Expenses incurred during any Period of Coverage, is $150.

4.3 Maximum Reimbursement. The maximum amount which the Participant may receive under this Plan in the form of payment or reimbursement for Health Care Expenses incurred in any Period of Coverage is $3,000.

4.4 Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of Highly Compensated Individuals or Key Employees (as defined in Code §105(h)(5)) as to the eligibility to participate and/or benefits provided under the Plan, and is therefore intended to comply in this respect with the requirements of the Code.

4.5 Maximum Employer Contributions. The maximum amount of Employer Contributions under the Plan for any Participant shall be the maximum amount, which the Participant may elect to receive in the form of Health Care Expense reimbursement under the Plan described in Section 4.3.

ARTICLE V – MEDICAL REIMBURSEMENT ACCOUNTS

5.1 Establishment of Accounts. The Administrator will establish and maintain its own books on Medical Reimbursement Account for each Period of Coverage with respect to each Participant who has elected to receive reimbursement of Health Care Expenses incurred during the Period of Coverage.

5.2 Crediting of Accounts. There shall be credited to a Participant's Medical Reimbursement Account for each Period of Coverage as of each date Compensation is paid, for the Participant in such Period of Coverage, an amount

equal to reduction, if any, to be made in such Compensation in accordance with the Participant's Benefit Election Form under the Section 125 Plan. Contributions shall be credited to Medical Reimbursement Accounts in equal amounts over a period of time established by the Employer. All amounts credited to such Medical Reimbursement Account shall be the property of the Employer until paid out pursuant to Article VI.

{If an Employee's net pay is not sufficient to fully fund his requested salary reduction, the contribution cannot be made up in the future when the Participation has earned salary sufficient to fund such benefits election.}

5.3 Debiting of Accounts. A Participant's Medical Reimbursement Account for each Period of Coverage shall be debited from time to time as provided in Section 6.2 hereof in the amount of any payment under Article VI to or for the benefit of the Participant for Health Care Expenses incurred during such Period of Coverage. Amounts debited to each such Medical Reimbursement Account shall be treated as payments of the earliest amounts credited to the Account and not yet treated paid, under a "first-in, first-out" approach.

5.4 Limitation on Reimbursements or Payments with Respect to Certain Participants. Not withstanding any other provision of this Plan, the Administrator may limit the amounts reimbursed or paid with respect to any Participant who is a Highly Compensated Individual (within the meaning of Code Section 105 (h)(5) or 125(e)) to the extent the Administrator deems such limitation to be advisable to assure compliance with any non-discrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section 5.5.

5.5 Forfeiture of Accounts. The amount credited to a Participant's Medical Reimbursement Account for any Period of Coverage shall be used only to reimburse the Participant for Health Care Expenses incurred during such Period of Coverage, and only if the Participant applies for reimbursement on or before the end of the Grace Period following the close of the Period of Coverage in which such expenses were incurred. If any balance remains in the Participant's Medical Reimbursement Account for a Period of Coverage after all reimbursements hereunder, such balance shall not be carried over to reimburse the Participant for Health Care Expenses incurred during a subsequent Period of Coverage, and shall be forfeited. (Forfeited amounts shall be used to pay the administrative expenses of the Plan).

ARTICLE VI - PAYMENT OF HEALTH CARE EXPENSE REIMBURSEMENTS

6.1 Claims for Reimbursement. A Participant may apply to the Employer for reimbursement of Health Care Expenses incurred by the Participant during the Period of Coverage by submitting a statement in writing to the Employer, in such form as the Employer may prescribe, setting forth:

(a) The amount, date and nature of the expense with respect to which a payment or reimbursement is requested;

(b) The name of the person, organization or entity to which the expense was or is to be paid;

(c) The name of the person for whom the expense was incurred and, if such person is not the Participant, the relationship of such person to the Participant; and

(d) Such other information as the Employer may from time to time require.

Such application shall be accompanied by statements showing the amounts of such expenses, together with any additional documentation, which the Administrator may request. Claims for reimbursement may be submitted at any time during the Period of Coverage or within the Grace Period.

Expenses shall be considered incurred when the health care is provided, not when the Participant is formally billed, charged for, or pays for the expense.

6.2 Reimbursement or Payment of Expenses. The Employer shall reimburse the Participant from the Participant's Medical Reimbursement Account for Health Care Expenses incurred during the Period of Coverage, for which the Participant submits a written application and documentation in accordance with Section 6.1. The Employer may, at its option, pay any such Health Care Expense directly to the person providing or supplying the health care in lieu of reimbursing the Participant. Notwithstanding anything herein to the contrary, a claim with respect to a Period of Coverage must be filed by the end of the Grace Period to be eligible for reimbursement.

Subject to Article VII, the amount available for reimbursement shall, at all times during the Period of Coverage, be equal to the amount of coverage purchased by the Participant (the amount the Participant elected to have contributed into his Medical Reimbursement Account for the Period of Coverage), less any previous reimbursements made for the Period of Coverage. In no event may the annual value of Benefits provided hereunder for any Participant pursuant to the Participant's election on his Benefit Election Form exceed the maximum reimbursement amount as described in Section 4.3.

ARTICLE VII - TERMINATION OF PARTICIPATION

7.1 Termination of Participation. (a) In the event that a Participant ceases to be a Participant in this Plan for any reason other than as provided by subsection (b) during a Period of Coverage, the Participant's Benefit Election Form relating to this Plan shall terminate. Except as provided in this Section 7.1 and Section 7.2,

the Participant shall be entitled to reimbursement only for Health Care Expenses incurred up to the date of termination, but only if the Participant (or estate) applies for such reimbursement in accordance with Section 6.1. No such reimbursement shall exceed the remaining balance, if any, at the date of employment termination in the Participant's Medical Reimbursement Account for the Period of Coverage in which the expenses were incurred.

(b) A Participant who terminates employment during a Period of Coverage due to disability or retirement shall be entitled to reimbursement for Health Care Expenses incurred within the same Plan Year as the termination until the Medical Reimbursement Account is exhausted, but only if the Participant (or the participant's estate) applies for such reimbursement in accordance with Section 6.1. No such reimbursement shall exceed the remaining balance, if any, in the Participant's Medical Reimbursement Account for the Period of Coverage in which the expenses were incurred, provided, however, that such Participant may be entitled to reimbursement up to the maximum amount which the Participant elected to receive in the form of Health Care Expense reimbursement for such Period of Coverage if the Participant continues to pay the Required Premium for such Period of Coverage subsequent to termination

7.2 Continuation of Coverage. If and to the extent required by law (including, without limitation, Sections 105, 125 and 4980N and regulations thereunder), in the event a Participant ceases to be an Employee and undertakes to pay Required Premium to the Employer on a monthly basis (or within such other time limit as may be provided for by law), coverage under the Plan shall continue so long as such Required Premiums are paid, but not beyond the end of the period for which such coverage is required by law. In addition, the former Participant shall be treated as a Participant under the Plan to such extent as is required by law, and shall be entitled to reimbursement for Health Care Expenses incurred during such period of continued coverage, subject to Section 7.3.

7.3 Limits on Time and Amount of Reimbursements. Reimbursements shall be made for any Period of Coverage under this Article VII only if the Participant applies for such reimbursement in accordance with Section 6.1 on or before the Grace Period following the close of the Period of Coverage. In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Article VII. No reimbursement under this Article VII shall exceed the remaining balance, if any, in the Participant's Medical Reimbursement Account for the Period of Coverage in which the expenses were incurred.

ARTICLE VIII - ADMINISTRATION

8.1 Plan Administrator. The Administrator shall have the sole responsibility for the administration of this Plan. The Administrator shall have the authority to appoint such other person or committee from time to time to supervise the administration of the Plan. The designated representatives of the Administrator shall have only those specific powers, duties, responsibilities and obligations as are specifically given them.

The Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. Furthermore, the Administrator may rely upon any such direction, information or action of another Employee of the Employer as being proper under this Plan, and is not required under this Plan to inquire into the propriety of any such direction, information or action. It is intended under this Plan that the Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Administrator nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

All usual and reasonable expenses of the Administrator that are not properly chargeable to or payable by the Plan (including payment out of forfeitures pursuant to Section 5.5) shall be paid by the Employer, and any expenses not paid by the Employer shall not be the responsibility of the Administrator personally. The Administrator or any other designated representative of the Employer who is an Employee of the Employer shall not receive any compensation with respect to services hereunder except as such person may be entitled to Benefits under this Plan.

It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

The Administrator will have full power to administer the Plan in all of its details subject to applicable requirements of law.

8.2 Records and Reports. The Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants and the balances, if any, which are maintained under this Plan. The Administrator shall be responsible for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 105(b) plans.

8.3 Examination of Records. The Administrator will make available to each Participant such records as pertain to the participant, for examination at reasonable times during normal business hours.

8.4 Reliance on Tables, etc. In administering the Plan, the Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by the accountant, counsel or other expert who is employed or engaged by the Administrator.

8.5 Rules and Decisions. The Administrator may adopt such rules, as it deems necessary, desirable, or appropriate. All rules and decisions of the Administrator, whether directionally or otherwise, shall be exercised in a uniform and consistent manner so that all persons similarly situated will receive substantially the same treatment. When making a determination or calculation, the Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or the legal counsel of the Employer.

8.6 Facility of Payment. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a Benefit or installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such person or to the person's legal representative or to a relative of such person or such person's benefit, or the Administrator may direct the Employer to apply the payment for the Benefit of such person in such a manner as the Administrator considers advisable. Any payment of a Benefit or installment thereof in accordance with the provisions of this Section 8.6 shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

8.7 Claims and Review Procedures.

(a) A claim for benefits under the Plan shall first be filed with the TPA. Notice of the decision shall be furnished to the claimant by the TPA within a reasonable period of time after receipt of the claim by TPA. If a Participant does not receive notice of denial of a claim for benefits under the Plan within 90 days of the filing of such claim, then the claim shall be deemed denied.

(b) A claimant may review all pertinent documents and may request a review by the TPA of any claim. Any such request must be filed in writing with the TPA within 90 days after the earlier of (i) receipt by the claimant of written notice of the decision on the claim or (ii) 90 days after the initial filing of such claim. Such written request for review shall contain all additional information, which the claimant wishes the TPA to consider.

(c) If such claim is denied by the TPA, a claimant may appeal in writing to PEIA. Such appeal must be filed with PEIA within 30 days of receipt of the TPA's decision denying such claim. All information relating to the denial, including a copy of the denial letter form the TPA, must be supplied to PEIA by the claimant. PEIA will, after reviewing the facts, make a final determination and notify the claimant of its decision. Such decision shall be final and binding.

8.8 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

8.9 Indemnification of Administrator. PEIA agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by PEIA) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

8.10 Appointment of Agent by Administrator. The Plan Administrator may delegate its duties to a TPA, and such TPA may perform all the duties of the Administrator as set forth in this Article VIII, subject to the terms of the Plan.

ARTICLE IX - AMENDMENT AND TERMINATION OF PLAN

9.1 Amendment of Plan. This Plan may be amended at any time by the PEIA to any extent and in any manner that it may deem advisable, by a written instrument signed by PEIA.

9.2 Termination of Plan. PEIA has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but PEIA will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time without liability. Upon termination or discontinuance of the Plan, all elections and reductions in compensation related to the Plan shall terminate, and reimbursements shall be made in accordance with Article VI and Article VII.

ARTICLE X - MISCELLANEOUS PROVISIONS

10.1 Communication to Employees. Promptly after the Plan is adopted, PEIA will notify all Employees of the availability and terms of the Plan.

10.2 Information to be Furnished. Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

10.3 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Administrator or the Employer, except as expressly provided herein, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby.

10.4 Benefits Solely from General Assets. The Benefits provided hereunder will be paid solely from the general assets of the Employer. The Benefits provided by the Plan are given in exchange for the Participant's salary reduction agreement. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the Benefit of any Participant and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account asset of the Employer from which any payment under the Plan may be made.

10.5 Non-assignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his creditors by any process whatsoever, and any attempt to cause such rights to be so subjected will not be recognized, except to such extent as may be required by law.

10.6 Non-alienation of Benefits. Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable hereunder shall be void. The Employer and PEIA shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits hereunder.

10.7 Divestment of Benefits. Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to the benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.

10.8 No Guarantee of Tax Consequences. Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under Article VI will be excludable from the

Participant's gross income for Federal or state income tax purposes, or that any other Federal or state treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under Article VI is excludable from the Participant's gross income for Federal or state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

10.9 Indemnification of Employer by Participants. If any Participant receives one or more payments or reimbursements under Article VI that are not for Health Care Expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal or state income tax or Social Security tax from such payment or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and state income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.10 Governing Law. The Plan will be construed, administered and enforced according to the laws of the State of West Virginia.

10.11 Execution of Documents. Each Employee, family member or beneficiary, does, by the acceptance of potential benefits under this Plan, agree to execute any documents, which may be necessary or proper in the carrying out of the purpose and intent of the Plan.

10.12 Election Not to Participate. Each eligible Participant shall have the right to elect not to participate in this Plan.

10.13 Not a Contract of Employment. This Plan shall not be deemed to constitute a contract between the Employer and the Participant or to be a consideration or an inducement for the employment of any Participant. Nothing contained in the Plan shall be deemed to give any Participant the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant at any time regardless of the effect which said discharge shall have upon the employee as a Participant of the Plan.

10.14 Severability. If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

10.15 Construction of the Plan. PEIA and/or Administrator may construe any ambiguous provisions of the Plan, correct any defect, supply any omission, or reconcile any inconsistency, in such manner and to such extent as PEIA in its

discretion may determine, any such action of PEIA shall be binding and conclusive upon all Participants.

ARTICLE XI - CONTINUATION COVERAGE

11.1 Right to Elect Continuation Coverage. To the extent required by COBRA, a Participant, the Participant's Spouse, ex-spouse, and the Participant's dependent child can elect continuation coverage of such optional benefits under the Employer's Medical Plan and Medical Reimbursement Plan.

DEPENDENT CARE REIMBURSEMENT PLAN

ARTICLE I --INTRODUCTION

1.1 Purpose of Plan. The purpose of the Plan is to enable Participants to elect to receive payments of reimbursements of their dependent care expenses that are excludable from the Participant's gross income under Section 129 of the Code.

1.2 Qualification of Plan. This Plan is intended to qualify as a dependent care assistance program under Section 129 of the Code, and is to be interpreted in a manner consistent with the requirements of Section 129.

1.3 Effective Date. The Plan is amended and restated effective January 1, 1999.

ARTICLE II - DEFINITIONS

The definitions in this Plan shall have the same meanings as set forth in the State of West Virginia Public Employees Insurance Agency Section 125 Plan, unless otherwise indicated below.

2.1 "Benefits" means any amount(s) paid to a Participant in the Plan as reimbursement for Dependent Care Expenses incurred by a Participant during a Period of Coverage by the Participant, Spouse, or Dependent.

2.2 "Dependent" means any individual who is (a) dependent (as defined in Code Section 152) of the Participant who is under the age of 13 and with respect to whom the Participant is entitled to an exemption under Section 151(c) of the Code, or (b) a dependent as defined in Code Section 152(c) or Spouse of the Participant who is physically or mentally incapable of caring for him or herself.

2.3 "Dependent Care Expenses" means expenses incurred by a Participant which (a) are incurred for the care of a Dependent of the Participant or for related household services, (b) are paid or payable to a Dependent Care Service Provider, and (c) are incurred to enable the Participant to be gainfully employed for any period of which there are one or more Dependents with respect to the Participant. "Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is described in Section 2.2(a) above or regularly spends at least eight (8) hours each day in the Participant's household.

Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses related are rendered.

2.4 "Dependent Care Reimbursement Account" means the account described in Article V hereof.

2.5 "Dependent Care Service Provider" means a person who provides care or other services described in Section 2.3 above, but shall not include (a) a dependent care center (as defined in Section 21(b)(2)(D) of the Code), unless the requirements of Code Section 21(b)(2)(C) are satisfied, or (b) a related individual described in Section 129(c) of the Code.

2.6 "Earned Income" means all income derived from wages, salaries, tips, self-employment and other employee compensation (such as disability benefits) but such term does not include any amounts received (i) under the Plan or any other Dependent Care program under Code Section 129, (ii) as pension or annuities; or (iii) as unemployment or Worker's Compensation.

2.7 "Effective Date" means this amendment and restatement is effective January 1, 1999.

2.8 "Eligible Expenses" means all Dependent Care Expenses incurred by a Participant or by his Spouse which are paid to a Dependent Care Service Provider.

2.9 "Grace Period" means the 90 day period immediately after the end of each Period of Coverage during which a Participant may submit claims for reimbursement from the Dependent Care Reimbursement Account for claims incurred during the immediately preceding Period of Coverage.

2.10 "Highly Compensated Individual" means a Participant who is (a) a 5 percent owner, (b) received compensation from the Employer in excess of $75,000 (as adjusted), (c) received compensation from the Employer in excess of $50,000 (as adjusted) and was in the top-paid group of Employees for such year, or (d) an officer who received compensation greater than 50 percent of the amount in effect under Section 415(b)(1)(A) of the Code for such year.

2.11 "Participant" means each Employee who elects to participate in the Plan in accordance with Article III.

2.12 "Period of Coverage" means the Plan Year. The Period of Coverage will be twelve (12) months, except for the periods of Coverage during which an Employee is a Participant for less than the entire Period of Coverage. A Period of Coverage shall not be for a duration, which would enable a Participant to defer the receipt of Compensation or to obtain coverage under the Plan only for periods during which a Participant expects to incur Dependent Care Expenses.

2.13 "Plan" means The State of West Virginia Public Employees Insurance Agency Dependent Care Reimbursement Plan as set forth herein, together with any and

all amendments and supplements hereto, which is designed to operate in conjunction with the Section 125 Plan.

2.14 "Plan Year" means the twelve-month period beginning July 1 and ending June 30.

2.15 "Section 125 Plan" means The State of West Virginia Public Employees Insurance Agency Section 125 Plan as amended from time to time.

The singular shall include the plural and vice-versa, whenever used herein, unless the context clearly indicates otherwise.

ARTICLE III - PARTICIPATION

3.1 Eligibility to Participate. All Eligible Employees may participate in and enter the Plan.

3.2 Commencement of Participation. An Eligible Employee may elect to become a Participant in the Plan by completing a Benefit Election Form and filing it with the Employer. Such an individual will become a Participant upon the effective date of an election to participate in the Plan as set forth in Article IV. In order to participate in the Plan during a particular Period of Coverage, an Employee must complete and file a Benefit Election Form during an Open Enrollment period designated by the Employer, which period shall end prior to the first day of such Period of Coverage. An Eligible Employee hired after Open Enrollment, must enroll during the month of hire or the following month.

On the Benefit Election Form, the Employee shall designate the amount of Compensation to be contributed to the Dependent Care Reimbursement Account, and thereby agrees to reduced Compensation by such amount.

3.3 Cessation of Participation. Except as provided in Article VII, a Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates, (b) the date on which the participant ceases to be an Eligible Employee, or (c) the date on which the election under the Section 125 Plan to receive Dependent Care Expense reimbursements expires or is terminated under the Section 125 Plan.

3.4 Reinstatement of Former Participant. A Former Participant who is eligible under Section 3.1 elects again under the Section 125 Plan to receive reimbursement of Dependent Care Expenses under this Plan, will again become a Participant in this Plan on the effective date of such election. However, in the case of a Participant who separates from service with the Employer during a Period of Coverage and elects to revoke existing benefit elections and terminates the receipt of Benefits for the remaining portion of the Period of Coverage, such a Participant who returns to service within the same Period of Coverage, will be

prohibited from making new benefit elections for the remaining portion of such Period of Coverage.

3.5 Salary Reduction. By participating in the Plan, each Participant agrees to have annual Compensation reduced by the amount of money the participant has elected to contribute to his Dependent Care Reimbursement Account under the Section 125 Plan. No Participant shall be entitled to reduce Compensation for Dependent Care Benefits by more than the aggregate maximum amount of Benefits specified in Section 4.4.

ARTICLE IV - ELECTION TO RECEIVE DEPENDENT CARE REIMBURSEMENTS

4.1 Election Procedure. A Participant may elect to receive Dependent Care Expense Reimbursement under this Plan by filing a Benefit Election Form in accordance with the procedures set forth in the Section 125 Plan. An election to receive Dependent Care Expense Reimbursements shall be irrevocable and remain in effect until the end of the Period of Coverage, unless there is a change in family status, as provided in the Section 125 Plan.

4.2 Maximum Dependent Care Reimbursement. The maximum amount which the Participant may receive in any Period of Coverage in the form of Dependent Care Expense Reimbursement under this Plan shall be the lesser of (a) the Participant's Earned Income for the Period of Coverage (after all reductions in compensation including the reduction related to Dependent Care Reimbursement), (b) the actual or deemed Earned Income of the Participant's Spouse for the Period of Coverage, or (c) $5,000 ($2,500 where a separate return is filed by a married individual). In the case of a Spouse who is a full-time student at an education institution or is physically or mentally incapable of caring for him or herself, such spouse shall be deemed to have Earned Income of not less than $200 per month if the Participant has one Dependent and $400 per month if the Participant has two or more Dependents.

4.3 Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of Highly Compensated Individuals or Key Employees (as defined in Code Section 414(q)) as the eligibility to participate, contributions and/or benefits, and to comply in this respect with the requirements of the Code. If, in the judgment of the Plan Administrator, the operation of the Plan in any Period of Coverage would result in such discrimination, then such Plan Administrator shall select and exclude from coverage under the Plan such Highly Compensated or Key Participants and/or reduce contributions and or Benefits under the Plan for such Participants, as shall be necessary to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate.

4.4 Maximum Employer Contributions. The maximum amount of Employer contributions under the Plan for any Participant shall be the maximum amount, which the Participant may receive in the form of Dependent Care Expense Reimbursement under the Plan.

ARTICLE V - DEPENDENT CARE REIMBURSEMENT ACCOUNTS

5.1 Establishment of Accounts. The Administrator will establish and maintain on its books a Dependent Care Reimbursement Account for each Period of Coverage with respect to each Participant who has elected to receive reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

5.2 Crediting of Accounts. There shall be credited to a Participant's Dependent Care Reimbursement Account for each Period of Coverage as of each date Compensation is paid, for the Participant in such Period of Coverage, an amount equal to the reduction, if any, to be made in such Compensation in accordance with the Participant's Benefit Election Form under the Section 125 Plan. Contributions shall be credited to Dependent Care Reimbursement Accounts in equal amounts over a period of time established by the Employer. All amounts credited to such Dependent Care Reimbursement Account shall be the property of the Employer until paid out pursuant to Article VI.

{If an Employee's net pay is not sufficient to fully fund the requested salary reduction, the contribution cannot be made up in the future when the Participant has earned salary sufficient to fund such benefit election}.

5.3 Debiting of Accounts. A Participant's Dependent Care Reimbursement Account for each Period of Coverage shall be debited from time to time as provided in Section 6.2 hereof in the amount of any payment under Article VI to or for the benefit of the Participant for Dependent Care Expenses incurred during such Period of Coverage. Amounts debited to each such Dependent Care Reimbursement Account shall be treated as payments of the earliest amounts credited to the Account and not yet treated as paid under this Section 5.3, under a "first-in, first-out" approach.

5.4 Forfeiture of Accounts. The amount credited to a Participant's Dependent Care Reimbursement Account for any Period of Coverage shall be used only to reimburse the Participant for Dependent Care Expenses incurred during such Period of Coverage, and only if the Participant applies for reimbursement on or before the end of the Grace Period following the Period of Coverage in which the expenses were incurred. If any balance remains in the Participant's Dependent Care Reimbursement Account for a Period of Coverage after all reimbursement hereunder, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Period of Coverage, but shall be forfeited. (Forfeited amounts shall be used to pay the administrative expenses of the Plan).

ARTICLE IV - PAYMENT OF DEPENDENT CARE EXPENSE REIMBURSEMENTS

6.1 Claims for Reimbursement. A Participant may apply to the Employer for reimbursement of Dependent Care Expenses incurred by the Participant during the Period of Coverage by submitting an application in writing to the Employer, in such form as the Employer may prescribe, setting forth.

(a) The amount, date and nature of the expense with respect to which a payment or reimbursement is requested.

(b) The names, address and tax identification number of the person, organization, or entity to which the expense was or is to be paid.

(c) Such other information as the Employer may from time to time require.

Such application shall be accompanied by a receipt showing the amounts of such expenses, together with any additional documentation, which the Administrator may request. Claims for reimbursement may be made at any time during the Period of Coverage or within the grace period.

Expenses shall be considered incurred when the dependent care is provided, and not when the Participant is formally billed, charged for, or pays for the expense.

6.2 Reimbursement or Payment of Expenses. The Employer shall reimburse the Participant from the Participant's Dependent Care Reimbursement Account for Dependent Care Expenses incurred during the Period of Coverage, for which the Participant submits a written application and documentation in accordance with Section 6.1. No Reimbursement or payment shall at any time exceed the balance of the Participant's Dependent Care Reimbursement Account for the Period of Coverage at the time of the Reimbursement or Payment. The amount of Dependent Care Expense not reimbursed or paid as a result of the preceding sentence will be carried over and reimbursed if and when the balance in the Participant's Dependent Care Reimbursement Account permits such reimbursement or payment. Notwithstanding anything herein to the contrary, a claim with respect to a Period of Coverage must be filed by the end of the Grace Period to be eligible for reimbursement. In no event may the annual value of Benefits provided hereunder for any Participant pursuant to the Participant's election on his Benefit Election Form exceed the maximum reimbursement amount as described in Section 4.2.

6.3 Limitation on Amount of Benefits. The average Benefits provided to Non-Highly Compensated Individuals must be at least 55% of the average Benefits provided to Highly Compensated Individuals under all Dependent Care Reimbursement Plans of the Employer. For purposes of this limitation, in the case of any Benefits provided through a salary reduction agreement, the Plan may disregard

any Participant whose Compensation is less than $25,000. For purposes of the above paragraph, there shall be excluded from consideration Employees who are described in Code Section 129(d)(9).

6.4 Principal Shareholders Limitation. Not more than 25 percent of the amounts paid or reimbursed by and Employer for Dependent Care Expenses incurred during a Period of Coverage may be provided for the class of Participants, each of whom (on any day of such Period of Coverage) owns more than 5 percent of the stock or of the capital or profits interest in such Employer. The ownership of stock in an Employer shall be determined in accordance with the rules provided under Section 1563(d) and (e) of the Code (without regard to Section 1563(e)(3)(C)). The Administrator shall reduce the Dependent Care Benefits for such Participants to the extent that it reasonably believes necessary to prevent this limitation from being exceeded.

6.5 Officers, Owners, and Highly Compensated Individuals. The Administrator shall also reduce the Dependent Care Benefits for Officers, Owner, and Highly Compensated Individuals and their Dependents, to the extent that absent such reduction, the Program would be discriminatory within the meaning of Section 129(d)(2) of the Code.

6.6 Verification of Information.

(a) Limitations. Participants shall furnish to the Administrator such information as the Administrator shall reasonably require to satisfy itself that the limitations contained in Sections 6.3, 6.4 and 6.5 are not violated. The Administrator may, but shall not be required to, require verification of such information, and refuse to pay Benefits unless and until it is satisfied that none of the limitations contained in Article IV and VI would be violated by such payment.

(b) Dependent Care Expenses. The Administrator may, but shall not be required to, require verification of Dependent Care Expenses for which Benefits are claimed and refuse to pay Benefits unless and until it is satisfied that such Benefits have been incurred. A Participant shall cooperate fully with such verification if the Administrator requires him to do so.

(c) Service Provider Identifying Information. No amount paid or incurred by the Employer for Benefits provided to a Participant shall be excluded from the gross income of a Participant unless:

(1) the name, address and taxpayer identification number of the facility or name, address, Social Security number and signature of the person performing the services are included on the Reimbursement Claim Form to which the exclusion relates; or

(2) if such person is an organization described in Section 501(c)(3) of the Code and exempt from tax under Section 501(a), the name and address of such person are included on the Reimbursement Claim Form to which the exclusion relates.

The preceding sentence shall not apply if the Participant can show that due diligence was exercised in attempting to provide the required information in the case of a failure to provide such information.

6.7 Limitation on Dependent Care Benefits. Notwithstanding anything herein to the contrary, no benefit shall be paid under this Article VI to the extent otherwise reimbursed.

ARTICLE VII - TERMINATION OF PARTICIPATION

7.1 Termination of Participation. In the event that a Participant ceases to be a Participant in this Plan for any reason, the Participant's election with respect to the Dependent Care Reimbursement Plan shall terminate. However, the Participant (or estate) shall be entitled to reimbursement for Dependent Care Expenses incurred within the same Plan Year of termination until the Dependent Care Reimbursement Account is exhausted, but only if the Participant (or estate) applies for such reimbursement in accordance with Section 6.1. No such reimbursement shall exceed the remaining balance, if any, in the Participant's Dependent Care Reimbursement Account for the Period of Coverage in which the expenses were incurred.

7.2 Leave of Absence. Upon termination of employment, Participants may no longer contribute to their Dependent Care Reimbursement Accounts. However, Participants who take an unpaid leave during a Period of Coverage may continue to contribute to their Dependent Care Reimbursement Accounts using after-tax dollars.

ARTICLE VIII - ADMINISTRATION

8.1 Plan Administrator. The Administrator shall have the sole responsibility for the administration of this Plan. The Administrator shall have the authority to appoint such other person or committee from time to time to supervise the administration of the Plan. The designated representatives of the Administrator shall have only those specific powers, duties, responsibilities and obligations as are specifically given them.

The Administrator warrants that any directions given, information furnished, or action by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. Furthermore, the Administrator may rely upon such direction, information or action of another

Employee or Employer as being proper under this Plan, and is not required under this Plan to inquire into the propriety of any such direction, information or action. It is intended under this Plan that the Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Administrator nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

All usual and reasonable expenses of the Administrator that are not properly chargeable to or payable by the Plan (including payment out of forfeitures pursuant to Section 5.4) shall be paid by the Employer, and any expenses not paid by the Employer shall not be the responsibility of the Administrator personally. The Administrator or any other designated representative of the Employer who is an Employee of the Employer shall not receive any compensation with respect to services hereunder except as such person may be entitled to Benefits under this Plan.

It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

The Administrator will have full power to administer the Plan in all of its details subject to applicable requirements of law.

8.2 Records and Reports. The Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants and the balances, if any, which are maintained under this Plan. The Administrator shall be responsible for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 129 Plans.

8.3 Examination of Records. The Administrator will make available to each Participant such records as pertain to the Participant, for examination at reasonable times during normal business hours.

8.4 Reliance on Tables, etc. In administering the Plan, the Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by any accountant, counsel or other expert who is employed or engaged by the Administrator.

8.5 Rules and Decisions. The Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Administrator, whether discretionary or otherwise, shall be exercised in a uniform and consistent manner so that all persons similarly situated will receive substantially

the same treatment. When making a determination or calculation, the Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or the legal counsel of the Employer.

8.6 Facility of Payment. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a Benefit or installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such person or to the person's legal representative or to a relative of such person for such person's benefit, or the Administrator may direct the Employer to apply the payment for the Benefit of such person in such manner as the Administrator considers advisable. Any payment of a Benefit or installment thereof in accordance with the provisions of this Section 8.6 shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

8.7 Claims and Review Procedures.

(a) A claim for Benefits under the Plan shall first be filed with the TPA. Notice of the decision shall be furnished to the claimant by the TPA within a reasonable period of time after receipt of the claim by the TPA. If a Participant does not receive notice of denial of a claim for Benefits under the Plan within 90 days of the filing of such claim, then the claim shall be deemed denied.

(b) A claimant may review all pertinent documents and may request a review by the TPA of any claim. Any such request must be filed in writing with the TPA within 90 days after the earlier of (i) receipt by the claimant of written notice of the decision on the claim or (ii) 90 days after the initial filing of such claim. Such written request for review shall contain all additional information, which the claimant wishes the TPA to consider. Notice of the decision on review shall be furnished in writing to the claimant within 90 days (unless special circumstances require an extension of up to 90 additional days) following the receipt of the request for review. The TPA's written decision shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan or of the Plan Documents on which the decision is based.

(c) If such claim is denied by the TPA, a claimant may appeal in writing to PEIA. Such appeal must be filed with PEIA within 30 days of receipt of the TPA's decision denying such claim. All information relating to the denial, including a copy of the denial letter from the TPA, must be supplied to PEIA by the claimant. PEIA will, after reviewing the facts, make a final determination and notify the claimant of its decision. Such decision shall be final and binding.

8.8 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

8.9 Indemnification of Administrator. PEIA agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by PEIA) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

8.10 Appointment of Agency by Plan Administrator. The Plan Administrator may delegate its duties to a TPA, and such TPA may perform all of the duties of the Administrator as set forth in this Article VIII, subject to the terms of the Plan.

ARTICLE IX - AMENDMENT OR TERMINATION OF PLAN

9.1 Amendment of Plan. This Plan may be amended at any time by the PEIA to any extent and in any manner that it may deem advisable, by a written instrument signed by PEIA.

9.2 Termination of Plan. PEIA has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but PEIA will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time without liability. Upon termination or discontinuance of the Plan, all elections and reductions in Compensation related to the Plan shall terminate, and reimbursements shall be made in accordance with Article VI and Article VII.

ARTICLE X - MISCELLANEOUS PROVISIONS

10.1 Communication to Employees. Promptly after the Plan is adopted, PEIA will notify all Employees of the availability and terms of the Plan.

10.2 Information to be Furnished. Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

10.3 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Administrator or the Employer, except as expressly provided herein, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby.

10.4 Benefits Solely from General Assets. The Benefits provided hereunder will be paid solely from the general assets of the Employer. The Benefits provided by the Plan are given in exchange for the Participant's salary reduction agreement. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or the person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

10.5 Non-assignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his creditors by any process whatsoever, and any attempt to cause such rights to be so subjected will not be recognized, except to such extent as may be required by law.

10.6 Non-alienation of Benefits. Benefits under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge garnishment, execution or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to Benefits payable hereunder, shall be void. The Employer and PEIA shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to Benefits hereunder.

10.7 Divestment of Benefits. Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to the benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.

10.8 Guarantee of Tax Consequences. Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under Article VI will be excludable from the Participant's gross income for Federal or State Income Tax purposes, or that any other Federal or State tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under Article VI is excludable from the Participant's gross income for Federal and state

income tax purposes, and to notify the Employer if the Participant has reason to believe any such payment is not so excludable.

10.9 Indemnification of Employer by Participants. If any Participant receives one or more payments or reimbursement under Article VI that are not for Dependent Care Expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal or State income tax or Social Security tax from such payment or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and State income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.10 Governing Law. The Plan will be construed, administered and enforced according to the laws of the State of West Virginia.

10.11 Execution of Documents. Each Employee, family member or beneficiary, does, by his acceptance of potential Benefits under this Plan agree to execute any documents, which may be necessary or proper in the carrying out of the purpose and intent of the Plan.

10.12 Election Not to Participate. Each eligible Participant shall have the right to elect not to participate in this Plan.

10.13 Not a Contract of Employment. This Plan shall not be deemed to constitute a contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant. Nothing contained in this Program shall be deemed to give any Participant the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant at any time regardless of the effect which such discharge shall have upon him or her as a Participant of the Plan.

10.14 Severability. If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

10.15 Construction of the Plan. PEIA and/or the Administrator may construe any ambiguous provisions of the Plan, correct any defect, supply any omission, or reconcile any inconsistency, in such manner and to such extent as PEIA in its discretion may determine, any such action of PEIA shall be binding and conclusive upon all Participants.

APPENDIX A

LISTING OF CURRENT TPAs

Third-Party Administrator for Medical Claims Processing and Customer Service

Acordia National
P. O. Box 2451
Charleston, WV 25329-2451
1-888-440-7342
1-304-353-7820

Third-Party Administrator for Medical Utilization Review

Intracorp
Appeals Department
523 Plymouth Road
Plymouth Meeting, PA 19462
1-888-440-7342

Third-Party Administrator for Prescription Drug Plan

Express Scripts
6625 West 78th Street
Bloomington, Minnesota 55439
1-877-256-4680

Administrator for Mountaineer Flexible Benefits

Fringe Benefits Management Company
P.O. Box 1878
Tallahassee, FL 32302
1-800-342-8017

Administrator for PEIA Basic and Optional Life Insurance and AD&D

Unum/Provident Life Insurance
2 Lakeside Commons, Suite 500
980 Hammond Drive
Atlanta, GA 30328
1-800-717-0590

Administrator for Nurse Line - WVU PEIA Nurseline

1-877-294-7342

Third-Party for Subrogation of Claims

Beacon Recovery
Beacon Recovery Group
205 Portland Street
Boston, MA 02114-1721
(617) 570-8000
Toll-free 1-800-874-0500

APPENDIX B

PREMIUMS (PPB, MANAGED CARE AND LIFE)

Premium Rate Tables for July 1, 2002
Attached

APPENDIX I

HIPAA – Privacy Amendment, Information From Health Plans To Plan Sponsor

Privacy Practices Amendments to All Health Plans

1. The group health plans will not disclose protected health information to PEIA, in its capacity as the plan sponsor, unless the required provisions set forth in PEIA's policies and procedures for use and disclosure of protected health information are met.

2. Uses and disclosures of protected health information will be made to plan sponsor employees and the workforce of PEIA in order to administer and achieve the purposes of the group health plans as set out in this Plan Document and West Virginia Code §§5-16-1 et seq. all to be done consistent with: PEIA's policies and procedures for use of protected health information; PEIA's Notice of Privacy Practices and Procedures (Appendix J), and applicable law.

3. The plan sponsor will not *use* or further disclose PHI received from the group health plans other than as permitted or required by the plan documents or as required by law.

4. The plan sponsor will ensure that any agents, including any subcontractor, to whom it provides protected health information received from the group health plans, agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information.

5. The plan sponsor will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

6. The plan sponsor will report to the group health plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the plan documents of which it becomes aware.

7. The plan sponsor will permit individuals to have access to any PHI which it has received from the group health plan, in accordance with PEIA's RIGHT OF ACCESS TO PROTECTED HEALTH INFORMATION policy.

8. The plan sponsor will make available protected health information for amendment and incorporate any amendments to protected health information in accordance with PEIA's INDIVIDUAL REQUESTS TO AMEND HEALTH INFORMATION policy.

9. The plan sponsor will make available the information required to provide an accounting of disclosures in accordance with PEIA's ACCOUNTING OF DISCLOSURES OF HEALTH INFORMATION policy.

10. The plan sponsor will make its internal practices, books, and records relating to the use and disclosure of protected health information received from the group health plans available to the Secretary, Department of Health and Human Services, for purposes of determining compliance by the group health plan with federal privacy regulations regarding PHI (specifically, 45 CFR Parts 160 and 164).

11. The plan sponsor will, if feasible, return or destroy all protected health information received from the group health plans that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

12. In order to provide adequate separation between the plan sponsor and the group health plans, only the following employees or classes of employees or other persons under the control of the plan sponsor will be given access to the protected health information to be disclosed. This will include any employee or person who receives protected health information relating to payment, *health care operations*, or other matters pertaining to the group health plans in the ordinary course of business. The following categories of employees and other members of the workforce will be given access to protected health information.

    12.1. Those who are assigned to the administration of the group health plans. This includes claim processing, maintenance of enrollment, payroll and premium, and eligibility records, analysis of payment and utilization data, and other matters pertaining to the ordinary course of business of the group health plan; and,

    12.2. Others who are authorized to have access to PHI on behalf of PEIA in its role as the plan sponsor, for purposes permitted by the Plan Document, including, but not limited to, benefit coordinators, payroll clerks, and personnel officers.

13. The plan sponsor will restrict the access to and use of PHI received from the group health plan by members of its workforce (as listed in item 12, above) to the plan administration functions that the plan sponsor performs for the group health plan.

14. Employees and others in the workforce will be subject to discipline, including suspension or termination, in the event any member of the workforce who is

authorized to have access to the group health plan's PHI violates any of the provisions of the Plan Documents as set forth in this policy.

REFERENCE: 45 CFR 164.504(f)

APPENDIX J

NOTICE OF PRIVACY PRACTICES

West Virginia Public Employees Insurance Agency (PEIA)
Capitol Complex, Building 5, Room 1001, 1900 Kanawha Boulevard, East Charleston, WV 25305-0710 •(304)558-7850

Effective date of this notice: April 14, 2003. If you have questions about this notice, please contact the person listed under Whom to Contact" at the end of this notice.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary

In order to provide you with benefits, PEIA will receive personal information about your health, from you, your physicians, hospitals, and others who provide you with health care services. We are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

Occasionally, we may use members' information when providing treatment. We use members' health information to provide benefits, including making claims payments and providing customer service. We disclose members' information to health care providers to assist them to provide you with treatment or to help them receive payment, we may disclose information to other insurance companies as necessary to receive payment, we may use the information within our organization to evaluate quality and improve health care operations, and we may make other uses and disclosures of members' information as required by law or as permitted by PEIA policies.

Kinds Of Information That This Notice Applies To

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you.

Who Must Abide by This Notice

- PEIA

- All employees, staff, students, volunteers and other personnel whose work is under the direct control of PEIA.

The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

Our Legal Duties

- We are required by law to maintain the privacy of your health information
- We are required to provide this notice of our privacy practices and legal duties regarding health information to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.

How We May Use or Disclose Your Health Information.

We may use your health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. Treatment. We may use your health information to provide you with medical care and services. This means that our employees, staff, students, volunteers and others whose work is under our direct control, may read your health information to learn about your medical condition and use it to help you make decisions about your care. For instance, a health plan nurse may take your blood pressure at a health fair. We will also disclose your information to others to provide you with options for medical treatment or services. For instance, we may use health information to identify members with certain chronic illnesses, and send information to them or to their doctors regarding treatment alternatives.

2. Payment. We will use your health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our customer service department or at our claims processing administrator may use your health information to help pay your claims. And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the subscriber and each dependent who are enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information confidentially: see the "Confidential Communication" section in this notice. We may also disclose some of your health

information to companies with whom we contract for payment-related services. For instance, if you owe us money, we may give information about you to a collection company that we contract with to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.

3. Health Care Operations. We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may also provide health information to students who are authorized to receive training here. We may disclose your health information as necessary to others who we contract with to provide administrative services or health care coverage. This includes our third-party administrators, available managed care plans, lawyers, auditors, accreditation services, and consultants, for instance.

4. Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the state health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by state auditors. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.

5. Public Health Activities. We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.

6. To Report Abuse. We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

7. Law Enforcement. We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations.

8. Specialized Purposes. We may disclose the health information of members of the armed forces as authorized by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, and protection of the president. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate

with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution.

9. To Avert a Serious Threat. We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

10. Family and Friends. We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.

11. Research. We may disclose your health information in connection with medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.

12. Information to Members. We may use your health information to provide you with additional information. This may include sending newsletters or other information to your address. This may also include giving you information about treatment options, alternative settings for care, or other health-related options that we cover.

13. Health Benefits Information. If your enrollment in PEIA's health plan is sponsored by your employer, your health information may be disclosed to your employer, as necessary for the administration of your employer's health benefit program for employees. Employers may receive this information only for purposes of administering their employee group health plans, and must have special rules to prevent the misuse of your information for other purposes.

Your Rights

1. Authorization. We may use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. If you authorize us to use or disclose your health information, in additional circumstances you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the person listed under "Whom to Contact" at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

2. Request Restrictions. You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

3. Confidential Communication. If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your health information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will agree to any reasonable request.

4. Inspect And Receive a Copy of Health Information. You have a right to inspect the health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under "Whom to Contact" at the end of this notice. We will respond to your request within 30 days. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

5. Amend Health Information. You have the right to ask us to amend health information about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

6. Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. We cannot include disclosures made before April 14, 2003. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures for national security purposes; disclosures to correctional or law

enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.

7. Paper Copy of this Privacy Notice. You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Whom to Contact" at the end of this notice.

8. Complaints. You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the:

Region III, Office for Civil Rights
U.S. Department of Health and Human Services
150 South Independence Mall West
Suite 372, Public Ledger Building
Philadelphia, PA 19106-9111.

All complaints must be in writing.

We will not take any retaliation against you if you file a complaint.

Our Right to Change This Notice

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all subscribers within 60 days of the effective date.

Whom to Contact

Contact the person listed below:

- For more information about this notice, or
- For more information about our privacy policies, or
- If you want to exercise any of your rights, as listed on this notice, or
- If you want to request a copy of our current notice of privacy practices.

Privacy Officer
West Virginia Public Employees Insurance Agency
Building 5, Room 1001,
1900 Kanawha Blvd. E.

Charleston, WV 25305-0710
304-558-7850 or 1-888-680-7342

Copies of this notice are also available at the reception desk of the PEIA office at the address above. This notice is also available by e-mail. Send an e-mail to: peia@peia.state.wv.us.

Bob Wise
Governor

Tom Susman
Director

WV Toll-free: 1-888-680-PEIA • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: www.peia.state.wv.us

MEMORANDUM

To: Insurance Coordinators

From: Tom Susman, Director

Date: April 17, 2002

RE: Premium Rate Tables Effective For Plan Year 2003

The enclosed premium rate tables should be incorporated into your PEIA Rate Table Manual. New pages with new page numbers and an effective date of July 1, 2002, are to be added to your current manual.

Please note that both managed care plans offer two options this year: Carelink Enhanced Plan and Basic Plan, and The Health Plan Option A and Option B, as well as the PEIA PPB plan. Also note that the PEIA PPB Plan employee contribution is now based on a nine (9) salary tier level instead of twenty-six (26). Additionally, the tobacco free discount has doubled from last year to $10.00 for a single policyholder and $20.00 for family policyholders.

For State agencies, colleges and universities, and county boards of education, the employee premiums will be based on the total annual salary as of June 30, 2002. For Non-State agencies, the employer will be billed the total premium and the employee share shall be such percentage as the employer deems proper under its own particular circumstances.

If you have any questions regarding the above, please contact your PEIA Premium Accounts Representative at (304) 558-7850 or toll free at (888) 680-7342.

TS:JE
Enclosure

WEST VIRGINIA
PUBLIC EMPLOYEES INSURANCE AGENCY

PPB PLAN OPTION CODES

(EFFECTIVE JULY 1, 2002)

Option Codes	*Salary Tiers*	*Annual Deductible*		*Annual Out-of-Pocket Maximum*
		Single Coverage	All Other Coverage	
001	$ 0 - $ 20,000	$ 100.00	$ 200.00	$ 800.00
002	$ 20,001 - $ 30,000	$ 150.00	$ 300.00	$1,100.00
003	$ 30,001 - $ 36,000	$ 200.00	$ 400.00	$1,250.00
004	$ 36,001 - $ 42,000	$ 225.00	$ 450.00	$1,500.00
005	$ 42,001 - $ 50,000	$ 250.00	$ 500.00	$1,750.00
006	$ 50,001 - $ 75,000	$ 375.00	$ 750.00	$1,800.00
007	$ 75,001 - $100,000	$ 425.00	$ 850.00	$1,900.00
008	$100,001 - $125,000	$ 500.00	$1,000.00	$2,000.00
009	$125,001 +	$ 600.00	$1,200.00	$2,250.00
010 (Non-State Plan B) (COBRA Plan B)		$ 500.00	$1,000.00	$2,000.00 (single coverage) $4,000.00 (all other coverage)
011 (Non-Medicare Retiree)		$ 375.00	$ 750.00	$1,500.00
012 (Medicare Retiree)		$ 150.00	$ 300.00	$1,000.00

NOTE: Option Codes 100, 200, 300 and 400 are no longer active codes.

PPB AND MANAGED CARE COVERAGE CODES

Coverage Codes	Description
HI01	PPB Plan – Option A
HI02*	PPB Plan – Option B
HMCL-1*	Carelink – Enhanced Plan (Managed Care HMO)
HMCL-2*	Carelink – Basic Plan (Managed Care HMO)
HMHP-A	The Health Plan – Option A (Managed Care HMO)
HMHP-B	The Health Plan – Option B (Managed Care HMO)

NOTE: Coverage Codes followed by "*" represent new codes effective July 1, 2002. Coverage Codes HMCL-A and HMCL-B are no longer active codes.

NOTE

FOR AGENCY CODING OF INSUREDS WHO RESIDE OUT-OF-STATE AND NOT IN A MANAGED CARE SERVICE AREA, THE DEFAULT CODE IS REGION 2.

REGION 1

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
(Includes Prescription Drug Coverage)

The Carelink Enhanced health plan option codes are as follows:

Health Coverage Code	HMCL-1

Option	(see table below)

First find the policyholder's annual salary range in column (a) and record the corresponding health option code from column (b). Within the policyholder's annual salary range find the appropriate tier, i.e., family composition, in column (c) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (d), (e) and (f), respectively.

Table for Region 1 Policyholders

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) Policyholder Portion	(f) Monthly Premium
0-20,000	001	1. Policyholder	268.00	28.00	296.00
		2. Policyholder and Child(ren)	335.00	92.00	427.00
		3. Family	544.00	128.00	672.00
		4. Family with Employee Spouse	544.00	107.00	651.00
20,001-30,000	002	1. Policyholder	268.00	40.00	308.00
		2. Policyholder and Child(ren)	335.00	110.00	445.00
		3. Family	544.00	163.00	707.00
		4. Family with Employee Spouse	544.00	133.00	677.00
30,001-36,000	003	1. Policyholder	268.00	44.00	312.00
		2. Policyholder and Child(ren)	335.00	114.00	449.00
		3. Family	544.00	172.00	716.00
		4. Family with Employee Spouse	544.00	140.00	684.00
36,001-42,000	004	1. Policyholder	268.00	47.00	315.00
		2. Policyholder and Child(ren)	335.00	123.00	458.00
		3. Family	544.00	190.00	734.00
		4. Family with Employee Spouse	544.00	150.00	694.00
42,001-50,000	005	1. Policyholder	268.00	59.00	327.00
		2. Policyholder and Child(ren)	335.00	149.00	484.00
		3. Family	544.00	225.00	769.00
		4. Family with Employee Spouse	544.00	178.00	722.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.139A
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
Table for Region 1 Policyholders
(continued)

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) Policyholder Portion	(f) Monthly Premium
50,001-75,000	006	1. Policyholder	268.00	77.00	345.00
		2. Policyholder and Child(ren)	335.00	187.00	522.00
		3. Family	544.00	290.00	834.00
		4. Family with Employee Spouse	544.00	240.00	784.00
75,001-100,000	007	1. Policyholder	268.00	102.00	370.00
		2. Policyholder and Child(ren)	335.00	239.00	574.00
		3. Family	544.00	362.00	906.00
		4. Family with Employee Spouse	544.00	312.00	856.00
100,001-125,000	008	1. Policyholder	268.00	132.00	400.00
		2. Policyholder and Child(ren)	335.00	290.00	625.00
		3. Family	544.00	453.00	997.00
		4. Family with Employee Spouse	544.00	403.00	947.00
125,001 and up	009	1. Policyholder	268.00	151.00	419.00
		2. Policyholder and Child(ren)	335.00	335.00	670.00
		3. Family	544.00	522.00	1,066.00
		4. Family with Employee Spouse	544.00	472.00	1,016.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.139B
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 1

CARELINK MANAGED CARE PLANS
BASIC PLAN
(Includes Generic Prescription Drug Coverage Only)

The Carelink Basic health plan option codes are as follows:

Health Coverage Code	HMCL-2	Option	(see table below)

First find the policyholder's annual salary range in column (a) and record the corresponding health option code from column (b). Within the policyholder's annual salary range find the appropriate tier, i.e., family composition, in column (c) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (d), (e) and (f), respectively.

Table for Region 1 Policyholders

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) Policyholder Portion	(f) Monthly Premium
0-20,000	001	1. Policyholder	268.00	.00	268.00
		2. Policyholder and Child(ren)	335.00	39.00	374.00
		3. Family	544.00	39.00	583.00
		4. Family with Employee Spouse	544.00	18.00	562.00
20,001-30,000	002	1. Policyholder	268.00	4.00	272.00
		2. Policyholder and Child(ren)	335.00	57.00	392.00
		3. Family	544.00	74.00	618.00
		4. Family with Employee Spouse	544.00	44.00	588.00
30,001-36,000	003	1. Policyholder	268.00	8.00	276.00
		2. Policyholder and Child(ren)	335.00	61.00	396.00
		3. Family	544.00	83.00	627.00
		4. Family with Employee Spouse	544.00	51.00	595.00
36,001-42,000	004	1. Policyholder	268.00	11.00	279.00
		2. Policyholder and Child(ren)	335.00	70.00	405.00
		3. Family	544.00	101.00	645.00
		4. Family with Employee Spouse	544.00	61.00	605.00
42,001-50,000	005	1. Policyholder	268.00	23.00	291.00
		2. Policyholder and Child(ren)	335.00	96.00	431.00
		3. Family	544.00	136.00	680.00
		4. Family with Employee Spouse	544.00	89.00	633.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.139C
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

CARELINK MANAGED CARE PLANS
BASIC PLAN
Table for Region 1 Policyholders
(continued)

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) Policyholder Portion	(f) Monthly Premium
50,001-75,000	006	1. Policyholder	268.00	41.00	309.00
		2. Policyholder and Child(ren)	335.00	134.00	469.00
		3. Family	544.00	201.00	745.00
		4. Family with Employee Spouse	544.00	151.00	695.00
75,001-100,000	007	1. Policyholder	268.00	66.00	334.00
		2. Policyholder and Child(ren)	335.00	186.00	521.00
		3. Family	544.00	273.00	817.00
		4. Family with Employee Spouse	544.00	223.00	767.00
100,001-125,000	008	1. Policyholder	268.00	96.00	364.00
		2. Policyholder and Child(ren)	335.00	237.00	572.00
		3. Family	544.00	364.00	908.00
		4. Family with Employee Spouse	544.00	314.00	858.00
125,001 and up	009	1. Policyholder	268.00	115.00	383.00
		2. Policyholder and Child(ren)	335.00	282.00	617.00
		3. Family	544.00	433.00	977.00
		4. Family with Employee Spouse	544.00	383.00	927.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.139D
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 2

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
(Includes Prescription Drug Coverage)

The Carelink Enhanced health plan option codes are as follows:

Health Coverage Code	HMCL-1	Option	(see table below)

First find the policyholder's annual salary range in column (a) and record the corresponding health option code from column (b). Within the policyholder's annual salary range find the appropriate tier, i.e., family composition, in column (c) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (d), (e) and (f), respectively.

Table for Region 2 Policyholders

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) Policyholder Portion	(f) Monthly Premium
0-20,000	001	1. Policyholder	268.00	31.00	299.00
		2. Policyholder and Child(ren)	335.00	100.00	435.00
		3. Family	544.00	140.00	684.00
		4. Family with Employee Spouse	544.00	119.00	663.00
20,001-30,000	002	1. Policyholder	268.00	43.00	311.00
		2. Policyholder and Child(ren)	335.00	118.00	453.00
		3. Family	544.00	175.00	719.00
		4. Family with Employee Spouse	544.00	145.00	689.00
30,001-36,000	003	1. Policyholder	268.00	47.00	315.00
		2. Policyholder and Child(ren)	335.00	122.00	457.00
		3. Family	544.00	184.00	728.00
		4. Family with Employee Spouse	544.00	152.00	696.00
36,001-42,000	004	1. Policyholder	268.00	50.00	318.00
		2. Policyholder and Child(ren)	335.00	131.00	466.00
		3. Family	544.00	202.00	746.00
		4. Family with Employee Spouse	544.00	162.00	706.00
42,001-50,000	005	1. Policyholder	268.00	62.00	330.00
		2. Policyholder and Child(ren)	335.00	157.00	492.00
		3. Family	544.00	237.00	781.00
		4. Family with Employee Spouse	544.00	190.00	734.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.139E
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
Table for Region 2 Policyholders
(continued)

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) Policyholder Portion	(f) Monthly Premium
50,001-75,000	006	1. Policyholder	268.00	80.00	348.00
		2. Policyholder and Child(ren)	335.00	195.00	530.00
		3. Family	544.00	302.00	846.00
		4. Family with Employee Spouse	544.00	252.00	796.00
75,001-100,000	007	1. Policyholder	268.00	105.00	373.00
		2. Policyholder and Child(ren)	335.00	247.00	582.00
		3. Family	544.00	374.00	918.00
		4. Family with Employee Spouse	544.00	324.00	868.00
100,001-125,000	008	1. Policyholder	268.00	135.00	403.00
		2. Policyholder and Child(ren)	335.00	298.00	633.00
		3. Family	544.00	465.00	1,009.00
		4. Family with Employee Spouse	544.00	415.00	959.00
125,001 and up	009	1. Policyholder	268.00	154.00	422.00
		2. Policyholder and Child(ren)	335.00	343.00	678.00
		3. Family	544.00	534.00	1,078.00
		4. Family with Employee Spouse	544.00	484.00	1,028.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.139F
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 2

CARELINK MANAGED CARE PLANS
BASIC PLAN
(Includes Generic Prescription Drug Coverage Only)

The Carelink Basic health plan option codes are as follows:

Health Coverage Code	HMCL-2	Option	(see table below)

First find the policyholder's annual salary range in column (a) and record the corresponding health option code from column (b). Within the policyholder's annual salary range find the appropriate tier, i.e., family composition, in column (c) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (d), (e) and (f), respectively.

Table for Region 2 Policyholders

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) Policyholder Portion	(f) Monthly Premium
0-20,000	001	1. Policyholder	268.00	.00	268.00
		2. Policyholder and Child(ren)	335.00	47.00	382.00
		3. Family	544.00	51.00	595.00
		4. Family with Employee Spouse	544.00	30.00	574.00
20,001-30,000	002	1. Policyholder	268.00	8.00	276.00
		2. Policyholder and Child(ren)	335.00	65.00	400.00
		3. Family	544.00	86.00	630.00
		4. Family with Employee Spouse	544.00	56.00	600.00
30,001-36,000	003	1. Policyholder	268.00	12.00	280.00
		2. Policyholder and Child(ren)	335.00	69.00	404.00
		3. Family	544.00	95.00	639.00
		4. Family with Employee Spouse	544.00	63.00	607.00
36,001-42,000	004	1. Policyholder	268.00	15.00	283.00
		2. Policyholder and Child(ren)	335.00	78.00	413.00
		3. Family	544.00	113.00	657.00
		4. Family with Employee Spouse	544.00	73.00	617.00
42,001-50,000	005	1. Policyholder	268.00	27.00	295.00
		2. Policyholder and Child(ren)	335.00	104.00	439.00
		3. Family	544.00	148.00	692.00
		4. Family with Employee Spouse	544.00	101.00	645.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.139G
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

CARELINK MANAGED CARE PLANS
BASIC PLAN
Table for Region 2 Policyholders
(continued)

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) Policyholder Portion	(f) Monthly Premium
50,001-75,000	006	1. Policyholder	268.00	45.00	313.00
		2. Policyholder and Child(ren)	335.00	142.00	477.00
		3. Family	544.00	213.00	757.00
		4. Family with Employee Spouse	544.00	163.00	707.00
75,001-100,000	007	1. Policyholder	268.00	70.00	338.00
		2. Policyholder and Child(ren)	335.00	194.00	529.00
		3. Family	544.00	285.00	829.00
		4. Family with Employee Spouse	544.00	235.00	779.00
100,001-125,000	008	1. Policyholder	268.00	100.00	368.00
		2. Policyholder and Child(ren)	335.00	245.00	580.00
		3. Family	544.00	376.00	920.00
		4. Family with Employee Spouse	544.00	326.00	870.00
125,001 and up	009	1. Policyholder	268.00	119.00	387.00
		2. Policyholder and Child(ren)	335.00	290.00	625.00
		3. Family	544.00	445.00	989.00
		4. Family with Employee Spouse	544.00	395.00	939.00

REGION 1

THE HEALTH PLAN MANAGED CARE PLANS
OPTION A
(Includes Prescription Drug Coverage)

The Health Plan Option A health plan option codes are as follows:

Health Coverage Code	HMHP-A	Option	(see table below)

First find the policyholder's annual salary range in column (a) and record the corresponding health option code from column (b). Within the policyholder's annual salary range find the appropriate tier, i.e., family composition, in column (c) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (d), (e) and (f), respectively.

Table for Region 1 Policyholders

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) Policyholder Portion	(f) Monthly Premium
0-20,000	001	1. Policyholder	268.00	26.00	294.00
		2. Policyholder and Child(ren)	335.00	70.00	405.00
		3. Family	544.00	98.00	642.00
		4. Family with Employee Spouse	544.00	77.00	621.00
20,001-30,000	002	1. Policyholder	268.00	38.00	306.00
		2. Policyholder and Child(ren)	335.00	88.00	423.00
		3. Family	544.00	133.00	677.00
		4. Family with Employee Spouse	544.00	103.00	647.00
30,001-36,000	003	1. Policyholder	268.00	42.00	310.00
		2. Policyholder and Child(ren)	335.00	92.00	427.00
		3. Family	544.00	142.00	686.00
		4. Family with Employee Spouse	544.00	110.00	654.00
36,001-42,000	004	1. Policyholder	268.00	45.00	313.00
		2. Policyholder and Child(ren)	335.00	101.00	436.00
		3. Family	544.00	160.00	704.00
		4. Family with Employee Spouse	544.00	120.00	664.00
42,001-50,000	005	1. Policyholder	268.00	57.00	325.00
		2. Policyholder and Child(ren)	335.00	127.00	462.00
		3. Family	544.00	195.00	739.00
		4. Family with Employee Spouse	544.00	148.00	692.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.140A
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

THE HEALTH PLAN MANAGED CARE PLANS
OPTION A
Table for Region 1 Policyholders
(continued)

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) Policyholder Portion	(f) Monthly Premium
50,001-75,000	006	1. Policyholder	268.00	75.00	343.00
		2. Policyholder and Child(ren)	335.00	165.00	500.00
		3. Family	544.00	260.00	804.00
		4. Family with Employee Spouse	544.00	210.00	754.00
75,001-100,000	007	1. Policyholder	268.00	100.00	368.00
		2. Policyholder and Child(ren)	335.00	217.00	552.00
		3. Family	544.00	332.00	876.00
		4. Family with Employee Spouse	544.00	282.00	826.00
100,001-125,000	008	1. Policyholder	268.00	130.00	398.00
		2. Policyholder and Child(ren)	335.00	268.00	603.00
		3. Family	544.00	423.00	967.00
		4. Family with Employee Spouse	544.00	373.00	917.00
125,001 and up	009	1. Policyholder	268.00	149.00	417.00
		2. Policyholder and Child(ren)	335.00	313.00	648.00
		3. Family	544.00	492.00	1,036.00
		4. Family with Employee Spouse	544.00	442.00	986.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.140B
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 1

THE HEALTH PLAN MANAGED CARE PLANS
OPTION B
(Includes Generic Prescription Drug Coverage Only)

The Health Plan Option B health plan option codes are as follows:

Health Coverage Code	HMHP-B	Option	(see table below)

First find the policyholder's annual salary range in column (a) and record the corresponding health option code from column (b). Within the policyholder's annual salary range find the appropriate tier, i.e., family composition, in column (c) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (d), (e) and (f), respectively.

Table for Region 1 Policyholders

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) Policyholder Portion	(f) Monthly Premium
0-20,000	001	1. Policyholder	268.00	.00	268.00
		2. Policyholder and Child(ren)	335.00	18.00	353.00
		3. Family	544.00	40.00	584.00
		4. Family with Employee Spouse	544.00	19.00	563.00
20,001-30,000	002	1. Policyholder	268.00	2.00	270.00
		2. Policyholder and Child(ren)	335.00	36.00	371.00
		3. Family	544.00	75.00	619.00
		4. Family with Employee Spouse	544.00	45.00	589.00
30,001-36,000	003	1. Policyholder	268.00	6.00	274.00
		2. Policyholder and Child(ren)	335.00	40.00	375.00
		3. Family	544.00	84.00	628.00
		4. Family with Employee Spouse	544.00	52.00	596.00
36,001-42,000	004	1. Policyholder	268.00	9.00	277.00
		2. Policyholder and Child(ren)	335.00	49.00	384.00
		3. Family	544.00	102.00	646.00
		4. Family with Employee Spouse	544.00	62.00	606.00
42,001-50,000	005	1. Policyholder	268.00	21.00	289.00
		2. Policyholder and Child(ren)	335.00	75.00	410.00
		3. Family	544.00	137.00	681.00
		4. Family with Employee Spouse	544.00	90.00	634.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.140C
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

THE HEALTH PLAN MANAGED CARE PLANS
OPTION B
Table for Region 1 Policyholders
(continued)

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) Policyholder Portion	(f) Monthly Premium
50,001-75,000	006	1. Policyholder	268.00	39.00	307.00
		2. Policyholder and Child(ren)	335.00	113.00	448.00
		3. Family	544.00	202.00	746.00
		4. Family with Employee Spouse	544.00	152.00	696.00
75,001-100,000	007	1. Policyholder	268.00	64.00	332.00
		2. Policyholder and Child(ren)	335.00	165.00	500.00
		3. Family	544.00	274.00	818.00
		4. Family with Employee Spouse	544.00	224.00	768.00
100,001-125,000	008	1. Policyholder	268.00	94.00	362.00
		2. Policyholder and Child(ren)	335.00	216.00	551.00
		3. Family	544.00	365.00	909.00
		4. Family with Employee Spouse	544.00	315.00	859.00
125,001 and up	009	1. Policyholder	268.00	113.00	381.00
		2. Policyholder and Child(ren)	335.00	261.00	596.00
		3. Family	544.00	434.00	978.00
		4. Family with Employee Spouse	544.00	384.00	928.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.141
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Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGIONS 1 AND 2

PEIA PPB PLAN
(Includes PEIA Prescription Drug Coverage)

The PEIA PPB health plan and prescription drug coverage and option codes are as follows:

Health Coverage Code	HI01

Option	(see table below)

Prescription Drug Coverage Code	PI01

Option	(none)

First find the appropriate table (Standard Tobacco User or Preferred Tobacco Free), then find the policyholder's annual salary range in column (a) and record the corresponding health option code from column (b). Within the policyholder's annual salary range find the appropriate tier, i.e., family composition, in column (c) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (d), (e) and (f), respectively.

* * *STANDARD (TOBACCO USER) PREMIUM TABLE* * *

Table for both <u>Region 1 and Region 2</u> Policyholders

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) *Standard (Tobacco User)* Policyholder Portion	(f) Total Monthly Premium
0-20,000	001	1. Policyholder	268.00	23.00	291.00
		2. Policyholder and Child(ren)	335.00	52.00	387.00
		3. Family	544.00	79.00	623.00
		4. Family with Employee Spouse	544.00	58.00	602.00
20,001-30,000	002	1. Policyholder	268.00	35.00	303.00
		2. Policyholder and Child(ren)	335.00	70.00	405.00
		3. Family	544.00	114.00	658.00
		4. Family with Employee Spouse	544.00	84.00	628.00
30,001-36,000	003	1. Policyholder	268.00	39.00	307.00
		2. Policyholder and Child(ren)	335.00	74.00	409.00
		3. Family	544.00	123.00	667.00
		4. Family with Employee Spouse	544.00	91.00	635.00
36,001-42,000	004	1. Policyholder	268.00	42.00	310.00
		2. Policyholder and Child(ren)	335.00	83.00	418.00
		3. Family	544.00	141.00	685.00
		4. Family with Employee Spouse	544.00	101.00	645.00
42,001-50,000	005	1. Policyholder	268.00	54.00	322.00
		2. Policyholder and Child(ren)	335.00	109.00	444.00
		3. Family	544.00	176.00	720.00
		4. Family with Employee Spouse	544.00	129.00	673.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.142
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Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

PEIA PPB PLAN

Table for both Region 1 and Region 2 Policyholders
(continued)

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) *Standard (Tobacco User)* Policyholder Portion	(f) Total Monthly Premium
50,001-75,000	006	1. Policyholder	268.00	72.00	340.00
		2. Policyholder and Child(ren)	335.00	147.00	482.00
		3. Family	544.00	241.00	785.00
		4. Family with Employee Spouse	544.00	191.00	735.00
75,001-100,000	007	1. Policyholder	268.00	97.00	365.00
		2. Policyholder and Child(ren)	335.00	199.00	534.00
		3. Family	544.00	313.00	857.00
		4. Family with Employee Spouse	544.00	263.00	807.00
100,001-125,000	008	1. Policyholder	268.00	127.00	395.00
		2. Policyholder and Child(ren)	335.00	250.00	585.00
		3. Family	544.00	404.00	948.00
		4. Family with Employee Spouse	544.00	354.00	898.00
125,001 and up	009	1. Policyholder	268.00	146.00	414.00
		2. Policyholder and Child(ren)	335.00	295.00	630.00
		3. Family	544.00	473.00	1,017.00
		4. Family with Employee Spouse	544.00	423.00	967.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.143
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Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGIONS 1 AND 2

PEIA PPB PLAN
(Includes PEIA Prescription Drug Coverage)

** * PREFERRED (TOBACCO FREE) PREMIUM TABLE * **

Table for both Region 1 and Region 2 Policyholders

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) *Preferred (Tobacco Free)* Policyholder Portion	(f) Total Monthly Premium
0-20,000	001	1. Policyholder	268.00	13.00	281.00
		2. Policyholder and Child(ren)	335.00	32.00	367.00
		3. Family	544.00	59.00	603.00
		4. Family with Employee Spouse	544.00	38.00	582.00
20,001-30,000	002	1. Policyholder	268.00	25.00	293.00
		2. Policyholder and Child(ren)	335.00	50.00	385.00
		3. Family	544.00	94.00	638.00
		4. Family with Employee Spouse	544.00	64.00	608.00
30,001-36,000	003	1. Policyholder	268.00	29.00	297.00
		2. Policyholder and Child(ren)	335.00	54.00	389.00
		3. Family	544.00	103.00	647.00
		4. Family with Employee Spouse	544.00	71.00	615.00
36,001-42,000	004	1. Policyholder	268.00	32.00	300.00
		2. Policyholder and Child(ren)	335.00	63.00	398.00
		3. Family	544.00	121.00	665.00
		4. Family with Employee Spouse	544.00	81.00	625.00
42,001-50,000	005	1. Policyholder	268.00	44.00	312.00
		2. Policyholder and Child(ren)	335.00	89.00	424.00
		3. Family	544.00	156.00	700.00
		4. Family with Employee Spouse	544.00	109.00	653.00
50,001-75,000	006	1. Policyholder	268.00	62.00	330.00
		2. Policyholder and Child(ren)	335.00	127.00	462.00
		3. Family	544.00	221.00	765.00
		4. Family with Employee Spouse	544.00	171.00	715.00
75,001-100,000	007	1. Policyholder	268.00	87.00	355.00
		2. Policyholder and Child(ren)	335.00	179.00	514.00
		3. Family	544.00	293.00	837.00
		4. Family with Employee Spouse	544.00	243.00	787.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.A.1.144
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

PEIA PPB PLAN

Table for both Region 1 and Region 2 Policyholders
(continued)

(a) Salary Range	(b) Option	(c) Tier	(d) Employer Portion	(e) *Preferred (Tobacco Free)* Policyholder Portion	(f) Total Monthly Premium
100,001-125,000	008	1. Policyholder	268.00	117.00	385.00
		2. Policyholder and Child(ren)	335.00	230.00	565.00
		3. Family	544.00	384.00	982.00
		4. Family with Employee Spouse	544.00	334.00	878.00
125,001 and up	009	1. Policyholder	268.00	136.00	404.00
		2. Policyholder and Child(ren)	335.00	275.00	610.00
		3. Family	544.00	453.00	997.00
		4. Family with Employee Spouse	544.00	403.00	947.00

REGION 1

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
(Includes Prescription Drug Coverage)

The Carelink Enhanced health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMCL-1

Option	(none)

Note that there is no premium difference based on policyholder's region. Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for Region 1 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium
NO	1. Policyholder	.00	321.00	321.00
	2. Policyholder and Child(ren)	.00	467.00	467.00
	3. Family	.00	749.00	749.00
YES	1. Policyholder	.00	473.00	473.00
	2. Policyholder and Child(ren)	.00	687.00	687.00
	3. Family	.00	1,101.00	1,101.00

REGION 1

CARELINK MANAGED CARE PLANS
BASIC PLAN
(Includes Generic Prescription Drug Coverage Only)

The Carelink Basic health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMCL-2

Option	(none)

Note that there is no premium difference based on policyholder's region. Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for Region 1 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium
NO	1. Policyholder	.00	285.00	285.00
	2. Policyholder and Child(ren)	.00	413.00	413.00
	3. Family	.00	658.00	658.00
YES	1. Policyholder	.00	419.00	419.00
	2. Policyholder and Child(ren)	.00	608.00	608.00
	3. Family	.00	968.00	968.00

REGION 2

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
(Includes Prescription Drug Coverage)

The Carelink Enhanced health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMCL-1

Option	(none)

Note that there is no premium difference based on policyholder's region. Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for Region 2 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium
NO	1. Policyholder	.00	324.00	324.00
	2. Policyholder and Child(ren)	.00	475.00	475.00
	3. Family	.00	761.00	761.00
YES	1. Policyholder	.00	477.00	477.00
	2. Policyholder and Child(ren)	.00	699.00	699.00
	3. Family	.00	1,119.00	1,119.00

REGION 2

CARELINK MANAGED CARE PLANS
BASIC PLAN
(Includes Generic Prescription Drug Coverage Only)

The Carelink Basic health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMCL-2	Option	(none)

Note that there is no premium difference based on policyholder's region. Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for Region 2 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium
NO	1. Policyholder	.00	289.00	289.00
	2. Policyholder and Child(ren)	.00	421.00	421.00
	3. Family	.00	670.00	670.00
YES	1. Policyholder	.00	425.00	425.00
	2. Policyholder and Child(ren)	.00	620.00	620.00
	3. Family	.00	986.00	986.00

REGION 1

THE HEALTH PLAN MANAGED CARE PLANS
OPTION A
(Includes Prescription Drug Coverage)

The Health Plan Option A health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMHP-A

Option	(None)

Note that there is no premium difference based on policyholder's region. Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for Region 1 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium
NO	1. Policyholder	.00	319.00	319.00
	2. Policyholder and Child(ren)	.00	445.00	445.00
	3. Family	.00	718.00	718.00
YES	1. Policyholder	.00	470.00	470.00
	2. Policyholder and Child(ren)	.00	654.00	654.00
	3. Family	.00	1,056.00	1,056.00

REGION 1

THE HEALTH PLAN MANAGED CARE PLANS
OPTION B
(Includes Generic Prescription Drug Coverage Only)

The Health Plan Option B health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMHP-B

Option	(None)

Note that there is no premium difference based on policyholder's region. Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for Region 1 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium
NO	1. Policyholder	.00	283.00	283.00
	2. Policyholder and Child(ren)	.00	392.00	392.00
	3. Family	.00	659.00	659.00
YES	1. Policyholder	.00	416.00	416.00
	2. Policyholder and Child(ren)	.00	576.00	576.00
	3. Family	.00	969.00	969.00

REGIONS 1 AND 2

PEIA PPB PLAN
(Includes PEIA Prescription Drug Coverage)

The PEIA PPB Indemnity health plan and prescription drug coverage and option codes are as follows:

Health Coverage Code	HI01

Option	004

Prescription Drug Coverage Code	PI01

Option	(none)

Note that there is no premium difference based on policyholder's region. Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion (Standard Tobacco User or Preferred Tobacco Free) and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for both Region 1 and Region 2 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) *Standard* Premium *(Tobacco User)*	(e) *Preferred* Premium *(Tobacco Free)*
NO	1. Policyholder	.00	316.00	306.00
	2. Policyholder and Child(ren)	.00	426.00	406.00
	3. Family	.00	698.00	678.00
YES	1. Policyholder	.00	460.00	450.00
	2. Policyholder and Child(ren)	.00	617.00	597.00
	3. Family	.00	1,018.00	998.00

REGION 2

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
(Includes Prescription Drug Coverage)

The Carelink Enhanced health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMCL-1

Option	(none)

Within the following table, first find the appropriate tier, i.e., the family composition, within column (b). Record the corresponding monthly premium amount from the correct column based upon years of credited service from among columns (d) through (i) with the appropriate tier row.

Table for Region 2 Policyholders

(a)	(b)	(c)	Policyholder Credited Service					
Policy-Holder Medicare	Tier	All Dependents Medicare	(d) 0-4 Years	(e) 5-9 Years	(f) 10-14 Years	(g) 15-19 Years	(h) 20-24 Years	(i) 25-99 Years
NO	Policyholder		315.00	295.00	275.00	255.00	235.00	225.00
	Policyholder & Dependents	NO	590.00	550.00	510.00	470.00	430.00	420.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.R.1.52A
		Page Date	2002.02.15

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 2

CARELINK MANAGED CARE PLANS
BASIC PLAN
(Includes Generic Prescription Drug Coverage Only)

The Carelink Basic health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMCL-2

Option	(none)

Within the following table, first find the appropriate tier, i.e., the family composition, within column (b). Record the corresponding monthly premium amount from the correct column based upon years of credited service from among columns (d) through (i) with the appropriate tier row.

Table for Region 2 Policyholders

(a)	(b)	(c)	Policyholder Credited Service					
Policy-Holder Medicare	Tier	All Dependents Medicare	(d) 0-4 Years	(e) 5-9 Years	(f) 10-14 Years	(g) 15-19 Years	(h) 20-24 Years	(i) 25-99 Years
NO	Policyholder	[redacted]	281.00	261.00	241.00	221.00	201.00	191.00
	Policyholder & Dependents	NO	480.00	445.00	410.00	375.00	340.00	330.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.R.1.53
		Page Date	2002.02.15

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 1

THE HEALTH PLAN MANAGED CARE PLANS
OPTION A
(Includes Prescription Drug Coverage)

The Health Plan Option A health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMHP-A

Option	(none)

Within the following table, first find the appropriate tier, i.e., the family composition, within column (b). Record the corresponding monthly premium amount from the correct column based upon years of credited service from among columns (d) through (i) with the appropriate tier row.

Table for Region 1 Policyholders

(a)	(b)	(c)	Policyholder Credited Service					
Policy-Holder Medicare	Tier	All Dependents Medicare	(d) 0-4 Years	(e) 5-9 Years	(f) 10-14 Years	(g) 15-19 Years	(h) 20-24 Years	(i) 25-99 Years
NO	Policyholder		343.00	323.00	303.00	283.00	263.00	253.00
	Policyholder & Dependents	NO	660.00	620.00	580.00	540.00	500.00	490.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	S.R.1.53A
		Page Date	2002.02.15

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 1

THE HEALTH PLAN MANAGED CARE PLANS
OPTION B
(Includes Generic Prescription Drug Coverage Only)

The Health Plan Option B health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMHP-B

Option	(none)

Within the following table, first find the appropriate tier, i.e., the family composition, within column (b). Record the corresponding monthly premium amount from the correct column based upon years of credited service from among columns (d) through (i) with the appropriate tier row.

Table for Region 1 Policyholders

(a)	(b)	(c)	Policyholder Credited Service					
Policy-Holder Medicare	Tier	All Dependents Medicare	(d) 0-4 Years	(e) 5-9 Years	(f) 10-14 Years	(g) 15-19 Years	(h) 20-24 Years	(i) 25-99 Years
NO	Policyholder		295.00	275.00	255.00	235.00	215.00	205.00
	Policyholder & Dependents	NO	539.00	504.00	469.00	434.00	399.00	389.00

REGIONS 1 AND 2

PEIA PPB PLAN
(Includes Prescription Drug Coverage)

The PEIA PPB health plan and prescription drug coverage and option codes are as follows:

Health Coverage Code	HI01

Options	011-012

Prescription Drug Coverage Code	PI01

Option	(none)

Note that *Option Code 012* is for Medicare-primary eligible retiree policyholders only. *Option Code 011* must be used for non-Medicare policyholders.

Below are three tables of premiums essentially stating PEIA PPB Plan premiums by the (retiree) policyholder's (latest) date of retirement. Table A is applicable only if the policyholder's date of retirement was prior to July 1, 1997. Tables B and C are applicable only if the policyholder's date of retirement was after June 30, 1997. Table A is also applicable for surviving dependent policyholders and for disability retiree policyholders, regardless of date of retirement.

First find the correct table below and follow the instructions for that table.

Table A -- For Survivors, Disability Retirees, and Retirees Whose Date of Retirement is Prior to 1997.07.01

Within the following table, first find within column (a) the correct Medicare-primary status of the policyholder. Within the applicable Medicare-primary status of the policyholder, find the appropriate tier, i.e., the family composition, within column (b). If the tier is simply policyholder, then record the corresponding monthly premium amount from column (d) or (e). If the tier is policyholder and dependent(s), find the applicable Medicare-primary status of the dependent(s) in column (c).

If not <u>all</u> dependents are Medicare primary, then use the "NO" option in column (c).

Table for both <u>Region 1 and Region 2</u> Policyholders

(a)	(b)	(c)	(d)	(e)
			Monthly Premiums	
Policyholder Medicare	**Tier**	**<u>ALL</u> Dependents Medicare**	***Standard (Tobacco User)***	***Preferred (Tobacco Free)***
NO	Policyholder		168.00	158.00
	Policyholder and Dependent(s)	NO	336.00	316.00
		YES	220.00	200.00
YES	Policyholder		62.00	52.00
	Policyholder and Dependent(s)	NO	230.00	210.00
		YES	108.00	88.00

PEIA PPB PLAN
(Continued)

Tables B and C -- For Retirees Whose Date of Retirement is After 1997.06.30

First find the appropriate table (Standard Tobacco User or Preferred Tobacco Free), then find within column (a) the correct Medicare-primary status of the policyholder. Within the applicable Medicare-primary status of the policyholder, find the appropriate tier, i.e., the family composition, within column (b). If the tier is simply policyholder, then record the corresponding monthly premium amount from the correct column, based on years of credited service, from among columns (d) through (i). If the tier is policyholder and dependent(s), find the applicable Medicare-Primary status of the dependent(s) in column (c) in order to be in the correct row before selecting the applicable premium from columns (d) through (i).

If not <u>all</u> dependents are Medicare primary, then use the "NO" option in column (c).

Tables for both <u>Region 1 and Region 2</u> Policyholders

**** * STANDARD (TOBACCO USER) PREMIUM TABLE * ****

(a)	(b)	(c)	Policyholder Credited Service					
Policy-Holder Medicare	Tier	<u>All</u> Dependents Medicare	(d) 0-4 Years	(e) 5-9 Years	(f) 10-14 Years	(g) 15-19 Years	(h) 20-24 Years	(i) 25-99 Years
NO	Policyholder		696.00	564.00	432.00	299.00	220.00	168.00
	Policyholder & Dependents	NO	1,678.00	1,343.00	1,007.00	672.00	470.00	336.00
		YES	1,196.00	951.00	707.00	464.00	318.00	220.00
YES	Policyholder		349.00	277.00	206.00	134.00	91.00	62.00
	Policyholder & Dependents	NO	1,133.00	908.00	682.00	456.00	320.00	230.00
		YES	728.00	573.00	418.00	263.00	169.00	108.00

**** * PREFERRED (TOBACCO FREE) PREMIUM TABLE * ****

(a)	(b)	(c)	Policyholder Credited Service					
Policy-Holder Medicare	Tier	<u>All</u> Dependents Medicare	(d) 0-4 Years	(e) 5-9 Years	(f) 10-14 Years	(g) 15-19 Years	(h) 20-24 Years	(i) 25-99 Years
NO	Policyholder		686.00	554.00	422.00	289.00	210.00	158.00
	Policyholder & Dependents	NO	1,658.00	1,323.00	987.00	652.00	450.00	316.00
		YES	1,176.00	931.00	687.00	444.00	298.00	200.00
YES	Policyholder		339.00	267.00	196.00	124.00	81.00	52.00
	Policyholder & Dependents	NO	1,113.00	888.00	662.00	436.00	300.00	210.00
		YES	708.00	553.00	398.00	243.00	149.00	88.00

Bob Wise
Governor

Tom Susman
Director

WV Toll-free: 1-888-680-PEIA • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: www.peia.state.wv.us

MEMORANDUM

To: Insurance Coordinators

From: Tom Susman, Director

Date: April 17, 2002

RE: Premium Rate Tables Effective For Plan Year 2003

The enclosed premium rate tables should be incorporated into your PEIA Rate Table Manual. New pages with new page numbers and an effective date of July 1, 2002, are to be added to your current manual.

Please note that both managed care plans offer two options this year: Carelink Enhanced Plan and Basic Plan, and The Health Plan Option A and Option B, as well as the PEIA PPB plan. Also note that the PEIA PPB Plan employee contribution is now based on a nine (9) salary tier level instead of twenty-six (26). Additionally, the tobacco free discount has doubled from last year to $10.00 for a single policyholder and $20.00 for family policyholders.

For State agencies, colleges and universities, and county boards of education, the employee premiums will be based on the total annual salary as of June 30, 2002. For Non-State agencies, the employer will be billed the total premium and the employee share shall be such percentage as the employer deems proper under its own particular circumstances.

If you have any questions regarding the above, please contact your PEIA Premium Accounts Representative at (304) 558-7850 or toll free at (888) 680-7342.

TS:JE
Enclosure
Non-State

Bob Wise
Governor

Tom Susman
Director

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MEMORANDUM

TO: Benefit Coordinators

FROM: Tom Susman, Director

DATE: April 8, 2002

RE: **Definition of Plan Participant**

This is to clarify the Public Employees Insurance Agency's recently revised definition of "Plan" participant, pursuant to Enrolled Senate Bill 592, passed on March 8, 2002, and effective ninety days from passage.

Under the new definition, "Plan", unless the context indicates otherwise, means the medical indemnity plan, the managed care plan option, or the **group life insurance plan** offered by the agency.

The impact of this legislation has nullified a portion of language within the West Virginia Public Employees Insurance Agency Plan Year 2002 Summary Plan Description booklet. Specifically, the bolded language on page 23 under "Using Accrued Sick and Annual Leave to Extend Coverage", states in part:

> Employees who were hired prior to July 1, 1988, and who currently carry "Life Insurance Only" coverage with PEIA as of June 30, 2001, *must elect some form of health insurance through PEIA effective no later than July 1, 2002, to be eligible to continue to qualify as a pre-July 1, 1988 employee and receive the 100% premium formula discussed below.*

Therefore, all PEIA policyholders who carry basic life insurance only may now continue in that status without losing their ability as a pre-July 1, 1988 employee to utilize their accrued sick and annual leave when they retire. In other words, they do not have to sign up for health coverage to maintain this benefit. Continuously carrying "life only" will preserve the pre-July 1, 1988 status.

PEIA is making every effort to notify employees of this change and the information will also be available on our web site at www.wvpeia.com. However, as a Benefit Coordinator, you play a crucial role in communicating this information to your potentially affected employees, should they be unaware of this legislation and submit a Change-In-Status form electing health insurance coverage to avoid future penalty.

Thank you for your continued support in communicating and administering the guidelines of PEIA. If you have any questions regarding this matter, please feel free to contact your PEIA eligibility representative toll free at (888) 680-7342 or at (304) 558-7850.

TS:BEB:ts

I:\barb\bc memo (plan part def).408.2002

WEST VIRGINIA
PUBLIC EMPLOYEES INSURANCE AGENCY

PPB PLAN OPTION CODES

(EFFECTIVE JULY 1, 2002)

Option Codes	*Salary Tiers*	*Annual Deductible*		*Annual Out-of-Pocket Maximum*
		Single Coverage	All Other Coverage	
001	$ 0 - $ 20,000	$ 100.00	$ 200.00	$ 800.00
002	$ 20,001 - $ 30,000	$ 150.00	$ 300.00	$1,100.00
003	$ 30,001 - $ 36,000	$ 200.00	$ 400.00	$1,250.00
004	$ 36,001 - $ 42,000	$ 225.00	$ 450.00	$1,500.00
005	$ 42,001 - $ 50,000	$ 250.00	$ 500.00	$1,750.00
006	$ 50,001 - $ 75,000	$ 375.00	$ 750.00	$1,800.00
007	$ 75,001 - $100,000	$ 425.00	$ 850.00	$1,900.00
008	$100,001 - $125,000	$ 500.00	$1,000.00	$2,000.00
009	$125,001 +	$ 600.00	$1,200.00	$2,250.00
010 (Non-State Plan B) (COBRA Plan B)		$ 500.00	$1,000.00	$2,000.00 (single coverage) $4,000.00 (all other coverage)
011 (Non-Medicare Retiree)		$ 375.00	$ 750.00	$1,500.00
012 (Medicare Retiree)		$ 150.00	$ 300.00	$1,000.00

NOTE: Option Codes 100, 200, 300 and 400 are no longer active codes.

PPB AND MANAGED CARE COVERAGE CODES

Coverage Codes	Description
HI01	PPB Plan – Option A
HI02*	PPB Plan – Option B
HMCL-1*	Carelink – Enhanced Plan (Managed Care HMO)
HMCL-2*	Carelink – Basic Plan (Managed Care HMO)
HMHP-A	The Health Plan – Option A (Managed Care HMO)
HMHP-B	The Health Plan – Option B (Managed Care HMO)

NOTE: Coverage Codes followed by "*" represent new codes effective July 1, 2002. Coverage Codes HMCL-A and HMCL-B are no longer active codes.

NOTE

FOR AGENCY CODING OF INSUREDS WHO RESIDE OUT-OF-STATE AND NOT IN A MANAGED CARE SERVICE AREA, THE DEFAULT CODE IS REGION 2.

REGION 1

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
(Includes Prescription Drug Coverage)

The Carelink Enhanced health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMCL-1	Option	(none)

Within the following table, first find the appropriate tier, i.e., family composition, in column (a) and then record the corresponding employer portion*, policyholder portion* and total monthly premium amounts from columns (b), (c), and (d), respectively.

Table for Region 1 Policyholders

(a) Tier	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium
1. Policyholder			320.00
2. Policyholder and Child(ren)			525.00
3. Family			870.00

* The PEIA does not prescribe the split between employer portion and policyholder portion for non-State agency premiums.

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.A.1.52A
		Page Date	2002.02.15

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 1

CARELINK MANAGED CARE PLANS
BASIC PLAN
(Includes Generic Prescription Drug Coverage Only)

The Carelink Basic health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMCL-2	Option	(none)

Within the following table, first find the appropriate tier, i.e., family composition, in column (a) and then record the corresponding employer portion*, policyholder portion* and total monthly premium amounts from columns (b), (c), and (d), respectively.

Table for Region 1 Policyholders

(a) Tier	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium
1. Policyholder			272.00
2. Policyholder and Child(ren)			454.00
3. Family			750.00

* The PEIA does not prescribe the split between employer portion and policyholder portion for non-State agency premiums.

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.A.1.52B
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 2

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
(Includes Prescription Drug Coverage)

The Carelink Enhanced health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMCL-1

Option	(none)

Within the following table, first find the appropriate tier, i.e., family composition, in column (a) and then record the corresponding employer portion*, policyholder portion* and total monthly premium amounts from columns (b), (c), and (d), respectively.

Table for Region 2 Policyholders

(a) Tier	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium
1. Policyholder			320.00
2. Policyholder and Child(ren)			536.00
3. Family			875.00

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* The PEIA does not prescribe the split between employer portion and policyholder portion for non-State agency premiums.

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.A.1.52C
		Page Date	2002.02.15

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 2

CARELINK MANAGED CARE PLANS
BASIC PLAN
(Includes Generic Prescription Drug Coverage Only)

The Carelink Basic health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMCL-2	Option	(none)

Within the following table, first find the appropriate tier, i.e., family composition, in column (a) and then record the corresponding employer portion*, policyholder portion* and total monthly premium amounts from columns (b), (c), and (d), respectively.

Table for Region 2 Policyholders

(a) Tier	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium
1. Policyholder			273.00
2. Policyholder and Child(ren)			464.00
3. Family			755.00

---

* The PEIA does not prescribe the split between employer portion and policyholder portion for non-State agency premiums.

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.A.1.53
		Page Date	2002.02.15

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 1

THE HEALTH PLAN MANAGED CARE PLANS
OPTION A
(Includes Prescription Drug Coverage)

The Health Plan Option A health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMHP-A

Option	(none)

Within the following table, first find the appropriate tier, i.e., family composition, in column (a) and then record the corresponding employer portion*, policyholder portion* and total monthly premium amounts from columns (b), (c), and (d), respectively.

Table for Region 1 Policyholders

(a) Tier	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium
1. Policyholder			341.00
2. Policyholder and Child(ren)			498.00
3. Family			827.00

---

* The PEIA does not prescribe the split between employer portion and policyholder portion for non-State agency premiums.

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.A.1.53A
		Page Date	2002.02.15

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 1

THE HEALTH PLAN MANAGED CARE PLANS
OPTION B
(Includes Generic Prescription Drug Coverage Only)

The Health Plan Option B health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMHP-B

Option	(none)

Within the following table, first find the appropriate tier, i.e., family composition, in column (a) and then record the corresponding employer portion*, policyholder portion* and total monthly premium amounts from columns (b), (c), and (d), respectively.

Table for Region 1 Policyholders

(a) Tier	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium
1. Policyholder			287.00
2. Policyholder and Child(ren)			425.00
3. Family			724.00

* The PEIA does not prescribe the split between employer portion and policyholder portion for non-State agency premiums.

REGIONS 1 AND 2

PEIA PPB PLANS
OPTION A
(Includes PEIA Prescription Drug Coverage)

The PEIA PPB health plan and prescription drug coverage and option codes are as follows:

Health Coverage Code	HI01	Option	004

Prescription Drug Coverage Code	PI01	Option	(none)

Within the following table, find the appropriate tier, i.e., family composition, in column (a) and record the corresponding employer portion*, policyholder portion (Standard Tobacco User or Preferred Tobacco Free)* and total monthly premium amounts from columns (b), (c), (d) and (e), respectively.

Table for both Region 1 and Region 2 Policyholders

(a) Tier	(b) Employer Portion	(c) Policyholder Portion	(d) *Standard* Premium *(Tobacco User)*	(e) *Preferred* Premium *(Tobacco Free)*
1. Policyholder			311.00	301.00
2. Policyholder and Child(ren)			631.00	611.00
3. Family			631.00	611.00

* The PEIA does not prescribe the split between employer portion and policyholder portion for non-State agency premiums.

REGIONS 1 AND 2

PEIA PPB PLANS
OPTION B
(Includes PEIA Prescription Drug Coverage)

The PEIA PPB health plan and prescription drug coverage and option codes are as follows:

Health Coverage Code	HI02	Option	010

Prescription Drug Coverage Code	PI01	Option	(none)

Within the following table, find the appropriate tier, i.e., family composition, in column (a) and record the corresponding employer portion*, policyholder portion (Standard Tobacco User or Preferred Tobacco Free)* and total monthly premium amounts from columns (b), (c), (d) and (e), respectively.

Table for both Region 1 and Region 2 Policyholders

(a) Tier	(b) Employer Portion	(c) Policyholder Portion	(d) *Standard* Premium *(Tobacco User)*	(e) *Preferred* Premium *(Tobacco Free)*
1. Policyholder			283.00	273.00
2. Policyholder and Child(ren)			560.00	540.00
3. Family			560.00	540.00

* The PEIA does not prescribe the split between employer portion and policyholder portion for non-State agency premiums.

Coverage	2. POLICYHOLDER BASIC LIFE	Page No.	N.S.A.2.3
		Page Date	2000.06.01

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	1998.01.01	Through	2000.06.30

Policyholder basic life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage of the same face value amount. The applicable coverage and option codes are as follows:

Policyholder Basic Life Coverage Code	LB01	Option	100

Policyholder AD&D Coverage Code	AB01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding employer portion and total monthly premium amounts from columns (b) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Less than 65	4.34	.00	4.34	Face Value $10,000
65 through 69	2.82	.00	2.82	Face Value $6,500
70 and older	2.18	.00	2.18	Face Value $5,000

Coverage	2. POLICYHOLDER BASIC LIFE	Page No.	N.S.A.2.4
		Page Date	2000.06.01

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2000.07.01	Through	

Policyholder basic life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage of the same face value amount. The applicable coverage and option codes are as follows:

Policyholder Basic Life Coverage Code	LB01	Option	100

Policyholder AD&D Coverage Code	AB01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding employer portion and total monthly premium amounts from columns (b) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Less than 65	4.81	.00	4.81	Face Value $10,000
65 through 69	3.12	.00	3.12	Face Value $6,500
70 and older	2.41	.00	2.41	Face Value $5,000

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.C.1.56
		Page Date	2002.02.15

Policyholder	☐ Active Employee ☒ COBRA Participant ☐ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 1

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
(Includes Prescription Drug Coverage)

The Carelink Enhanced health maintenance organization (HMO) health plan and option codes are as follows:

Health Coverage Code	HMCL-1

Option	(none)

Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for Region 1 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium
NO	1. Policyholder	.00	321.00	321.00
	2. Policyholder and Child(ren)	.00	536.00	536.00
	3. Family	.00	887.00	887.00
YES	1. Policyholder	.00	480.00	480.00
	2. Policyholder and Child(ren)	.00	788.00	788.00
	3. Family	.00	1,305.00	1,305.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.C.1.56A
		Page Date	2002.02.15

Policyholder	☐ Active Employee	☒ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 1

CARELINK MANAGED CARE PLANS
BASIC PLAN
(Includes Generic Prescription Drug Coverage Only)

The Carelink Basic health maintenance organization (HMO) health plan and option codes are as follows:

Health Coverage Code	HMCL-2

Option	(none)

Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for Region 1 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium
NO	1. Policyholder	.00	277.00	277.00
	2. Policyholder and Child(ren)	.00	463.00	463.00
	3. Family	.00	765.00	765.00
YES	1. Policyholder	.00	408.00	408.00
	2. Policyholder and Child(ren)	.00	681.00	681.00
	3. Family	.00	1,125.00	1,125.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.C.1.56B
		Page Date	2002.02.15

Policyholder	☐ Active Employee	☒ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 2

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
(Includes Prescription Drug Coverage)

The Carelink Enhanced health maintenance organization (HMO) health plan and option codes are as follows:

Health Coverage Code	HMCL-1

Option	(none)

Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for Region 2 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium
NO	1. Policyholder	.00	326.00	326.00
	2. Policyholder and Child(ren)	.00	547.00	547.00
	3. Family	.00	893.00	893.00
YES	1. Policyholder	.00	480.00	480.00
	2. Policyholder and Child(ren)	.00	804.00	804.00
	3. Family	.00	1,313.00	1,313.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.C.1.56C
		Page Date	2002.02.15

Policyholder	☐ Active Employee ☒ COBRA Participant ☐ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 2

CARELINK MANAGED CARE PLANS
BASIC PLAN
(Includes Generic Prescription Drug Coverage Only)

The Carelink Basic health maintenance organization (HMO) health plan and option codes are as follows:

Health Coverage Code	HMCL-2

Option	(none)

Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for Region 2 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium
NO	1. Policyholder	.00	278.00	278.00
	2. Policyholder and Child(ren)	.00	473.00	473.00
	3. Family	.00	770.00	770.00
YES	1. Policyholder	.00	410.00	410.00
	2. Policyholder and Child(ren)	.00	696.00	696.00
	3. Family	.00	1,133.00	1,133.00

REGION 1

THE HEALTH PLAN MANAGED CARE PLANS
OPTION A
(Includes Prescription Drug Coverage)

The Health Plan Option A health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMHP-A	Option	(none)

Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for Region 1 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium
NO	1. Policyholder	.00	348.00	348.00
	2. Policyholder and Child(ren)	.00	508.00	508.00
	3. Family	.00	844.00	844.00
YES	1. Policyholder	.00	512.00	512.00
	2. Policyholder and Child(ren)	.00	747.00	747.00
	3. Family	.00	1,241.00	1,241.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.C.1.57A
		Page Date	2002.02.15

Policyholder	☐ Active Employee	☒ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 1

THE HEALTH PLAN MANAGED CARE PLANS
OPTION B
(Includes Generic Prescription Drug Coverage Only)

The Health Plan Option B health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMHP-B

Option	(none)

Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion and total monthly premium amounts from columns (c), (d), and (e), respectively.

Table for Region 1 Policyholders

(a) Disability Premium	(b) Tier	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium
NO	1. Policyholder	.00	293.00	293.00
	2. Policyholder and Child(ren)	.00	434.00	434.00
	3. Family	.00	738.00	738.00
YES	1. Policyholder	.00	431.00	431.00
	2. Policyholder and Child(ren)	.00	638.00	638.00
	3. Family	.00	1,086.00	1,086.00

REGIONS 1 AND 2

PEIA PPB PLANS
OPTION A
(Includes PEIA Prescription Drug Coverage)

The PEIA PPB health plan and prescription drug coverage and option codes are as follows:

Health Coverage Code	HI01	Option	004

Prescription Drug Coverage Code	PI01	Option	(none)

Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion (Standard Tobacco User or Preferred Tobacco Free) and total monthly premium amounts from columns (c), (d) and (e), respectively.

Table for both Region 1 and Region 2 Policyholders

(a) **Disability Premium**	(b) **Tier**	(c) **Employer Portion**	(d) ***Standard*** **Premium** ***(Tobacco User)***	(e) ***Preferred*** **Premium** ***(Tobacco Free)***
NO	1. Policyholder	.00	317.00	307.00
	2. Policyholder and Child(ren)	.00	643.00	623.00
	3. Family	.00	643.00	623.00
YES	1. Policyholder	.00	462.00	452.00
	2. Policyholder and Child(ren)	.00	937.00	917.00
	3. Family	.00	937.00	917.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.C.1.59
		Page Date	2002.02.15

Policyholder	☐ Active Employee	☒ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGIONS 1 AND 2

PEIA PPB PLANS
OPTION B
(Includes PEIA Prescription Drug Coverage)

The PEIA PPB health plan and prescription drug coverage and option codes are as follows:

Health Coverage Code	HI02	Option	010

Prescription Drug Coverage Code	PI01	Option	(none)

Within the following table, first find the applicable disability premium status in column (a), which will typically be "no." Next, within that disability premium status, find the appropriate tier, i.e., family composition, in column (b) and record the corresponding employer portion, policyholder portion (Standard Tobacco User or Preferred Tobacco Free) and total monthly premium amounts from columns (c), (d) and (e), respectively.

Table for both Region 1 and Region 2 Policyholders

(a) **Disability Premium**	(b) **Tier**	(c) **Employer Portion**	(d) ***Standard*** **Premium** ***(Tobacco User)***	(e) ***Preferred*** **Premium** ***(Tobacco Free)***
NO	1. Policyholder	.00	288.00	278.00
	2. Policyholder and Child(ren)	.00	571.00	551.00
	3. Family	.00	571.00	551.00
YES	1. Policyholder	.00	420.00	410.00
	2. Policyholder and Child(ren)	.00	830.00	810.00
	3. Family	.00	830.00	810.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.R.1.59
		Page Date	2002.02.15

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 2

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
(Includes Prescription Drug Coverage)

The Carelink Enhanced health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMCL-1

Option	(none)

Within the following table, first find the appropriate tier, i.e., the family composition, within column (b). Record the corresponding monthly premium amount from the correct column based upon years of credited service from among columns (d) through (i) with the appropriate tier row.

Table for Region 2 Policyholders

(a)	(b)	(c)	Policyholder Credited Service					
Policy-Holder Medicare	Tier	All Dependents Medicare	(d) 0-4 Years	(e) 5-9 Years	(f) 10-14 Years	(g) 15-19 Years	(h) 20-24 Years	(i) 25-99 Years
NO	Policyholder	[redacted]	315.00	295.00	275.00	255.00	235.00	225.00
	Policyholder & Dependents	NO	590.00	550.00	510.00	470.00	430.00	420.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.R.1.59A
		Page Date	2002.02.15

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 2

CARELINK MANAGED CARE PLANS
BASIC PLAN
(Includes Generic Prescription Drug Coverage Only)

The Carelink Basic health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMCL-2

Option	(none)

Within the following table, first find the appropriate tier, i.e., the family composition, within column (b). Record the corresponding monthly premium amount from the correct column based upon years of credited service from among columns (d) through (i) with the appropriate tier row.

Table for Region 2 Policyholders

(a)	(b)	(c)	Policyholder Credited Service					
Policy-Holder Medicare	Tier	All Dependents Medicare	(d) 0-4 Years	(e) 5-9 Years	(f) 10-14 Years	(g) 15-19 Years	(h) 20-24 Years	(i) 25-99 Years
NO	Policyholder	[redacted]	281.00	261.00	241.00	221.00	201.00	191.00
	Policyholder & Dependents	NO	480.00	445.00	410.00	375.00	340.00	330.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.R.1.60
		Page Date	2002.02.15

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 1

THE HEALTH PLAN MANAGED CARE PLANS
OPTION A
(Includes Prescription Drug Coverage)

The Health Plan Option A health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMHP-A

Option	(none)

Within the following table, first find the appropriate tier, i.e., the family composition, within column (b). Record the corresponding monthly premium amount from the correct column based upon years of credited service from among columns (d) through (i) with the appropriate tier row.

Table for Region 1 Policyholders

(a)	(b)	(c)	Policyholder Credited Service					
Policy-Holder Medicare	Tier	All Dependents Medicare	(d) 0-4 Years	(e) 5-9 Years	(f) 10-14 Years	(g) 15-19 Years	(h) 20-24 Years	(i) 25-99 Years
NO	Policyholder		343.00	323.00	303.00	283.00	263.00	253.00
	Policyholder & Dependents	NO	660.00	620.00	580.00	540.00	500.00	490.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.R.1.60A
		Page Date	2002.02.15

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGION 1

THE HEALTH PLAN MANAGED CARE PLANS
OPTION B
(Includes Generic Prescription Drug Coverage Only)

The Health Plan Option B health maintenance organization (HMO) health plan option codes are as follows:

Health Coverage Code	HMHP-B

Option	(none)

Within the following table, first find the appropriate tier, i.e., the family composition, within column (b). Record the corresponding monthly premium amount from the correct column based upon years of credited service from among columns (d) through (i) with the appropriate tier row.

Table for Region 1 Policyholders

(a)	(b)	(c)	Policyholder Credited Service					
Policy-Holder Medicare	Tier	All Dependents Medicare	(d) 0-4 Years	(e) 5-9 Years	(f) 10-14 Years	(g) 15-19 Years	(h) 20-24 Years	(i) 25-99 Years
NO	Policyholder		295.00	275.00	255.00	235.00	215.00	205.00
	Policyholder & Dependents	NO	539.00	504.00	469.00	434.00	399.00	389.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.R.1.61
		Page Date	2002.02.15

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

REGIONS 1 AND 2

PEIA PPB PLAN
(Includes Prescription Drug Coverage)

The PEIA PPB health plan and prescription drug coverage and option codes are as follows:

Health Coverage Code	HI01

Options	011-012

Prescription Drug Coverage Code	PI01

Option	(none)

Note that *Option Code 012* is for Medicare-primary eligible retiree policyholders only. *Option Code 011* must be used for non-Medicare policyholders.

Below are three tables of premiums essentially stating PEIA PPB Plan premiums by the (retiree) policyholder's (latest) date of retirement. Table A is applicable only if the policyholder's date of retirement was prior to July 1, 1997. Tables B and C are applicable only if the policyholder's date of retirement was after June 30, 1997. Table A is also applicable for surviving dependent policyholders and for disability retiree policyholders, regardless of date of retirement.

First find the correct table below and follow the instructions for that table.

Table A -- For Survivors, Disability Retirees, and Retirees Whose Date of Retirement is Prior to 1997.07.01

Within the following table, first find within column (a) the correct Medicare-primary status of the policyholder. Within the applicable Medicare-primary status of the policyholder, find the appropriate tier, i.e., the family composition, within column (b). If the tier is simply policyholder, then record the corresponding monthly premium amount from column (d), Standard Tobacco User, or (e), Preferred Tobacco Free. If the tier is policyholder and dependent(s), find the applicable Medicare-primary status of the dependent(s) in column (c).

If not <u>all</u> dependents are Medicare primary, then use the "NO" option in column (c).

Table for both <u>Region 1 and Region 2</u> Policyholders

(a)	(b)	(c)	(d)	(e)
			Monthly Premiums	
Policyholder Medicare	Tier	<u>ALL</u> Dependents Medicare	*Standard (Tobacco User)*	*Preferred (Tobacco Free)*
NO	Policyholder		168.00	158.00
	Policyholder and Dependent(s)	NO	336.00	316.00
		YES	220.00	200.00
YES	Policyholder		62.00	52.00
	Policyholder and Dependent(s)	NO	230.00	210.00
		YES	108.00	88.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	N.S.R.1.62
		Page Date	2002.02.15

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	2003.06.30

PEIA PPB PLAN
(Continued)

Tables B and C -- For Retirees Whose Date of Retirement is After 1997.06.30

Within the following tables (Standard Tobacco User and Preferred Tobacco Free), first find within column (a) the correct Medicare-primary status of the policyholder. Within the applicable Medicare-primary status of the policyholder, find the appropriate tier, i.e., the family composition, within column (b). If the tier is simply policyholder, then record the corresponding monthly premium amount from the correct column, based on years of credited service, from among columns (d) through (i). If the tier is policyholder and dependent(s), find the applicable Medicare-primary status of the dependent(s) in column (c) in order to be in the correct row before selecting the applicable premium from columns (d) through (i).

Note that the set of dependent(s) has Medicare status of NO if <u>at least one</u> dependent is not Medicare-primary eligible and YES otherwise, i.e., if <u>all</u> dependents are Medicare-primary eligible.

Tables for both <u>Region 1 and Region 2</u> Policyholders

**** * STANDARD (TOBACCO USER) PREMIUM TABLE * ****

(a)	(b)	(c)	Policyholder Credited Service					
Policy-Holder Medicare	Tier	<u>All</u> Dependents Medicare	(d) 0-4 Years	(e) 5-9 Years	(f) 10-14 Years	(g) 15-19 Years	(h) 20-24 Years	(i) 25-99 Years
NO	Policyholder		696.00	564.00	432.00	299.00	220.00	168.00
	Policyholder & Dependents	NO	1,678.00	1,343.00	1,007.00	672.00	470.00	336.00
		YES	1,196.00	951.00	707.00	464.00	318.00	220.00
YES	Policyholder		349.00	277.00	206.00	134.00	91.00	62.00
	Policyholder & Dependents	NO	1,133.00	908.00	682.00	456.00	320.00	230.00
		YES	728.00	573.00	418.00	263.00	169.00	108.00

**** * PREFERRED (TOBACCO FREE) PREMIUM TABLE * ****

(a)	(b)	(c)	Policyholder Credited Service					
Policy-Holder Medicare	Tier	<u>All</u> Dependents Medicare	(d) 0-4 Years	(e) 5-9 Years	(f) 10-14 Years	(g) 15-19 Years	(h) 20-24 Years	(i) 25-99 Years
NO	Policyholder		686.00	554.00	422.00	289.00	210.00	158.00
	Policyholder & Dependents	NO	1,658.00	1,323.00	987.00	652.00	450.00	316.00
		YES	1,176.00	931.00	687.00	444.00	298.00	200.00
YES	Policyholder		339.00	267.00	196.00	124.00	81.00	52.00
	Policyholder & Dependents	NO	1,113.00	888.00	662.00	436.00	300.00	210.00
		YES	708.00	553.00	398.00	243.00	149.00	88.00

Coverage	2. POLICYHOLDER BASIC LIFE	Page No.	N.S.R.2.4
		Page Date	2000.06.01

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2000.07.01	Through	

Policyholder basic life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. The applicable coverage and option codes are as follows:

Policyholder Basic Life Coverage Code	LB01

Option	(see table below)

Policyholder AD&D Coverage Code	(none)

Option	(none)

There are two options associated with retiree basic life insurance coverage depending on whether or not the policyholder is entitled to a waiver of the basic life insurance premium. Within the following table within column (a) find the correct waiver status and record the option ("300" for the usual no premium waiver situation and "200" for those limited premium waiver situations). Next find the applicable policyholder age* within column (b). From columns (c), (d) and (e) record the employer portion, policyholder portion and total monthly premium, respectively. Column (f) represents the applicable insurance amounts.

(a) Waiver Status	(b) Policyholder Age*	(c) Employer Portion	(d) Policyholder Portion	(e) Monthly Premium	(f) Comments
NO Option = 300	Less than 67	.00	2.26	2.26	$5,000 Face Value
	67 and up	.00	1.13	1.13	$2,500 Face Value
YES Option = 200	Less than 65	.00	.00	.00	$10,000 Face Value
	65-66	.00	.00	.00	$5,000 Face Value
	67 and up	.00	.00	.00	$2,500 Face Value

---

* The policyholder's age for determination of basic life (and AD&D) coverage follows Medicare guidelines in that your age in any month is computed as your age as of the last day of the preceding month, with one exception. If your birthday is January 1, then the rule is applied as if your birthday was on December 31, i.e., the day before your actual birthday.

Cecil H. Underwood
Governor

Robert L. Ayers, ARM
Executive Director

WV Toll-free: 1-888-680-PEIA • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: www.peia.state.wv.us

Memorandum

To: Insurance Coordinators

From: Kimberly Covert KC
Chief Financial Officer

Date: August 9,2000

Re: Optional Life Premium Rate Tables / Early Warning Report

Due to positive claims experience in the optional life insurance program, rates are being reduced by 7%. If actual claims experience again increases, rates will be adjusted accordingly in the future.

Please find enclosed a listing of policyholders whose optional life premium will change on September 1, 2000. Also enclosed are new rate tables for optional life and dependent life that should be incorporated into your PEIA Rate Table Manual. New pages, with new page numbers, through dates and an effective date of September 1, 2000, are to be added to your current manual. These new premium amounts will be billed for policyholders that are enrolled in optional and dependent life insurance on your agency September invoice.

State Capitol Complex • Building 5, Room 1001 • 1900 Kanawha Boulevard, E. • Charleston, WV 25305-0710

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.7
		Page Date	2000.0808

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 1
(Face Value $5,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	100

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.33	.33	Face Value $5,000
30 – 34	.00	.39	.39	
35 – 39	.00	.50	.50	
40 – 44	.00	.87	.87	
45 – 49	.00	1.20	1.20	
50 – 54	.00	1.89	1.89	
55 – 59	.00	3.16	3.16	
60 – 64	.00	4.54	4.54	
65 – 69	.00	4.72	4.72	Face Value $3,250
70 and up	.00	9.75	9.75	Face Value $2,250

---

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 2
(Face Value $10,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	200

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.66	.66	Face Value $10,000
30 - 34	.00	.78	.78	
35 - 39	.00	.99	.99	
40 - 44	.00	1.73	1.73	
45 - 49	.00	2.40	2.40	
50 - 54	.00	3.77	3.77	
55 - 59	.00	6.32	6.32	
60 - 64	.00	9.08	9.08	
65 - 69	.00	9.44	9.44	Face Value $6,500
70 and up	.00	19.49	19.49	Face Value $4,500

---

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 3
(Face Value $20,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	300

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.32	1.32	Face Value $20,000
30 - 34	.00	1.56	1.56	
35 - 39	.00	1.98	1.98	
40 - 44	.00	3.46	3.46	
45 - 49	.00	4.80	4.80	
50 - 54	.00	7.54	7.54	
55 - 59	.00	12.64	12.64	
60 - 64	.00	18.16	18.16	
65 - 69	.00	18.88	18.88	Face Value $13,000
70 and up	.00	38.99	38.99	Face Value $9,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.10
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 4
(Face Value $30,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	400

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.98	1.98	Face Value $30,000
30 - 34	.00	2.34	2.34	
35 - 39	.00	2.97	2.97	
40 - 44	.00	5.19	5.19	
45 - 49	.00	7.20	7.20	
50 - 54	.00	11.31	11.31	
55 - 59	.00	18.96	18.96	
60 - 64	.00	27.24	27.24	
65 - 69	.00	28.31	28.31	Face Value $19,500
70 and up	.00	58.48	58.48	Face Value $13,500

---

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 5
(Face Value $40,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	500

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	2.64	2.64	Face Value $40,000
30 - 34	.00	3.12	3.12	
35 - 39	.00	3.96	3.96	
40 - 44	.00	6.92	6.92	
45 - 49	.00	9.60	9.60	
50 - 54	.00	15.08	15.08	
55 - 59	.00	25.28	25.28	
60 - 64	.00	36.32	36.32	
65 - 69	.00	37.75	37.75	Face Value $26,000
70 and up	.00	77.98	77.98	Face Value $18,000

---

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 6
(Face Value $50,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	600

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.30	3.30	Face Value $50,000
30 - 34	.00	3.90	3.90	
35 - 39	.00	4.95	4.95	
40 - 44	.00	8.65	8.65	
45 - 49	.00	12.00	12.00	
50 - 54	.00	18.85	18.85	
55 - 59	.00	31.60	31.60	
60 - 64	.00	45.40	45.40	
65 - 69	.00	47.19	47.19	Face Value $32,500
70 and up	.00	97.47	97.47	Face Value $22,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.13
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 7
(Face Value $75,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	700

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	4.95	4.95	Face Value $75,000
30 - 34	.00	5.85	5.85	
35 - 39	.00	7.43	7.43	
40 - 44	.00	12.98	12.98	
45 - 49	.00	18.00	18.00	
50 - 54	.00	28.28	28.28	
55 - 59	.00	47.40	47.40	
60 - 64	.00	68.10	68.10	
65 - 69	.00	70.79	70.79	Face Value $48,750
70 and up	.00	146.20	146.20	Face Value $33,750

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE

Page No.	S.R.3.14
Page Date	2000.0808

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 1
(Face Value $5,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	100

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.30	.30	Face Value $5,000
30 – 34	.00	.36	.36	
35 – 39	.00	.46	.46	
40 – 44	.00	.80	.80	
45 – 49	.00	1.12	1.12	
50 – 54	.00	1.76	1.76	
55 – 59	.00	2.94	2.94	
60 – 64	.00	4.22	4.22	
65 – 69	.00	4.38	4.38	Face Value $3,250
70 and up	.00	9.06	9.06	Face Value $2,250

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.15
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 2
(Face Value $10,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	200

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.62	.62	Face Value $10,000
30 - 34	.00	.72	.72	
35 - 39	.00	.92	.92	
40 - 44	.00	1.60	1.60	
45 - 49	.00	2.24	2.24	
50 - 54	.00	3.50	3.50	
55 - 59	.00	5.88	5.88	
60 - 64	.00	8.44	8.44	
65 - 69	.00	8.78	8.78	Face Value $6,500
70 and up	.00	18.12	18.12	Face Value $4,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE

Page No.	S.R.3.16
Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 3
(Face Value $20,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	300

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.22	1.22	Face Value $20,000
30 - 34	.00	1.46	1.46	
35 - 39	.00	1.84	1.84	
40 - 44	.00	3.22	3.22	
45 - 49	.00	4.46	4.46	
50 - 54	.00	7.02	7.02	
55 - 59	.00	11.76	11.76	
60 - 64	.00	16.88	16.88	
65 - 69	.00	17.56	17.56	Face Value $13,000
70 and up	.00	36.26	36.26	Face Value $9,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.17
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 4
(Face Value $30,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	400

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.84	1.84	Face Value $30,000
30 - 34	.00	2.18	2.18	
35 - 39	.00	2.76	2.76	
40 - 44	.00	4.82	4.82	
45 - 49	.00	6.70	6.70	
50 - 54	.00	10.52	10.52	
55 - 59	.00	17.64	17.64	
60 - 64	.00	25.34	25.34	
65 - 69	.00	26.32	26.32	Face Value $19,500
70 and up	.00	54.38	54.38	Face Value $13,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.18
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 5
(Face Value $40,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	500

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	2.46	2.46	Face Value $40,000
30 - 34	.00	2.90	2.90	
35 - 39	.00	3.68	3.68	
40 - 44	.00	6.44	6.44	
45 - 49	.00	8.92	8.92	
50 - 54	.00	14.02	14.02	
55 - 59	.00	23.52	23.52	
60 - 64	.00	33.78	33.78	
65 - 69	.00	35.10	35.10	Face Value $26,000
70 and up	.00	72.52	72.52	Face Value $18,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 6
(Face Value $50,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	600

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.06	3.06	Face Value $50,000
30 - 34	.00	3.62	3.62	
35 - 39	.00	4.60	4.60	
40 - 44	.00	8.04	8.04	
45 - 49	.00	11.16	11.16	
50 - 54	.00	17.54	17.54	
55 - 59	.00	29.38	29.38	
60 - 64	.00	42.22	42.22	
65 - 69	.00	43.88	43.88	Face Value $32,500
70 and up	.00	90.64	90.64	Face Value $22,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 7
(Face Value $75,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	700

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	4.60	4.60	Face Value $75,000
30 - 34	.00	5.44	5.44	
35 - 39	.00	6.90	6.90	
40 - 44	.00	12.08	12.08	
45 - 49	.00	16.74	16.74	
50 - 54	.00	26.30	26.30	
55 - 59	.00	44.08	44.08	
60 - 64	.00	63.34	63.34	
65 - 69	.00	65.84	65.84	Face Value $48,750
70 and up	.00	135.96	135.96	Face Value $33,750

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	4. DEPENDENT LIFE	Page No.	S.R.4.2
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

DEPENDENT LIFE PLAN 1
(Face Value $5,000 Spouse, $2,000 Each Child)

This coverage is available to retirees only, not to survivors. The applicable coverage and option codes for this plan are as follows:

Dependent Life Coverage Code	LD01

Option	100

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	2.46	2.46	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE	Page No.	S.R.4.3
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

DEPENDENT LIFE PLAN 2
(Face Value $10,000 Spouse, $4,000 Each Child)

This coverage is available to retirees only, not to survivors. The applicable coverage and option codes for this plan are as follows:

Dependent Life Coverage Code	LD01

Option	200

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	4.92	4.92	Spouse $10,000 Each Child $4,000

Coverage	4. DEPENDENT LIFE	Page No.	S.R.4.4
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

DEPENDENT LIFE PLAN 1
(Face Value $5,000 Spouse, $2,000 Each Child)

This coverage is available to retirees only, not to survivors. The applicable coverage and option codes for this plan are as follows:

Dependent Life Coverage Code	LD01

Option	100

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	2.28	2.28	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE

Page No.	S.R.4.5
Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

DEPENDENT LIFE PLAN 2
(Face Value $10,000 Spouse, $4,000 Each Child)

This coverage is available to retirees only, not to survivors. The applicable coverage and option codes for this plan are as follows:

Dependent Life Coverage Code	LD01

Option	200

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	4.58	4.58	Spouse $10,000 Each Child $4,000

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.7
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 1
(Face Value $5,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	100
Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.42	.42	Face Value $5,000
30 - 34	.00	.46	.46	
35 - 39	.00	.54	.54	
40 - 44	.00	.86	.86	
45 - 49	.00	1.10	1.10	
50 - 54	.00	1.64	1.64	
55 - 59	.00	2.66	2.66	
60 - 64	.00	3.76	3.76	
65 - 69	.00	3.84	3.84	Face Value $3,250
70 and up	.00	7.84	7.84	Face Value $2,250

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.8
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 2
(Face Value $10,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	200
Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.82	.82	Face Value $10,000
30 - 34	.00	.90	.90	
35 - 39	.00	1.08	1.08	
40 - 44	.00	1.70	1.70	
45 - 49	.00	2.20	2.20	
50 - 54	.00	3.28	3.28	
55 - 59	.00	5.32	5.32	
60 - 64	.00	7.52	7.52	
65 - 69	.00	7.70	7.70	Face Value $6,500
70 and up	.00	15.68	15.68	Face Value $4,500

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 3
(Face Value $20,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	300

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.62	1.62	Face Value $20,000
30 - 34	.00	1.80	1.80	
35 - 39	.00	2.16	2.16	
40 - 44	.00	3.40	3.40	
45 - 49	.00	4.38	4.38	
50 - 54	.00	6.56	6.56	
55 - 59	.00	10.64	10.64	
60 - 64	.00	15.04	15.04	
65 - 69	.00	15.38	15.38	Face Value $13,000
70 and up	.00	31.38	31.38	Face Value $9,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.10
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 4
(Face Value $30,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	400

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	2.44	2.44	Face Value $30,000
30 - 34	.00	2.70	2.70	
35 - 39	.00	3.24	3.24	
40 - 44	.00	5.10	5.10	
45 - 49	.00	6.58	6.58	
50 - 54	.00	9.84	9.84	
55 - 59	.00	15.96	15.96	
60 - 64	.00	22.56	22.56	
65 - 69	.00	23.08	23.08	Face Value $19,500
70 and up	.00	47.06	47.06	Face Value $13,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.11
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 5
(Face Value $40,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	500

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.24	3.24	Face Value $40,000
30 - 34	.00	3.60	3.60	
35 - 39	.00	4.32	4.32	
40 - 44	.00	6.80	6.80	
45 - 49	.00	8.76	8.76	
50 - 54	.00	13.12	13.12	
55 - 59	.00	21.28	21.28	
60 - 64	.00	30.08	30.08	
65 - 69	.00	30.76	30.76	Face Value $26,000
70 and up	.00	62.74	62.74	Face Value $18,000

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 6
(Face Value $50,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	600

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	4.06	4.06	Face Value $50,000
30 - 34	.00	4.50	4.50	
35 - 39	.00	5.40	5.40	
40 - 44	.00	8.50	8.50	
45 - 49	.00	10.96	10.96	
50 - 54	.00	16.40	16.40	
55 - 59	.00	26.60	26.60	
60 - 64	.00	37.60	37.60	
65 - 69	.00	38.46	38.46	Face Value $32,500
70 and up	.00	78.42	78.42	Face Value $22,500

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 7
(Face Value $75,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	700

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	6.08	6.08	Face Value $75,000
30 - 34	.00	6.76	6.76	
35 - 39	.00	8.10	8.10	
40 - 44	.00	12.76	12.76	
45 - 49	.00	16.44	16.44	
50 - 54	.00	24.60	24.60	
55 - 59	.00	39.90	39.90	
60 - 64	.00	56.40	56.40	
65 - 69	.00	57.68	57.68	Face Value $48,750
70 and up	.00	117.62	117.62	Face Value $33,750

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 8
(Face Value $100,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	800

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	8.10	8.10	Face Value $100,000
30 - 34	.00	9.00	9.00	
35 - 39	.00	10.80	10.80	
40 - 44	.00	17.00	17.00	
45 - 49	.00	21.90	21.90	
50 - 54	.00	32.80	32.80	
55 - 59	.00	53.20	53.20	
60 - 64	.00	75.20	75.20	
65 - 69	.00	76.90	76.90	Face Value $65,000
70 and up	.00	156.84	156.84	Face Value $45,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.15
		Page Date	200.0808

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 9
(Face Value $150,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	900

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	12.16	12.16	Face Value $150,000
30 - 34	.00	13.50	13.50	
35 - 39	.00	16.20	16.20	
40 - 44	.00	25.50	25.50	
45 - 49	.00	32.86	32.86	
50 - 54	.00	49.20	49.20	
55 - 59	.00	79.80	79.80	
60 - 64	.00	112.80	112.80	
65 - 69	.00	115.34	115.34	Face Value $97,500
70 and up	.00	235.24	235.24	Face Value $67,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 10
(Face Value $200,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	950

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	16.20	16.20	Face Value $200,000
30 - 34	.00	18.00	18.00	
35 - 39	.00	21.60	21.60	
40 - 44	.00	34.00	34.00	
45 - 49	.00	43.80	43.80	
50 - 54	.00	65.60	65.60	
55 - 59	.00	106.40	106.40	
60 - 64	.00	150.40	150.40	
65 - 69	.00	153.80	153.80	Face Value $130,000
70 and up	.00	313.66	313.66	Face Value $90,000

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.17
		Page Date	2000.0808

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☒ State	☐ Non-State	
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 1
(Face Value $5,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	100

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.40	.40	Face Value $5,000
30 - 34	.00	.42	.42	
35 - 39	.00	.50	.50	
40 - 44	.00	.80	.80	
45 - 49	.00	1.02	1.02	
50 - 54	.00	1.52	1.52	
55 - 59	.00	2.48	2.48	
60 - 64	.00	3.50	3.50	
65 - 69	.00	3.58	3.58	Face Value $3,250
70 and up	.00	7.30	7.30	Face Value $2,250

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.18
		Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☒ State	☐ Non-State	
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 2
(Face Value $10,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	200

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.76	.76	Face Value $10,000
30 - 34	.00	.84	.84	
35 - 39	.00	1.00	1.00	
40 - 44	.00	1.58	1.58	
45 - 49	.00	2.04	2.04	
50 - 54	.00	3.06	3.06	
55 - 59	.00	4.94	4.94	
60 - 64	.00	7.00	7.00	
65 - 69	.00	7.16	7.16	Face Value $6,500
70 and up	.00	14.58	14.58	Face Value $4,500

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.19
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 3
(Face Value $20,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	300

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.50	1.50	Face Value $20,000
30 - 34	.00	1.68	1.68	
35 - 39	.00	2.00	2.00	
40 - 44	.00	3.16	3.16	
45 - 49	.00	4.08	4.08	
50 - 54	.00	6.10	6.10	
55 - 59	.00	9.90	9.90	
60 - 64	.00	13.98	13.98	
65 - 69	.00	14.30	14.30	Face Value $13,000
70 and up	.00	29.18	29.18	Face Value $9,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 4
(Face Value $30,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	400

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	2.26	2.26	Face Value $30,000
30 - 34	.00	2.52	2.52	
35 - 39	.00	3.02	3.02	
40 - 44	.00	4.74	4.74	
45 - 49	.00	6.12	6.12	
50 - 54	.00	9.16	9.16	
55 - 59	.00	14.84	14.84	
60 - 64	.00	20.98	20.98	
65 - 69	.00	21.46	21.46	Face Value $19,500
70 and up	.00	43.76	43.76	Face Value $13,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.21
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 5
(Face Value $40,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	500

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.02	3.02	Face Value $40,000
30 - 34	.00	3.34	3.34	
35 - 39	.00	4.02	4.02	
40 - 44	.00	6.32	6.32	
45 - 49	.00	8.14	8.14	
50 - 54	.00	12.20	12.20	
55 - 59	.00	19.80	19.80	
60 - 64	.00	27.98	27.98	
65 - 69	.00	28.60	28.60	Face Value $26,000
70 and up	.00	58.34	58.34	Face Value $18,000

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 6
(Face Value $50,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	600

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.78	3.78	Face Value $50,000
30 - 34	.00	4.18	4.18	
35 - 39	.00	5.02	5.02	
40 - 44	.00	7.90	7.90	
45 - 49	.00	10.20	10.20	
50 - 54	.00	15.26	15.26	
55 - 59	.00	24.74	24.74	
60 - 64	.00	34.96	34.96	
65 - 69	.00	35.76	35.76	Face Value $32,500
70 and up	.00	72.94	72.94	Face Value $22,500

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.23
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 7
(Face Value $75,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	700

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	5.66	5.66	Face Value $75,000
30 - 34	.00	6.28	6.28	
35 - 39	.00	7.54	7.54	
40 - 44	.00	11.86	11.86	
45 - 49	.00	15.28	15.28	
50 - 54	.00	22.88	22.88	
55 - 59	.00	37.10	37.10	
60 - 64	.00	52.46	52.46	
65 - 69	.00	53.64	53.64	Face Value $48,750
70 and up	.00	109.38	109.38	Face Value $33,750

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 8
(Face Value $100,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	800

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	7.54	7.54	Face Value $100,000
30 - 34	.00	8.38	8.38	
35 - 39	.00	10.04	10.04	
40 - 44	.00	15.82	15.82	
45 - 49	.00	20.36	20.36	
50 - 54	.00	30.50	30.50	
55 - 59	.00	49.48	49.48	
60 - 64	.00	69.94	69.94	
65 - 69	.00	71.52	71.52	Face Value $65,000
70 and up	.00	145.86	145.86	Face Value $45,000

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 9
(Face Value $150,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	900

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	11.30	11.30	Face Value $150,000
30 - 34	.00	12.56	12.56	
35 - 39	.00	15.06	15.06	
40 - 44	.00	23.72	23.72	
45 - 49	.00	30.56	30.56	
50 - 54	.00	45.76	45.76	
55 - 59	.00	74.22	74.22	
60 - 64	.00	104.90	104.90	
65 - 69	.00	107.26	107.26	Face Value $97,500
70 and up	.00	218.78	218.78	Face Value $67,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 10
(Face Value $200,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	950

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	15.06	15.06	Face Value $200,000
30 - 34	.00	16.74	16.74	
35 - 39	.00	20.08	20.08	
40 - 44	.00	31.62	31.62	
45 - 49	.00	40.74	40.74	
50 - 54	.00	61.00	61.00	
55 - 59	.00	98.96	98.96	
60 - 64	.00	139.88	139.88	
65 - 69	.00	143.04	143.04	Face Value $130,000
70 and up	.00	291.70	291.70	Face Value $90,000

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	4. DEPENDENT LIFE	Page No.	S.A.4.1
		Page Date	1997.04.01

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1990.09.01	Through	1997.06.30

DEPENDENT LIFE PLAN

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	(none)

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	1.82	1.82	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE	Page No.	S.A.4.2
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

DEPENDENT LIFE PLAN 1
(Face Value $5,000 Spouse, $2,000 Each Child)

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	100

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	1.97	1.97	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE	Page No.	S.A.4.3
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

DEPENDENT LIFE PLAN 2
(Face Value $10,000 Spouse, $4,000 Each Child)

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	200

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	3.94	3.94	Spouse $10,000 Each Child $4,000

Coverage	4. DEPENDENT LIFE	Page No.	S.A.4.4
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

DEPENDENT LIFE PLAN 1
(Face Value $5,000 Spouse, $2,000 Each Child)

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	100

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	1.84	1.84	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE	Page No.	S.A.4.5
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

DEPENDENT LIFE PLAN 2
(Face Value $10,000 Spouse, $4,000 Each Child)

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	200

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	3.66	3.66	Spouse $10,000 Each Child $4,000

Cecil H. Underwood
Governor

Robert L. Ayers, ARM
Executive Director

WV Toll-free: 1-888-680-PEIA • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: www.peia.state.wv.us

Memorandum

To: Insurance Coordinators

From: Kimberly Covert KC
Chief Financial Officer

Date: August 9,2000

Re: Optional Life Premium Rate Tables / Early Warning Report

Due to positive claims experience in the optional life insurance program, rates are being reduced by 7%. If actual claims experience again increases, rates will be adjusted accordingly in the future.

Please find enclosed a listing of policyholders whose optional life premium will change on September 1, 2000. Also enclosed are new rate tables for optional life and dependent life that should be incorporated into your PEIA Rate Table Manual. New pages, with new page numbers, through dates and an effective date of September 1, 2000, are to be added to your current manual. These new premium amounts will be billed for policyholders that are enrolled in optional and dependent life insurance on your agency September invoice.

State Capitol Complex • Building 5, Room 1001 • 1900 Kanawha Boulevard, E. • Charleston, WV 25305-0710

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.7
		Page Date	2000.0808

Policyholder	☐ Active Employee	☐ COBRA Participant	☒ Retiree/Survivor
	☒ State	☐ Non-State	
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 1
(Face Value $5,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	100

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.33	.33	Face Value $5,000
30 – 34	.00	.39	.39	
35 – 39	.00	.50	.50	
40 – 44	.00	.87	.87	
45 – 49	.00	1.20	1.20	
50 – 54	.00	1.89	1.89	
55 – 59	.00	3.16	3.16	
60 – 64	.00	4.54	4.54	
65 – 69	.00	4.72	4.72	Face Value $3,250
70 and up	.00	9.75	9.75	Face Value $2,250

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.8
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 2
(Face Value $10,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	200

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.66	.66	Face Value $10,000
30 - 34	.00	.78	.78	
35 - 39	.00	.99	.99	
40 - 44	.00	1.73	1.73	
45 - 49	.00	2.40	2.40	
50 - 54	.00	3.77	3.77	
55 - 59	.00	6.32	6.32	
60 - 64	.00	9.08	9.08	
65 - 69	.00	9.44	9.44	Face Value $6,500
70 and up	.00	19.49	19.49	Face Value $4,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.9
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 3
(Face Value $20,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	300

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.32	1.32	Face Value $20,000
30 - 34	.00	1.56	1.56	
35 - 39	.00	1.98	1.98	
40 - 44	.00	3.46	3.46	
45 - 49	.00	4.80	4.80	
50 - 54	.00	7.54	7.54	
55 - 59	.00	12.64	12.64	
60 - 64	.00	18.16	18.16	
65 - 69	.00	18.88	18.88	Face Value $13,000
70 and up	.00	38.99	38.99	Face Value $9,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 4
(Face Value $30,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	400

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.98	1.98	Face Value $30,000
30 - 34	.00	2.34	2.34	
35 - 39	.00	2.97	2.97	
40 - 44	.00	5.19	5.19	
45 - 49	.00	7.20	7.20	
50 - 54	.00	11.31	11.31	
55 - 59	.00	18.96	18.96	
60 - 64	.00	27.24	27.24	
65 - 69	.00	28.31	28.31	Face Value $19,500
70 and up	.00	58.48	58.48	Face Value $13,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.11
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 5
(Face Value $40,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	500

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	2.64	2.64	Face Value $40,000
30 - 34	.00	3.12	3.12	
35 - 39	.00	3.96	3.96	
40 - 44	.00	6.92	6.92	
45 - 49	.00	9.60	9.60	
50 - 54	.00	15.08	15.08	
55 - 59	.00	25.28	25.28	
60 - 64	.00	36.32	36.32	
65 - 69	.00	37.75	37.75	Face Value $26,000
70 and up	.00	77.98	77.98	Face Value $18,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.12
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 6
(Face Value $50,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	600

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.30	3.30	Face Value $50,000
30 - 34	.00	3.90	3.90	
35 - 39	.00	4.95	4.95	
40 - 44	.00	8.65	8.65	
45 - 49	.00	12.00	12.00	
50 - 54	.00	18.85	18.85	
55 - 59	.00	31.60	31.60	
60 - 64	.00	45.40	45.40	
65 - 69	.00	47.19	47.19	Face Value $32,500
70 and up	.00	97.47	97.47	Face Value $22,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 7
(Face Value $75,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	700

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	4.95	4.95	Face Value $75,000
30 - 34	.00	5.85	5.85	
35 - 39	.00	7.43	7.43	
40 - 44	.00	12.98	12.98	
45 - 49	.00	18.00	18.00	
50 - 54	.00	28.28	28.28	
55 - 59	.00	47.40	47.40	
60 - 64	.00	68.10	68.10	
65 - 69	.00	70.79	70.79	Face Value $48,750
70 and up	.00	146.20	146.20	Face Value $33,750

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.14
		Page Date	2000.0808

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 1
(Face Value $5,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	100

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.30	.30	Face Value $5,000
30 – 34	.00	.36	.36	
35 – 39	.00	.46	.46	
40 – 44	.00	.80	.80	
45 – 49	.00	1.12	1.12	
50 – 54	.00	1.76	1.76	
55 – 59	.00	2.94	2.94	
60 – 64	.00	4.22	4.22	
65 – 69	.00	4.38	4.38	Face Value $3,250
70 and up	.00	9.06	9.06	Face Value $2,250

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.15
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 2
(Face Value $10,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	200

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.62	.62	Face Value $10,000
30 - 34	.00	.72	.72	
35 - 39	.00	.92	.92	
40 - 44	.00	1.60	1.60	
45 - 49	.00	2.24	2.24	
50 - 54	.00	3.50	3.50	
55 - 59	.00	5.88	5.88	
60 - 64	.00	8.44	8.44	
65 - 69	.00	8.78	8.78	Face Value $6,500
70 and up	.00	18.12	18.12	Face Value $4,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 3
(Face Value $20,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	300

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.22	1.22	Face Value $20,000
30 - 34	.00	1.46	1.46	
35 - 39	.00	1.84	1.84	
40 - 44	.00	3.22	3.22	
45 - 49	.00	4.46	4.46	
50 - 54	.00	7.02	7.02	
55 - 59	.00	11.76	11.76	
60 - 64	.00	16.88	16.88	
65 - 69	.00	17.56	17.56	Face Value $13,000
70 and up	.00	36.26	36.26	Face Value $9,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE

Page No.	S.R.3.17
Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 4
(Face Value $30,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	400

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.84	1.84	Face Value $30,000
30 - 34	.00	2.18	2.18	
35 - 39	.00	2.76	2.76	
40 - 44	.00	4.82	4.82	
45 - 49	.00	6.70	6.70	
50 - 54	.00	10.52	10.52	
55 - 59	.00	17.64	17.64	
60 - 64	.00	25.34	25.34	
65 - 69	.00	26.32	26.32	Face Value $19,500
70 and up	.00	54.38	54.38	Face Value $13,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 5
(Face Value $40,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	500

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	2.46	2.46	Face Value $40,000
30 - 34	.00	2.90	2.90	
35 - 39	.00	3.68	3.68	
40 - 44	.00	6.44	6.44	
45 - 49	.00	8.92	8.92	
50 - 54	.00	14.02	14.02	
55 - 59	.00	23.52	23.52	
60 - 64	.00	33.78	33.78	
65 - 69	.00	35.10	35.10	Face Value $26,000
70 and up	.00	72.52	72.52	Face Value $18,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.R.3.19
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 6
(Face Value $50,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	600

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.06	3.06	Face Value $50,000
30 - 34	.00	3.62	3.62	
35 - 39	.00	4.60	4.60	
40 - 44	.00	8.04	8.04	
45 - 49	.00	11.16	11.16	
50 - 54	.00	17.54	17.54	
55 - 59	.00	29.38	29.38	
60 - 64	.00	42.22	42.22	
65 - 69	.00	43.88	43.88	Face Value $32,500
70 and up	.00	90.64	90.64	Face Value $22,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 7
(Face Value $75,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	700

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	4.60	4.60	Face Value $75,000
30 - 34	.00	5.44	5.44	
35 - 39	.00	6.90	6.90	
40 - 44	.00	12.08	12.08	
45 - 49	.00	16.74	16.74	
50 - 54	.00	26.30	26.30	
55 - 59	.00	44.08	44.08	
60 - 64	.00	63.34	63.34	
65 - 69	.00	65.84	65.84	Face Value $48,750
70 and up	.00	135.96	135.96	Face Value $33,750

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	4. DEPENDENT LIFE	Page No.	S.R.4.2
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

DEPENDENT LIFE PLAN 1
(Face Value $5,000 Spouse, $2,000 Each Child)

This coverage is available to retirees only, not to survivors. The applicable coverage and option codes for this plan are as follows:

Dependent Life Coverage Code	LD01

Option	100

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	2.46	2.46	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE	Page No.	S.R.4.3
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

DEPENDENT LIFE PLAN 2
(Face Value $10,000 Spouse, $4,000 Each Child)

This coverage is available to retirees only, not to survivors. The applicable coverage and option codes for this plan are as follows:

Dependent Life Coverage Code	LD01

Option	200

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	4.92	4.92	Spouse $10,000 Each Child $4,000

Coverage	4. DEPENDENT LIFE	Page No.	S.R.4.4
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

DEPENDENT LIFE PLAN 1
(Face Value $5,000 Spouse, $2,000 Each Child)

This coverage is available to retirees only, not to survivors. The applicable coverage and option codes for this plan are as follows:

Dependent Life Coverage Code	LD01

Option	100

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	2.28	2.28	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE	Page No.	S.R.4.5
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

DEPENDENT LIFE PLAN 2
(Face Value $10,000 Spouse, $4,000 Each Child)

This coverage is available to retirees only, not to survivors. The applicable coverage and option codes for this plan are as follows:

Dependent Life Coverage Code	LD01

Option	200

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	4.58	4.58	Spouse $10,000 Each Child $4,000

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.7
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 1
(Face Value $5,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	100
Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.42	.42	Face Value $5,000
30 - 34	.00	.46	.46	
35 - 39	.00	.54	.54	
40 - 44	.00	.86	.86	
45 - 49	.00	1.10	1.10	
50 - 54	.00	1.64	1.64	
55 - 59	.00	2.66	2.66	
60 - 64	.00	3.76	3.76	
65 - 69	.00	3.84	3.84	Face Value $3,250
70 and up	.00	7.84	7.84	Face Value $2,250

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 2
(Face Value $10,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	200

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.82	.82	Face Value $10,000
30 - 34	.00	.90	.90	
35 - 39	.00	1.08	1.08	
40 - 44	.00	1.70	1.70	
45 - 49	.00	2.20	2.20	
50 - 54	.00	3.28	3.28	
55 - 59	.00	5.32	5.32	
60 - 64	.00	7.52	7.52	
65 - 69	.00	7.70	7.70	Face Value $6,500
70 and up	.00	15.68	15.68	Face Value $4,500

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.9
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 3
(Face Value $20,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	300

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.62	1.62	Face Value $20,000
30 - 34	.00	1.80	1.80	
35 - 39	.00	2.16	2.16	
40 - 44	.00	3.40	3.40	
45 - 49	.00	4.38	4.38	
50 - 54	.00	6.56	6.56	
55 - 59	.00	10.64	10.64	
60 - 64	.00	15.04	15.04	
65 - 69	.00	15.38	15.38	Face Value $13,000
70 and up	.00	31.38	31.38	Face Value $9,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 4
(Face Value $30,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	400

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	2.44	2.44	Face Value $30,000
30 - 34	.00	2.70	2.70	
35 - 39	.00	3.24	3.24	
40 - 44	.00	5.10	5.10	
45 - 49	.00	6.58	6.58	
50 - 54	.00	9.84	9.84	
55 - 59	.00	15.96	15.96	
60 - 64	.00	22.56	22.56	
65 - 69	.00	23.08	23.08	Face Value $19,500
70 and up	.00	47.06	47.06	Face Value $13,500

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 5
(Face Value $40,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	500

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.24	3.24	Face Value $40,000
30 - 34	.00	3.60	3.60	
35 - 39	.00	4.32	4.32	
40 - 44	.00	6.80	6.80	
45 - 49	.00	8.76	8.76	
50 - 54	.00	13.12	13.12	
55 - 59	.00	21.28	21.28	
60 - 64	.00	30.08	30.08	
65 - 69	.00	30.76	30.76	Face Value $26,000
70 and up	.00	62.74	62.74	Face Value $18,000

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 6
(Face Value $50,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	600

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	4.06	4.06	Face Value $50,000
30 - 34	.00	4.50	4.50	
35 - 39	.00	5.40	5.40	
40 - 44	.00	8.50	8.50	
45 - 49	.00	10.96	10.96	
50 - 54	.00	16.40	16.40	
55 - 59	.00	26.60	26.60	
60 - 64	.00	37.60	37.60	
65 - 69	.00	38.46	38.46	Face Value $32,500
70 and up	.00	78.42	78.42	Face Value $22,500

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 7
(Face Value $75,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	700

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	6.08	6.08	Face Value $75,000
30 - 34	.00	6.76	6.76	
35 - 39	.00	8.10	8.10	
40 - 44	.00	12.76	12.76	
45 - 49	.00	16.44	16.44	
50 - 54	.00	24.60	24.60	
55 - 59	.00	39.90	39.90	
60 - 64	.00	56.40	56.40	
65 - 69	.00	57.68	57.68	Face Value $48,750
70 and up	.00	117.62	117.62	Face Value $33,750

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 8
(Face Value $100,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	800

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	8.10	8.10	Face Value $100,000
30 - 34	.00	9.00	9.00	
35 - 39	.00	10.80	10.80	
40 - 44	.00	17.00	17.00	
45 - 49	.00	21.90	21.90	
50 - 54	.00	32.80	32.80	
55 - 59	.00	53.20	53.20	
60 - 64	.00	75.20	75.20	
65 - 69	.00	76.90	76.90	Face Value $65,000
70 and up	.00	156.84	156.84	Face Value $45,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.15
		Page Date	200.0808

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 9
(Face Value $150,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	900

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	12.16	12.16	Face Value $150,000
30 - 34	.00	13.50	13.50	
35 - 39	.00	16.20	16.20	
40 - 44	.00	25.50	25.50	
45 - 49	.00	32.86	32.86	
50 - 54	.00	49.20	49.20	
55 - 59	.00	79.80	79.80	
60 - 64	.00	112.80	112.80	
65 - 69	.00	115.34	115.34	Face Value $97,500
70 and up	.00	235.24	235.24	Face Value $67,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 10
(Face Value $200,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	950

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	16.20	16.20	Face Value $200,000
30 - 34	.00	18.00	18.00	
35 - 39	.00	21.60	21.60	
40 - 44	.00	34.00	34.00	
45 - 49	.00	43.80	43.80	
50 - 54	.00	65.60	65.60	
55 - 59	.00	106.40	106.40	
60 - 64	.00	150.40	150.40	
65 - 69	.00	153.80	153.80	Face Value $130,000
70 and up	.00	313.66	313.66	Face Value $90,000

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.17
		Page Date	2000.0808

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 1
(Face Value $5,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	100
Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.40	.40	Face Value $5,000
30 - 34	.00	.42	.42	
35 - 39	.00	.50	.50	
40 - 44	.00	.80	.80	
45 - 49	.00	1.02	1.02	
50 - 54	.00	1.52	1.52	
55 - 59	.00	2.48	2.48	
60 - 64	.00	3.50	3.50	
65 - 69	.00	3.58	3.58	Face Value $3,250
70 and up	.00	7.30	7.30	Face Value $2,250

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.18
		Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☒ State	☐ Non-State	
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 2
(Face Value $10,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	200
Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.76	.76	Face Value $10,000
30 - 34	.00	.84	.84	
35 - 39	.00	1.00	1.00	
40 - 44	.00	1.58	1.58	
45 - 49	.00	2.04	2.04	
50 - 54	.00	3.06	3.06	
55 - 59	.00	4.94	4.94	
60 - 64	.00	7.00	7.00	
65 - 69	.00	7.16	7.16	Face Value $6,500
70 and up	.00	14.58	14.58	Face Value $4,500

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.19
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 3
(Face Value $20,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	300

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.50	1.50	Face Value $20,000
30 - 34	.00	1.68	1.68	
35 - 39	.00	2.00	2.00	
40 - 44	.00	3.16	3.16	
45 - 49	.00	4.08	4.08	
50 - 54	.00	6.10	6.10	
55 - 59	.00	9.90	9.90	
60 - 64	.00	13.98	13.98	
65 - 69	.00	14.30	14.30	Face Value $13,000
70 and up	.00	29.18	29.18	Face Value $9,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 4
(Face Value $30,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	400

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	2.26	2.26	Face Value $30,000
30 - 34	.00	2.52	2.52	
35 - 39	.00	3.02	3.02	
40 - 44	.00	4.74	4.74	
45 - 49	.00	6.12	6.12	
50 - 54	.00	9.16	9.16	
55 - 59	.00	14.84	14.84	
60 - 64	.00	20.98	20.98	
65 - 69	.00	21.46	21.46	Face Value $19,500
70 and up	.00	43.76	43.76	Face Value $13,500

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.21
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 5
(Face Value $40,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	500

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.02	3.02	Face Value $40,000
30 - 34	.00	3.34	3.34	
35 - 39	.00	4.02	4.02	
40 - 44	.00	6.32	6.32	
45 - 49	.00	8.14	8.14	
50 - 54	.00	12.20	12.20	
55 - 59	.00	19.80	19.80	
60 - 64	.00	27.98	27.98	
65 - 69	.00	28.60	28.60	Face Value $26,000
70 and up	.00	58.34	58.34	Face Value $18,000

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 6
(Face Value $50,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	600

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.78	3.78	Face Value $50,000
30 - 34	.00	4.18	4.18	
35 - 39	.00	5.02	5.02	
40 - 44	.00	7.90	7.90	
45 - 49	.00	10.20	10.20	
50 - 54	.00	15.26	15.26	
55 - 59	.00	24.74	24.74	
60 - 64	.00	34.96	34.96	
65 - 69	.00	35.76	35.76	Face Value $32,500
70 and up	.00	72.94	72.94	Face Value $22,500

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.23
		Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☒ State	☐ Non-State	
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 7
(Face Value $75,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	700

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	5.66	5.66	Face Value $75,000
30 - 34	.00	6.28	6.28	
35 - 39	.00	7.54	7.54	
40 - 44	.00	11.86	11.86	
45 - 49	.00	15.28	15.28	
50 - 54	.00	22.88	22.88	
55 - 59	.00	37.10	37.10	
60 - 64	.00	52.46	52.46	
65 - 69	.00	53.64	53.64	Face Value $48,750
70 and up	.00	109.38	109.38	Face Value $33,750

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.24
		Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☒ State	☐ Non-State	
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 8
(Face Value $100,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	800

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	7.54	7.54	Face Value $100,000
30 - 34	.00	8.38	8.38	
35 - 39	.00	10.04	10.04	
40 - 44	.00	15.82	15.82	
45 - 49	.00	20.36	20.36	
50 - 54	.00	30.50	30.50	
55 - 59	.00	49.48	49.48	
60 - 64	.00	69.94	69.94	
65 - 69	.00	71.52	71.52	Face Value $65,000
70 and up	.00	145.86	145.86	Face Value $45,000

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.25
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 9
(Face Value $150,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	900

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	11.30	11.30	Face Value $150,000
30 - 34	.00	12.56	12.56	
35 - 39	.00	15.06	15.06	
40 - 44	.00	23.72	23.72	
45 - 49	.00	30.56	30.56	
50 - 54	.00	45.76	45.76	
55 - 59	.00	74.22	74.22	
60 - 64	.00	104.90	104.90	
65 - 69	.00	107.26	107.26	Face Value $97,500
70 and up	.00	218.78	218.78	Face Value $67,500

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	S.A.3.26
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 10
(Face Value $200,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	950

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	15.06	15.06	Face Value $200,000
30 - 34	.00	16.74	16.74	
35 - 39	.00	20.08	20.08	
40 - 44	.00	31.62	31.62	
45 - 49	.00	40.74	40.74	
50 - 54	.00	61.00	61.00	
55 - 59	.00	98.96	98.96	
60 - 64	.00	139.88	139.88	
65 - 69	.00	143.04	143.04	Face Value $130,000
70 and up	.00	291.70	291.70	Face Value $90,000

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	4. DEPENDENT LIFE	Page No.	S.A.4.1
		Page Date	1997.04.01

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1990.09.01	Through	1997.06.30

DEPENDENT LIFE PLAN

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	(none)

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	1.82	1.82	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE	Page No.	S.A.4.2
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

DEPENDENT LIFE PLAN 1
(Face Value $5,000 Spouse, $2,000 Each Child)

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	100

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	1.97	1.97	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE	Page No.	S.A.4.3
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

DEPENDENT LIFE PLAN 2
(Face Value $10,000 Spouse, $4,000 Each Child)

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	200

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	3.94	3.94	Spouse $10,000 Each Child $4,000

Coverage	4. DEPENDENT LIFE

Page No.	S.A.4.4
Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

DEPENDENT LIFE PLAN 1
(Face Value $5,000 Spouse, $2,000 Each Child)

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	100

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	1.84	1.84	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE	Page No.	S.A.4.5
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☒ State ☐ Non-State		
Premium Effective Dates	2000.09.01	Through	

DEPENDENT LIFE PLAN 2
(Face Value $10,000 Spouse, $4,000 Each Child)

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	200

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	3.66	3.66	Spouse $10,000 Each Child $4,000

Cecil H. Underwood
Governor

Robert L. Ayers, ARM
Executive Director

WV Toll-free: 1-888-680-PEIA • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: www.peia.state.wv.us

Memorandum

To: Insurance Coordinators

From: Kimberly Covert KC
Chief Financial Officer

Date: August 9,2000

Re: Optional Life Premium Rate Tables / Early Warning Report

Due to positive claims experience in the optional life insurance program, rates are being reduced by 7%. If actual claims experience again increases, rates will be adjusted accordingly in the future.

Please find enclosed a listing of policyholders whose optional life premium will change on September 1, 2000. Also enclosed are new rate tables for optional life and dependent life that should be incorporated into your PEIA Rate Table Manual. New pages, with new page numbers, through dates and an effective date of September 1, 2000, are to be added to your current manual. These new premium amounts will be billed for policyholders that are enrolled in optional and dependent life insurance on your agency September invoice.

State Capitol Complex • Building 5, Room 1001 • 1900 Kanawha Boulevard, E. • Charleston, WV 25305-0710

OPTIONAL LIFE PLAN 1
(Face Value $5,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	100

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.42	.42	Face Value $5,000
30 - 34	.00	.46	.46	
35 - 39	.00	.54	.54	
40 - 44	.00	.86	.86	
45 - 49	.00	1.10	1.10	
50 - 54	.00	1.64	1.64	
55 - 59	.00	2.66	2.66	
60 - 64	.00	3.76	3.76	
65 - 69	.00	3.84	3.84	Face Value $3,250
70 and up	.00	7.84	7.84	Face Value $2,250

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.A.3.8
		Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	

Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 2
(Face Value $10,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	200

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.82	.82	Face Value $10,000
30 – 34	.00	.90	.90	
35 – 39	.00	1.08	1.08	
40 – 44	.00	1.70	1.70	
45 – 49	.00	2.20	2.20	
50 – 54	.00	3.28	3.28	
55 – 59	.00	5.32	5.32	
60 – 64	.00	7.52	7.52	
65 – 69	.00	7.70	7.70	Face Value $6,500
70 and up	.00	15.68	15.68	Face Value $4,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 3
(Face Value $20,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	300

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.62	1.62	Face Value $20,000
30 - 34	.00	1.80	1.80	
35 - 39	.00	2.16	2.16	
40 - 44	.00	3.40	3.40	
45 - 49	.00	4.38	4.38	
50 - 54	.00	6.56	6.56	
55 - 59	.00	10.64	10.64	
60 - 64	.00	15.04	15.04	
65 - 69	.00	15.38	15.38	Face Value $13,000
70 and up	.00	31.38	31.38	Face Value $9,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.A.3.10
		Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	

Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 4
(Face Value $30,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	400

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	2.44	2.44	Face Value $30,000
30 - 34	.00	2.70	2.70	
35 - 39	.00	3.24	3.24	
40 - 44	.00	5.10	5.10	
45 - 49	.00	6.58	6.58	
50 - 54	.00	9.84	9.84	
55 - 59	.00	15.96	15.96	
60 - 64	.00	22.56	22.56	
65 - 69	.00	23.08	23.08	Face Value $19,500
70 and up	.00	47.06	47.06	Face Value $13,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 5
(Face Value $40,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	500

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.24	3.24	Face Value $40,000
30 - 34	.00	3.60	3.60	
35 - 39	.00	4.32	4.32	
40 - 44	.00	6.80	6.80	
45 - 49	.00	8.76	8.76	
50 - 54	.00	13.12	13.12	
55 - 59	.00	21.28	21.28	
60 - 64	.00	30.08	30.08	
65 - 69	.00	30.76	30.76	Face Value $26,000
70 and up	.00	62.74	62.74	Face Value $18,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.A.3.12
		Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	

Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 6
(Face Value $50,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	600

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	4.06	4.06	Face Value $50,000
30 - 34	.00	4.50	4.50	
35 - 39	.00	5.40	5.40	
40 - 44	.00	8.50	8.50	
45 - 49	.00	10.96	10.96	
50 - 54	.00	16.40	16.40	
55 - 59	.00	26.60	26.60	
60 - 64	.00	37.60	37.60	
65 - 69	.00	38.46	38.46	Face Value $32,500
70 and up	.00	78.42	78.42	Face Value $22,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.A.3.13
		Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	

Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 7
(Face Value $75,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	700

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	6.08	6.08	Face Value $75,000
30 - 34	.00	6.76	6.76	
35 - 39	.00	8.10	8.10	
40 - 44	.00	12.76	12.76	
45 - 49	.00	16.44	16.44	
50 - 54	.00	24.60	24.60	
55 - 59	.00	39.90	39.90	
60 - 64	.00	56.40	56.40	
65 - 69	.00	57.68	57.68	Face Value $48,750
70 and up	.00	117.62	117.62	Face Value $33,750

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 8
(Face Value $100,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	800

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	8.10	8.10	Face Value $100,000
30 - 34	.00	9.00	9.00	
35 - 39	.00	10.80	10.80	
40 - 44	.00	17.00	17.00	
45 - 49	.00	21.90	21.90	
50 - 54	.00	32.80	32.80	
55 - 59	.00	53.20	53.20	
60 - 64	.00	75.20	75.20	
65 - 69	.00	76.90	76.90	Face Value $65,000
70 and up	.00	156.84	156.84	Face Value $45,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 9
(Face Value $150,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	900

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	12.16	12.16	Face Value $150,000
30 - 34	.00	13.50	13.50	
35 - 39	.00	16.20	16.20	
40 - 44	.00	25.50	25.50	
45 - 49	.00	32.86	32.86	
50 - 54	.00	49.20	49.20	
55 - 59	.00	79.80	79.80	
60 - 64	.00	112.80	112.80	
65 - 69	.00	115.34	115.34	Face Value $97,500
70 and up	.00	235.24	235.24	Face Value $67,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 10
(Face Value $200,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	950

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	16.20	16.20	Face Value $200,000
30 - 34	.00	18.00	18.00	
35 - 39	.00	21.60	21.60	
40 - 44	.00	34.00	34.00	
45 - 49	.00	43.80	43.80	
50 - 54	.00	65.60	65.60	
55 - 59	.00	106.40	106.40	
60 - 64	.00	150.40	150.40	
65 - 69	.00	153.80	153.80	Face Value $130,000
70 and up	.00	313.66	313.66	Face Value $90,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.A.3.17
		Page Date	2000.0808

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 1
(Face Value $5,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	100

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.40	.40	Face Value $5,000
30 - 34	.00	.42	.42	
35 - 39	.00	.50	.50	
40 - 44	.00	.80	.80	
45 - 49	.00	1.02	1.02	
50 - 54	.00	1.52	1.52	
55 - 59	.00	2.48	2.48	
60 - 64	.00	3.50	3.50	
65 - 69	.00	3.58	3.58	Face Value $3,250
70 and up	.00	7.30	7.30	Face Value $2,250

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 2
(Face Value $10,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	200

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.76	.76	Face Value $10,000
30 - 34	.00	.84	.84	
35 - 39	.00	1.00	1.00	
40 - 44	.00	1.58	1.58	
45 - 49	.00	2.04	2.04	
50 - 54	.00	3.06	3.06	
55 - 59	.00	4.94	4.94	
60 - 64	.00	7.00	7.00	
65 - 69	.00	7.16	7.16	Face Value $6,500
70 and up	.00	14.58	14.58	Face Value $4,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 3
(Face Value $20,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	300

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.50	1.50	Face Value $20,000
30 - 34	.00	1.68	1.68	
35 - 39	.00	2.00	2.00	
40 - 44	.00	3.16	3.16	
45 - 49	.00	4.08	4.08	
50 - 54	.00	6.10	6.10	
55 - 59	.00	9.90	9.90	
60 - 64	.00	13.98	13.98	
65 - 69	.00	14.30	14.30	Face Value $13,000
70 and up	.00	29.18	29.18	Face Value $9,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 4
(Face Value $30,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	400

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	2.26	2.26	Face Value $30,000
30 - 34	.00	2.52	2.52	
35 - 39	.00	3.02	3.02	
40 – 44	.00	4.74	4.74	
45 - 49	.00	6.12	6.12	
50 - 54	.00	9.16	9.16	
55 - 59	.00	14.84	14.84	
60 - 64	.00	20.98	20.98	
65 - 69	.00	21.46	21.46	Face Value $19,500
70 and up	.00	43.76	43.76	Face Value $13,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 5
(Face Value $40,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	500

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.02	3.02	Face Value $40,000
30 - 34	.00	3.34	3.34	
35 - 39	.00	4.02	4.02	
40 - 44	.00	6.32	6.32	
45 - 49	.00	8.14	8.14	
50 - 54	.00	12.20	12.20	
55 - 59	.00	19.80	19.80	
60 - 64	.00	27.98	27.98	
65 - 69	.00	28.60	28.60	Face Value $26,000
70 and up	.00	58.34	58.34	Face Value $18,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 6
(Face Value $50,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	600

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.78	3.78	Face Value $50,000
30 - 34	.00	4.18	4.18	
35 - 39	.00	5.02	5.02	
40 - 44	.00	7.90	7.90	
45 - 49	.00	10.20	10.20	
50 - 54	.00	15.26	15.26	
55 - 59	.00	24.74	24.74	
60 - 64	.00	34.96	34.96	
65 - 69	.00	35.76	35.76	Face Value $32,500
70 and up	.00	72.94	72.94	Face Value $22,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.A.3.23
		Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 7
(Face Value $75,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	700

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	5.66	5.66	Face Value $75,000
30 - 34	.00	6.28	6.28	
35 - 39	.00	7.54	7.54	
40 - 44	.00	11.86	11.86	
45 - 49	.00	15.28	15.28	
50 - 54	.00	22.88	22.88	
55 - 59	.00	37.10	37.10	
60 - 64	.00	52.46	52.46	
65 - 69	.00	53.64	53.64	Face Value $48,750
70 and up	.00	109.38	109.38	Face Value $33,750

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.A.3.24
		Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 8
(Face Value $100,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	800

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	7.54	7.54	Face Value $100,000
30 - 34	.00	8.38	8.38	
35 - 39	.00	10.04	10.04	
40 - 44	.00	15.82	15.82	
45 - 49	.00	20.36	20.36 ✓	
50 - 54	.00	30.50	30.50	
55 - 59	.00	49.48	49.48	
60 - 64	.00	69.94	69.94	
65 - 69	.00	71.52	71.52	Face Value $65,000
70 and up	.00	145.86	145.86	Face Value $45,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.A.3.25
		Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 9
(Face Value $150,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	900

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	11.30	11.30	Face Value $150,000
30 - 34	.00	12.56	12.56	
35 - 39	.00	15.06	15.06	
40 - 44	.00	23.72	23.72	
45 - 49	.00	30.56	30.56	
50 - 54	.00	45.76	45.76	
55 - 59	.00	74.22	74.22	
60 - 64	.00	104.90	104.90	
65 - 69	.00	107.26	107.26	Face Value $97,500
70 and up	.00	218.78	218.78	Face Value $67,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.A.3.26
		Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 10
(Face Value $200,000 Through Age 64)

Policyholder optional life coverage for active employees includes policyholder accidental death and dismemberment (AD&D) coverage at the same face value. The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	950

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	15.06	15.06	Face Value $200,000
30 - 34	.00	16.74	16.74	
35 - 39	.00	20.08	20.08	
40 - 44	.00	31.62	31.62	
45 - 49	.00	40.74	40.74	
50 - 54	.00	61.00	61.00	
55 - 59	.00	98.96	98.96	
60 - 64	.00	139.88	139.88	
65 - 69	.00	143.04	143.04	Face Value $130,000
70 and up	.00	291.70	291.70	Face Value $90,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	4. DEPENDENT LIFE	Page No.	N.S.A.4.2
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

DEPENDENT LIFE PLAN 1
(Face Value $5,000 Spouse, $2,000 Each Child)

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	100

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	1.97	1.97	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE	Page No.	N.S.A.4.3
		Page Date	2000.08.08

Policyholder	☒ Active Employee ☐ COBRA Participant ☐ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

DEPENDENT LIFE PLAN 2
(Face Value $10,000 Spouse, $4,000 Each Child)

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	200

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	3.94	3.94	Spouse $10,000 Each Child $4,000

Coverage	4. DEPENDENT LIFE

Page No.	N.S.A.4.4
Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	

Premium Effective Dates	2000.09.01	Through	

DEPENDENT LIFE PLAN 1
(Face Value $5,000 Spouse, $2,000 Each Child)

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	100

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	1.84	1.84	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE

Page No.	N.S.A.4.5
Page Date	2000.08.08

Policyholder	☒ Active Employee	☐ COBRA Participant	☐ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2000.09.01	Through	

DEPENDENT LIFE PLAN 2
(Face Value $10,000 Spouse, $4,000 Each Child)

The applicable coverage and option codes are as follows:

Dependent Life Coverage Code	LD01

Option	200

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	3.66	3.66	Spouse $10,000 Each Child $4,000

OPTIONAL LIFE PLAN 1
(Face Value $5,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	100

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.33	.33	Face Value $5,000
30 – 34	.00	.39	.39	
35 – 39	.00	.50	.50	
40 – 44	.00	.87	.87	
45 – 49	.00	1.20	1.20	
50 – 54	.00	1.89	1.89	
55 – 59	.00	3.16	3.16	
60 – 64	.00	4.54	4.54	
65 – 69	.00	4.72	4.72	Face Value $3,250
70 and up	.00	9.75	9.75	Face Value $2,250

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.R.3.8
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 2
(Face Value $10,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	200

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.66	.66	Face Value $10,000
30 - 34	.00	.78	.78	
35 - 39	.00	.99	.99	
40 - 44	.00	1.73	1.73	
45 - 49	.00	2.40	2.40	
50 - 54	.00	3.77	3.77	
55 - 59	.00	6.32	6.32	
60 - 64	.00	9.08	9.08	
65 - 69	.00	9.44	9.44	Face Value $6,500
70 and up	.00	19.49	19.49	Face Value $4,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.R.3.9
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 3
(Face Value $20,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	300

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.32	1.32	Face Value $20,000
30 - 34	.00	1.56	1.56	
35 - 39	.00	1.98	1.98	
40 - 44	.00	3.46	3.46	
45 - 49	.00	4.80	4.80	
50 - 54	.00	7.54	7.54	
55 - 59	.00	12.64	12.64	
60 - 64	.00	18.16	18.16	
65 - 69	.00	18.88	18.88	Face Value $13,000
70 and up	.00	38.99	38.99	Face Value $9,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 4
(Face Value $30,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	400

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.98	1.98	Face Value $30,000
30 - 34	.00	2.34	2.34	
35 - 39	.00	2.97	2.97	
40 - 44	.00	5.19	5.19	
45 - 49	.00	7.20	7.20	
50 - 54	.00	11.31	11.31	
55 - 59	.00	18.96	18.96	
60 - 64	.00	27.24	27.24	
65 - 69	.00	28.31	28.31	Face Value $19,500
70 and up	.00	58.48	58.48	Face Value $13,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 5
(Face Value $40,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	500

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	2.64	2.64	Face Value $40,000
30 - 34	.00	3.12	3.12	
35 - 39	.00	3.96	3.96	
40 - 44	.00	6.92	6.92	
45 - 49	.00	9.60	9.60	
50 - 54	.00	15.08	15.08	
55 - 59	.00	25.28	25.28	
60 - 64	.00	36.32	36.32	
65 - 69	.00	37.75	37.75	Face Value $26,000
70 and up	.00	77.98	77.98	Face Value $18,000

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 6
(Face Value $50,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	600

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.30	3.30	Face Value $50,000
30 - 34	.00	3.90	3.90	
35 - 39	.00	4.95	4.95	
40 - 44	.00	8.65	8.65	
45 - 49	.00	12.00	12.00	
50 - 54	.00	18.85	18.85	
55 - 59	.00	31.60	31.60	
60 - 64	.00	45.40	45.40	
65 - 69	.00	47.19	47.19	Face Value $32,500
70 and up	.00	97.47	97.47	Face Value $22,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.R.3.13
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

OPTIONAL LIFE PLAN 7
(Face Value $75,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	700

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	4.95	4.95	Face Value $75,000
30 - 34	.00	5.85	5.85	
35 - 39	.00	7.43	7.43	
40 - 44	.00	12.98	12.98	
45 - 49	.00	18.00	18.00	
50 - 54	.00	28.28	28.28	
55 - 59	.00	47.40	47.40	
60 - 64	.00	68.10	68.10	
65 - 69	.00	70.79	70.79	Face Value $48,750
70 and up	.00	146.20	146.20	Face Value $33,750

---

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 1
(Face Value $5,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	100

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.30	.30	Face Value $5,000
30 – 34	.00	.36	.36	
35 – 39	.00	.46	.46	
40 – 44	.00	.80	.80	
45 – 49	.00	1.12	1.12	
50 – 54	.00	1.76	1.76	
55 – 59	.00	2.94	2.94	
60 – 64	.00	4.22	4.22	
65 – 69	.00	4.38	4.38	Face Value $3,250
70 and up	.00	9.06	9.06	Face Value $2,250

---

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 2
(Face Value $10,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	200

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	.62	.62	Face Value $10,000
30 - 34	.00	.72	.72	
35 - 39	.00	.92	.92	
40 - 44	.00	1.60	1.60	
45 - 49	.00	2.24	2.24	
50 - 54	.00	3.50	3.50	
55 - 59	.00	5.88	5.88	
60 - 64	.00	8.44	8.44	
65 - 69	.00	8.78	8.78	Face Value $6,500
70 and up	.00	18.12	18.12	Face Value $4,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.R.3.16
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 3
(Face Value $20,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	300

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.22	1.22	Face Value $20,000
30 - 34	.00	1.46	1.46	
35 - 39	.00	1.84	1.84	
40 - 44	.00	3.22	3.22	
45 - 49	.00	4.46	4.46	
50 - 54	.00	7.02	7.02	
55 - 59	.00	11.76	11.76	
60 - 64	.00	16.88	16.88	
65 - 69	.00	17.56	17.56	Face Value $13,000
70 and up	.00	36.26	36.26	Face Value $9,000

---

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 4
(Face Value $30,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	400

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	1.84	1.84	Face Value $30,000
30 - 34	.00	2.18	2.18	
35 - 39	.00	2.76	2.76	
40 - 44	.00	4.82	4.82	
45 - 49	.00	6.70	6.70	
50 - 54	.00	10.52	10.52	
55 - 59	.00	17.64	17.64	
60 - 64	.00	25.34	25.34	
65 - 69	.00	26.32	26.32	Face Value $19,500
70 and up	.00	54.38	54.38	Face Value $13,500

---

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 5
(Face Value $40,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	500

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	2.46	2.46	Face Value $40,000
30 - 34	.00	2.90	2.90	
35 - 39	.00	3.68	3.68	
40 - 44	.00	6.44	6.44	
45 - 49	.00	8.92	8.92	
50 - 54	.00	14.02	14.02	
55 - 59	.00	23.52	23.52	
60 - 64	.00	33.78	33.78	
65 - 69	.00	35.10	35.10	Face Value $26,000
70 and up	.00	72.52	72.52	Face Value $18,000

---

* The policyholder's age is the age that the policyholder was on the most recent past September 1.

OPTIONAL LIFE PLAN 6
(Face Value $50,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	600

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	3.06	3.06	Face Value $50,000
30 - 34	.00	3.62	3.62	
35 - 39	.00	4.60	4.60	
40 - 44	.00	8.04	8.04	
45 - 49	.00	11.16	11.16	
50 - 54	.00	17.54	17.54	
55 - 59	.00	29.38	29.38	
60 - 64	.00	42.22	42.22	
65 - 69	.00	43.88	43.88	Face Value $32,500
70 and up	.00	90.64	90.64	Face Value $22,500

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	3. POLICYHOLDER OPTIONAL LIFE	Page No.	N.S.R.3.20
		Page Date	2000.08.08

Policyholder	☐ Active Employee	☐ COBRA Participant	☒ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2000.09.01	Through	

OPTIONAL LIFE PLAN 7
(Face Value $75,000 Through Age 64)

Policyholder optional life coverage for retired employees does not include accidental death and dismemberment (AD&D) coverage. (Life insurance coverage is not available to survivors.) The applicable coverage and option codes for this plan are as follows:

Policyholder Optional Life Coverage Code	LO01	Option	700

Policyholder Optional AD&D Coverage Code	AO01	Option	(none)

Within the following table find the applicable policyholder age* in column (a) and record the corresponding policyholder portion and total monthly premium amounts from columns (c) and (d), respectively.

(a) Policyholder Age*	(b) Employer Portion	(c) Policyholder Portion	(d) Monthly Premium	(e) Comments
Under 30	.00	4.60	4.60	Face Value $75,000
30 - 34	.00	5.44	5.44	
35 - 39	.00	6.90	6.90	
40 - 44	.00	12.08	12.08	
45 - 49	.00	16.74	16.74	
50 - 54	.00	26.30	26.30	
55 - 59	.00	44.08	44.08	
60 - 64	.00	63.34	63.34	
65 - 69	.00	65.84	65.84	Face Value $48,750
70 and up	.00	135.96	135.96	Face Value $33,750

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* The policyholder's age is the age that the policyholder was on the most recent past September 1.

Coverage	4. DEPENDENT LIFE	Page No.	N.S.R.4.2
		Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

DEPENDENT LIFE PLAN 1
(Face Value $5,000 Spouse, $2,000 Each Child)

This coverage is available to retirees only, not to survivors. The applicable coverage and option codes for this plan are as follows:

Dependent Life Coverage Code	LD01

Option	100

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	2.46	2.46	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE

Page No.	N.S.R.4.3
Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	1997.07.01	Through	2000.08.31

DEPENDENT LIFE PLAN 2
(Face Value $10,000 Spouse, $4,000 Each Child)

This coverage is available to retirees only, not to survivors. The applicable coverage and option codes for this plan are as follows:

Dependent Life Coverage Code	LD01

Option	200

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	4.92	4.92	Spouse $10,000 Each Child $4,000

Coverage	4. DEPENDENT LIFE

Page No.	N.S.R.4.4
Page Date	2000.08.08

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retiree/Survivor ☐ State ☒ Non-State		
Premium Effective Dates	2000.09.01	Through	

DEPENDENT LIFE PLAN 1
(Face Value $5,000 Spouse, $2,000 Each Child)

This coverage is available to retirees only, not to survivors. The applicable coverage and option codes for this plan are as follows:

Dependent Life Coverage Code	LD01

Option	100

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	2.28	2.28	Spouse $5,000 Each Child $2,000

Coverage	4. DEPENDENT LIFE

Page No.	N.S.R.4.5
Page Date	2000.08.08

Policyholder	☐ Active Employee	☐ COBRA Participant	☒ Retiree/Survivor
	☐ State	☒ Non-State	
Premium Effective Dates	2000.09.01	Through	

DEPENDENT LIFE PLAN 2
(Face Value $10,000 Spouse, $4,000 Each Child)

This coverage is available to retirees only, not to survivors. The applicable coverage and option codes for this plan are as follows:

Dependent Life Coverage Code	LD01

Option	200

(a) Employer Portion	(b) Policyholder Portion	(c) Monthly Premium	(d) Comments
.00	4.58	4.58	Spouse $10,000 Each Child $4,000

Bob Wise
Governor

Tom Susman
Director

WV Toll-free: 1-888-680-PEIA • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: www.peia.state.wv.us

MEMORANDUM

To: Insurance Coordinators
County Commissions

From: Tom Susman
Director

Date: May 7, 2002

Subject: **Premium Rate Tables For Retired Deputy Sheriffs (Before Attaining Age 55)**

The enclosed premium rate tables should be incorporated into your PEIA Rate Table Manual. New pages with new page numbers and an effective date of July 1, 2002, are to be added to your current manual.

The premiums are for deputy sheriffs who elect to retire before their fifty-fifth birthday. Once they reach age fifty-five, the regular retiree/surviving dependent premium rates will apply.

If you have any questions regarding the above matter, please contact your PEIA Premium Accounts Representative at (304) 558-7850, or toll free at (888) 680-7342.

TS/JE

Enclosures

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	D.S.1.13
		Page Date	2002.05.01

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retired Deputy Sheriff ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	

CARELINK MANAGED CARE PLANS
ENHANCED PLAN
(Includes Prescription Drug Coverage)

The Carelink Enhanced health maintenance organization (HMO) health plan option code is as follows:

Health Coverage Code	HMCL-1	Option	

For Deputy Sheriffs Electing to Take Early Retirement Prior to Age Fifty-Five.

Below is the table of premiums for the Carelink Enhanced health plan for Deputy Sheriffs that elect to take early retirement prior to their fifty-fifth birthday. This table is applicable only until the retired Deputy Sheriff attains the age of fifty-five, at which time, the retiree/survivor premiums will be used. Should a retired Deputy Sheriff die while on early retirement, and has not yet reached the age of fifty-five, the retiree/survivor premiums will also be used, regardless of the age of the retired Deputy Sheriff at the time of his/her death.

After determining that the retiring Deputy Sheriff has not attained the age of fifty-five at the time retirement begins, find within column (b) the appropriate tier, i.e., the family composition. If the tier is simply policyholder, then record the corresponding monthly premium amount from column (d). If the tier is policyholder and dependents(s), apply the monthly premium in column (d).

Table for Region 2 Policyholders

(a) Policyholder Medicare	(b) Tier	(d) Monthly Premiums
NO	Policyholder	672.00
	Policyholder and Dependent(s)	1,149.00

CARELINK MANAGED CARE PLANS
BASIC PLAN
(Includes Prescription Drug Coverage)

The Carelink Basic health maintenance organization (HMO) health plan option code is as follows:

Health Coverage Code	HMCL-2	Option	

For Deputy Sheriffs Electing to Take Early Retirement Prior to Age Fifty-Five.

Below is the table of premiums for the Carelink Basic health plan for Deputy Sheriffs that elect to take early retirement prior to their fifty-fifth birthday. This table is applicable only until the retired Deputy Sheriff attains the age of fifty-five, at which time, the retiree/survivor premiums will be used. Should a retired Deputy Sheriff die while on early retirement, and has not yet reached the age of fifty-five, the retiree/survivor premiums will also be used, regardless of the age of the retired Deputy Sheriff at the time of his/her death.

After determining that the retiring Deputy Sheriff has not attained the age of fifty-five at the time retirement begins, find within column (b) the appropriate tier, i.e., the family composition. If the tier is simply policyholder, then record the corresponding monthly premium amount from column (d). If the tier is policyholder and dependents(s), apply the monthly premium in column (d).

Table for Region 2 Policyholders

(a) Policyholder Medicare	(b) Tier	(d) Monthly Premiums
NO	Policyholder	638.00
	Policyholder and Dependent(s)	1,039.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	D.S.1.15
		Page Date	2002.05.01

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retired Deputy Sheriff ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	

THE HEALTH PLAN MANAGED CARE PLANS
OPTION A
(Includes Prescription Drug Coverage)

The Health Plan Option A health maintenance organization (HMO) health plan option code is as follows:

Health Coverage Code	HMHP-A	Option	

For Deputy Sheriffs Electing to Take Early Retirement Prior to Age Fifty-Five.

Below is the table of premiums for The Health Plan Option A health plan for Deputy Sheriffs that elect to take early retirement prior to their fifty-fifth birthday. This table is applicable only until the retired Deputy Sheriff attains the age of fifty-five, at which time, the retiree/survivor premiums will be used. Should a retired Deputy Sheriff die while on early retirement, and has not yet reached the age of fifty-five, the retiree/survivor premiums will also be used, regardless of the age of the retired Deputy Sheriff at the time of his/her death.

After determining that the retiring Deputy Sheriff has not attained the age of fifty-five at the time retirement begins, find within column (b) the appropriate tier, i.e., the family composition. If the tier is simply policyholder, then record the corresponding monthly premium amount from column (d). If the tier is policyholder and dependents(s), apply the monthly premium in column (d).

Table for Region 1 Policyholders

(a) Policyholder Medicare	(b) Tier	(d) Monthly Premiums
NO	Policyholder	591.00
	Policyholder and Dependent(s)	1,029.00

THE HEALTH PLAN MANAGED CARE PLANS
OPTION B
(Includes Prescription Drug Coverage)

The Health Plan Option B health maintenance organization (HMO) health plan option code is as follows:

Health Coverage Code	HMHP-B	Option	

For Deputy Sheriffs Electing to Take Early Retirement Prior to Age Fifty-Five.

Below is the table of premiums for The Health Plan Option B health plan for Deputy Sheriffs that elect to take early retirement prior to their fifty-fifth birthday. This table is applicable only until the retired Deputy Sheriff attains the age of fifty-five, at which time, the retiree/survivor premiums will be used. Should a retired Deputy Sheriff die while on early retirement, and has not yet reached the age of fifty-five, the retiree/survivor premiums will also be used, regardless of the age of the retired Deputy Sheriff at the time of his/her death.

After determining that the retiring Deputy Sheriff has not attained the age of fifty-five at the time retirement begins, find within column (b) the appropriate tier, i.e., the family composition. If the tier is simply policyholder, then record the corresponding monthly premium amount from column (d). If the tier is policyholder and dependents(s), apply the monthly premium in column (d).

Table for Region 1 Policyholders

(a) Policyholder Medicare	(b) Tier	(d) Monthly Premiums
NO	Policyholder	514.00
	Policyholder and Dependent(s)	890.00

Coverage	1. HEALTH AND PRESCRIPTION DRUG	Page No.	D.S.1.17
		Page Date	2002.05.01

Policyholder	☐ Active Employee ☐ COBRA Participant ☒ Retired Deputy Sheriff ☐ State ☒ Non-State		
Premium Effective Dates	2002.07.01	Through	

PEIA PPB PLAN A

(Includes Prescription Drug Coverage)

The PEIA PPB health plan option code is as follows:

Health Coverage Code	HI01

Option	

Below is the table of premiums for the PEIA PPB Plan A for Deputy Sheriffs that elect to take early retirement prior to their fifty-fifth birthday. This table is applicable only until the retired Deputy Sheriff attains the age of fifty-five, at which time, Table B or C of the retiree premiums will be used. Should a retired Deputy Sheriff die while on early retirement, and has not yet reached the age of fifty-five, Table A of the surviving dependents premiums will be used, regardless of the age of the retired Deputy Sheriff at the time of his/her death.

Table D -- For Deputy Sheriffs Electing to Take Early Retirement Prior to Age Fifty-Five.

After determining that the retiring Deputy Sheriff has not attained the age of fifty-five at the time retirement begins, find within column (b) the appropriate tier, i.e., the family composition. If the tier is simply policyholder, then record the corresponding monthly premium amount from column (c) Tobacco User, or (d) Tobacco Free. If the tier is policyholder and dependents(s), apply the monthly premium from column (c) Tobacco User, or (d) Tobacco Free.

Table for Region 1 Policyholders

(a) Policyholder Medicare	(b) Tier	(c) *Standard* Premium *(Tobacco User)*	(d) *Preferred* Premium *(Tobacco Free)*
NO	Policyholder	426.00	416.00
	Policyholder and Dependent(s)	1,017.00	997.00

PEIA PPB PLAN B

(Includes Prescription Drug Coverage)

The PEIA PPB health plan option code is as follows:

Health Coverage Code	HI02

Option	

Below is the table of premiums for the PEIA PPB Plan B for Deputy Sheriffs that elect to take early retirement prior to their fifty-fifth birthday. This table is applicable only until the retired Deputy Sheriff attains the age of fifty-five, at which time, Table B or C of the retiree premiums will be used. Should a retired Deputy Sheriff die while on early retirement, and has not yet reached the age of fifty-five, Table A of the surviving dependents premiums will be used, regardless of the age of the retired Deputy Sheriff at the time of his/her death.

Table D -- For Deputy Sheriffs Electing to Take Early Retirement Prior to Age Fifty-Five.

After determining that the retiring Deputy Sheriff has not attained the age of fifty-five at the time retirement begins, find within column (b) the appropriate tier, i.e., the family composition. If the tier is simply policyholder, then record the corresponding monthly premium amount from column (c) Tobacco User, or (d) Tobacco Free. If the tier is policyholder and dependents(s), apply the monthly premium from column (c) Tobacco User, or (d) Tobacco Free.

Table for Region 1 Policyholders

(a) Policyholder Medicare	(b) Tier	(c) *Standard* Premium *(Tobacco User)*	(d) *Preferred* Premium *(Tobacco Free)*
NO	Policyholder	218.00	208.00
	Policyholder and Dependent(s)	518.00	518.00

APPENDIX C

DEDUCTIBLES, COINSURANCE AND COPAYMENTS FOR MEDICAL BENEFITS PLAN

ANNUAL MEDICAL DEDUCTIBLES

PEIA PPB Plan In-Network Deductibles				
Annual Salary (state agencies, colleges, universities and county boards of education)	Employee Only	Employee & Child(ren)	Family	Family with Employee Spouse*
$ 0 - 20,000	$100	$200	$200	$200
$20,001 - 30,000	$150	$300	$300	$300
$30,001 - 36,000	$200	$400	$400	$400
$36,001 - 42,000	$225	$450	$450	$450
$42,001 - 50,000	$250	$500	$500	$500
$50,001 - 75,000	$375	$750	$750	$750
$75,001 - 100,000	$425	$850	$850	$850
$100,001 - 125,000	$500	$1,000	$1,000	$1,000
$125,001 +	$600	$1,200	$1,200	$1,200
Non-state Plan A	$225	N/A	$450	N/A
Non-State Plan B	$500	N/A	$1,000	N/A
Non-Medicare Retirees	$375	N/A	$750	N/A
Medicare Retirees	$150	N/A	$300	N/A

The out-of-network deductible is twice the in-network deductible listed above. The out-of-network deductible satisfies the in-network deductible, but the in-network deductible does not count toward the out-of-network deductible.

*Deductibles for Family with Employee Spouse coverage are based on the average of the two employee's salaries. Add the annual salaries together and divide by two to get the basis of the premium. This provision does not apply to local government agency or retired employees.

COINSURANCE FOR IN-NETWORK AND OUT-OF-NETWORK BENEFITS

	If you live in WV, you will pay:	If you live in a bordering county of a surrounding state, you will pay:	If you live out-of-state (beyond bordering counties), you will pay:
Access Care in WV or in a bordering county of a surrounding state using PPO providers	20% Coinsurance	20% Coinsurance	20% Coinsurance
Access care outside WV (beyond bordering counties) using PPO providers *with* prior approval	20% Coinsurance	20% Coinsurance	20% Coinsurance
Access care outside WV (beyond bordering counties) using non-PPO providers *with* prior approval	20% Coinsurance	20% Coinsurance	20% Coinsurance
Access care outside WV (beyond bordering counties) using PPO providers *without* prior approval	40% Coinsurance	40% Coinsurance	20% Coinsurance
Access care outside WV (beyond bordering counties) using non-PPO providers *without* prior approval	40% Coinsurance	40% Coinsurance	40% Coinsurance

SERVICES COVERED IN FULL

Type of Service	PPB Insured Responsibility
Routine Prenatal Care (Physician Services)	$0; Covered in full*
Well Child Exams and Immunizations	$0; Covered in full
High Risk Birth Score Program	$0; Covered in full
Annual Screening Mammogram	$0; Covered in full
Annual Pap Smear Test	$0; Covered in full ($10 preventive care office visit copay applies)
Colorectal Cancer Screening Test	$0; Covered in full ($10 preventive care office visit copay applies)
Prostate Cancer Screening Test	$0; Covered in full ($10 preventive care office visit copay applies)

*Deductible applies only if not met in hospital services.

SERVICES SUBJECT TO COPAYMENT ONLY

Type of Service	PPB Insured Responsibility
Physician Office Visits – preventive care	$10 copayment/visit with no deductible
Physician Office Visits – treat illness or injury	$15 copayment per visit with no deductible
Adult Routine Physical Exams	$10 copayment per visit with no deductible
Second Surgical Options*	$15 copayment/visit with no deductible

*No copayment if required by utilization management.

APPENDIX D

BENEFITS MAXIMUMS

Out-of-Pocket Maximum Amounts			
Employee Status	Employee's Annual Salary	Annual In-Network Out-of-Pocket Maximum	Annual Out-of-Network Out-of-Pocket Maximum
Active, State Agencies, Colleges and Universities, Boards of Education	$ 0 - 20,000	$800	$1,600
	$20,001 - 30,000	$1,100	$2,200
	$30,001 - 36,000	$1,250	$2,500
	$36,001 - 42,000	$1,500	$3,000
	$42,001 - 50,000	$1,750	$3,500
	$50,001 - 75,000	$1,800	$3,600
	$75,001 - 100,000	$1,900	$3,800
	$100,001 - 125,000	$2,000	$4,000
	$125,001 +	$2,250	$4,500
Non-State Plan A	Not applicable	$1,500	$3,000
Non-State Plan B	Not applicable	$1,000/single;$2,000/family	$2,000/single;$4,000/family
Retired, Non-Medicare	Not applicable	$1,500	$3,000
Retired, Medicare	Not applicable	$1,000	$1,000

ANNUAL BENEFIT MAXIMUMS

Annual Benefit Maximums	
Type of Service	Benefit Maximum (per member per plan year)
*Outpatient Mental Health/Chemical Dependency	20 visits
Christian Science Treatment	$1,000
*Outpatient Therapy Services: This benefit includes outpatient physical, occupational, massage, speech, and vision therapies, acupuncture and chiropractic care.	$1,000 (total amount allowed for all therapies combined)
Inpatient Rehabilitation	150 days
Skilled Nursing Facility	100 days

*Additional benefits may be recommended by Intracorp when medically necessary and appropriate. Approval must be obtained before additional services are rendered.

APPENDIX E

MEDICAL EQUIPMENT NOT COVERED

Examples of Durable Medical Equipment that are not covered expenses:

Bath Paraffin (Unit)
Bathroom Equipment:
- toilet seat
- commode
- scale
- bathtub seat, bathtub lift
- rail or grab bar

Bed Baths
Bed Boards
Breast Pump
Chair, Recliner or Autotilt
Chair Tables
Child's Stroller
Contour Chair
Diapers (Adult or infant)
Diathermy Machines
Earplugs or Molds
Electric Bed
Environmental Control
Equipment:
- air cleaner
- air filter
- air conditioner
- dehumidifier
- dust extractor
- air freshener
- humidifier
- sweeper

Enuresis Unit
Escalator, Elevator or Stair Lift
Exercise Bike, Stairmaster
Food Liquidizer/Food Processor
Hearing Aid
Heat Lamps
Heating Pad
Hydraulic Van or Car Lift
Ice Bag
Irrigating Kit
Language Master and other vocabulary assistance devices
Lift Chair
Massage Devices, Vibrators
Muscle Stimulators
Orthopedic Mattress
Percussion Packs
Professional Medical Equipment:
- blood pressure kit
- stethoscope, etc.

Pulse Tachometer
Rollabout Chairs
Room Heater (Portable)
Sauna Baths
Standing Tables
Telephone Arms
Thermometer
Trapeze Bar
Treadmill, Jogger
Walking Cane with Seat
Waterbed
Whirlpool or Hydro Massage Equipment
Wig, Wig Styling
Transfer Bars or Benches
Geri Chairs
Special Adaptive Equipment

Supplies such as tape, gauze, diapers, swabs, elastic bandages, and aspirin are not covered for any reason.

APPENDIX F

PEIA OUT-OF-STATE PPO PROGRAM

Preferred Provider Organizations

For services provided outside the State of West Virginia, the PEIA/Acordia National network principally utilizes three network relationships. In the State of Ohio, the network is Medical Mutual of Ohio's SuperMed Plus Network. In Maryland, Washington, D.C., and North Carolina, the network is the Alliance Network. For all other states, the network is Beech Street. These networks review their providers for quality standards such as licensing, background and treatment patterns. As part of their agreement with the network, the amount paid for services is a discounted amount. Remember, all services you receive out-of-state, other than services by a PPO provider in a county that borders West Virginia, must have prior approval in order to receive the highest level of benefit. However, if you are traveling out-of-state and you have an emergency or accident, go directly to the nearest provider for treatment without calling for approval first. Your medical identification card carries the logos for Alliance Network, Medical Mutual of Ohio's (MMO) SuperMed Plus Network and the Beech Street Network.

When receiving services, always follow these important steps:

1. Always carry your most current Identification Card.

2. When seeking services outside West Virginia and beyond the bordering counties, you must call Acordia National at (304) 353-7820 or (888) 440-7342 for prior approval to receive the highest level of benefits.

3. If you are experiencing an emergency or have an accident while outside of West Virginia or a bordering county, prior approval is not necessary to receive the highest level of benefits. If you are admitted to the hospital, you or your provider must call Intracorp within 48 hours of the admission.

4. If your out-of-state service is approved, please make sure your provider is a preferred provider with Alliance, MMO, or Beech Street.

5. Call Acordia National at (304) 353-7820 or (888) 440-7342 for network provider information.

6. When you arrive at the doctor's office or hospital, present your Identification Card, and the doctor or hospital will verify your membership and coverage information.

7. After you receive medical attention, your claim is routed to Acordia National.

8. All PPO providers are paid directly, relieving you of any hassle and worry. You will need to pay for out-of-pocket expenses (deductible, copayments, coinsurance and non-covered services). Acordia National will send you an Explanation of Benefits.

To locate providers in the PEIA/Acordia National Network, call Acordia National at (888) 440-7342.

APPENDIX G

COORDINATION OF PEIA'S BENEFITS WITH OTHER BENEFITS

I. APPLICABILITY

A. This Coordination of Benefits ("COB") provision applies to This Plan when an employee, retired employee or covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefit determination rules, another plan determines its benefits first. The above reduction is described in Section IV, "Effect on the Benefits of This Plan."

C. This Plan will never provide benefits as both a Primary Plan and a Secondary Plan for the same item of Allowable Expense incurred by the same person. No person may receive benefits for the same item of Allowable Expense from more than one PEIA-sponsored plan. "PEIA-sponsored plan" shall include both this Plan and any plan offered by an insurance company, health maintenance organization or other entity which has a contract with the PEIA to provide group medical benefits to PEIA-eligible employees and dependents.

D. This Plan will not coordinate benefits with any optional dental, vision or disability insurance offered through the PEIA-sponsored flexible benefits plan.

E. For any PEIA-insured person who is eligible for Medicare Parts A and B, This Plan will coordinate benefits as if the person has enrolled for both Part A and B coverage, regardless of whether or not the person has actually enrolled for such coverage.

II. DEFINITIONS

A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance and group subscriber contracts.

(2) Uninsured arrangements of group or group-type coverage.

(3) Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans.

(4) Group-type contract. Group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description are included in the definition of "Plan" whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, "franchise" or "blanket").

(5) The amount by which group or group-type hospital PPB benefits exceed $100 per day. Hospital PPB benefits are benefits not related to expenses incurred.

(6) The medical benefits coverage is group, group-type and individual automobile medical pay provisions; and

(7) Coverage under a governmental plan, or coverage required or provided by law. This does not include a State plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

(8) For purposes of Section III, Paragraph B (1)(b) only, "Plan" shall also include, for any person covered as a spouse or other dependent under This Plan (i.e., the PEIA Plan), individual hospital and surgical insurance coverage or individual major medical insurance coverage in which the spouse or dependent is the named insured or certificate holder and in which:

(a) The policy covers a specified disease, accident only, disability, or other limited benefits; and

(b) The policy is specifically designed, represented and sold as a supplement to other basic sickness and accident coverage; and

(c) The entire premium for the policy is paid by the insured or insured's family.

B. "This Plan" is the part of the PEIA group benefit plan that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan;" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Allowable Expenses under This Plan are calculated according to PEIA fee schedules, rates and payment policies.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because a covered person does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES

A. General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies;

(1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, retired employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent under this Plan:

(a) Where two employees, both eligible to enroll for PEIA coverage in their own names, are married to each other and are covered under one PEIA family plan (one spouse is treated as the named policyholder and the other as a dependent for purposes of these rules.

(b) W.Va. Code §5-16-13(a) provides that when a person is covered as a spouse or other dependent under the PEIA Plan, then "such spouse and dependent coverage shall be limited to excess or secondary coverage for each spouse and dependent who has primary coverage from any other source. For purposes of this section, the term 'primary coverage' means individual or group hospital and surgical insurance coverage or individual or group major medical insurance coverage or group prescription drug coverage in which the spouse or dependent is the named insured or certificate holder." Accordingly, whenever a person is covered under This Plan (i.e., the PEIA Plan) as a spouse or other dependent, and such person also has other individual or group hospital and surgical coverage or individual or group major medical coverage or group prescription drug coverage in which the person is the named insured or certificate holder, then This Plan shall be the Secondary Plan and such other plan of coverage shall be the Primary Plan and determine its benefits first.

(c) Where a spouse would be subject to both Paragraphs B(1)(a) and (b) above, then only (a) shall apply.

(d) Exception to the rule stated in Paragraph B(1) above: for retirees covered by the PEIA PPB Plan and Medicare, regardless of age, Medicare is primary and PEIA is secondary (this may not be applicable to Medicare End Stage Renal Disease benefits) and for PEIA PPB Plan active employees who are age 65 or older and eligible for Medicare PEIA PPB is usually primary.

(e) Exception to the rule stated in Paragraph B(1) above: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is (i) Secondary to the Plan covering the person as a dependent, and (ii) Primary to the Plan covering the person as other than a dependent (e.g., a retired employee), then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in Paragraph B(3) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents";

(a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year (considering only the month and day, and not the year, of birth); but

(b) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child or divorced or separated parents, benefits for the child are determined in this order;

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that person has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. The plan of the spouse of the parent with custody of the child shall be the Tertiary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge. For purposes of this paragraph, the PEIA will not be deemed to have actual knowledge of a court decree until actual receipt of a copy of that decree by the PEIA.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III B(2).

(5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is nether laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as the employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.

(6). Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (e.g., the Consolidated Omnibus Budget Reconciliation Act of 1987, as amended) or state law also as covered under another plan, the following shall be the order of benefit determination:

(a) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

(b) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(7) Longer/Shorter Length of Coverage. If none of the above rules determines the order of the benefits, the benefits of the Plan which covered an employee, retired employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

IV. EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of the COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds either: (a) one hundred percent (100%) of the actual charges by providers to the insured in a Claim Determination Period, or (b) the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision, depending on the type of PEIA coverage (see C. below) under which the person is covered. In these cases, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than either: (a) those actual charges, or (b) the benefits that would be payable under This Plan in the absence of this COB provision, depending on the type of PEIA coverage under which the person is covered.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any application benefit limit of This Plan.

C. Methods of Coordination. When This Plan is a Secondary Plan, there are two methods of calculating the amount which This Plan will pay. The method which will be applied depends upon the PEIA coverage the person has:

(1) **"Traditional" Method.** Under the traditional method of coordinating benefits, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than the actual charge.

The traditional method shall be used to coordinate benefits only for:

(a) Retired employees or their dependents who are covered under PEIA "Basic Plan;"

(b) Dependents of retired employees, for whom Medicare is the Primary Plan and who are covered under the PEIA "Basic Plan; and,

(c) Active employees or their dependents for whom Medicare is the Primary Plan (e.g., persons who are eligible for Medicare because of End Stage Renal Disease).

(2) **"Carve-out" Method.** Under the carve-out method of coordinating benefits, the benefits that would be payable under This Plan in the absence of this COB provision will be reduced by the benefits payable under the other plans. "Benefits payable under the other plans" shall include benefits that would have been payable had claim been duly made therefore.

The carve-out method shall be used to coordinate benefits for:

(a) Active employees and their dependents who are not included in Paragraph C (1) above ("Traditional" Method);

(b) Retired employees and their dependents who are enrolled in the PEIA "Basic Plan II," or PEIA "Catastrophic Plan," and

(c) Retired employees who are enrolled in the PEIA "Basic Plan," and their dependents who are not included in Paragraph C (1)(b) above.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. PEIA has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person to the extent reasonably necessary to apply these rules. To the

extent permissible under existing law and to the extent reasonably required PEIA need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give PEIA any facts it reasonably needs to pay the claim.

VI. FACILITY OF PAYMENT

A payment made under another plan may include any amount which should have been paid under This Plan. If it does, PEIA may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. PEIA will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. RIGHT OF RECOVERY

If the amount of the payments made by PEIA is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

PEIA shall have the right, after making reasonable attempts to collect from the person or entity to whom or for whom an overpayment has been made, to deduct the amount of the overpayment from other benefits or payments which are or may become payable to or on behalf of the person or entity to or for whom the overpayment was made.

APPENDIX H

ANNUAL PRESCRIPTION COPAYMENTS

Product Type	Express Scripts Network Drug Store (up to a 34-day supply)	Network Drug Store *Maintenance Medications Only* (up to a 90-day supply)	Non-Network Drug Store	Mail Service (up to a 34-day supply)	Mail Service *Maintenance Medications Only* (up to a 90-day supply)	Retail Maintenance Network *Maintenance Medications Only* (up to a 90-day supply)
Generic Drug	$5.00	$15.00	100%*	$5.00	$10.00	$10.00
Preferred Brand-Name Drug	$15.00	$45.00	100%*	$15.00	$30.00	$30.00
Non-Preferred Brand-Name Drug	$30.00	$90.00	100%*	$30.00	$60.00	$60.00

*If a prescription is filled at a drug store that is not a part of the current TPA-P's network, the insured will be responsible for the entire cost at the time of purchase. The claim can be submitted to the TPA-P for reimbursement of PEIA's allowed amount for the drug, which is based on the Average Wholesale Price (AWP) less the PEIA discount, minus the dispensing fee and a $3.00 processing fee.

COPAYMENTS (RETIREE DRUG COPAY ASSISTANCE)

As a PEIA member eligible for premium assistance, you (and your enrolled dependents) are also approved for prescription drug copayment assistance. This copayment assistance is available to retirees whose gross income is less than 250% of the Federal Poverty level.

Following is a chart listing your reduced copayments according to the years of service you have accrued.

Years of Active Service	New Brand Preferred Copayment		New Brand Non-Preferred Copayment	
	Retail	Mail Order or Retail Maintenance Pharmacy	Retail	Mail Order or Retail Maintenance Pharmacy
20 or More*	$ 6	$12	$21	$42
10 through 19*	$ 9	$18	$29	$58
5 through 9*	$12	$24	$30	$60
Less than 5**	$15	$30	$30	$60

*Generic copayment is $3.00 retail, and $6.00 mail order or retail maintenance pharmacy.
**Generic copayment is $5.00 retail, and $10.00 mail order or retail maintenance pharmacy.

APPENDIX I

PLAN AMENDMENTS

Bob Wise
Governor

Tom Susman
Director

WV Toll-free: 1-888-680-PEIA • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: www.wvpeia.com

April 14, 2003

FILED
2003 APR 14 P 3:56
OFFICE WEST VIRGINIA
SECRETARY OF STATE

The Honorable Joe Manchin III
Secretary of State
State Capitol Complex
Building 1, Suite 157-K
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0770

Re: PEIA Plan Document Amendments

Dear Secretary Manchin:

Enclosed please find an amended version of the West Virginia Public Employees Insurance Agency's Plan Document. This amendment is effective today, April 14, 2003. The only substantive amendments from the existing Plan Document are the additions of Appendix I and Appendix J, both relating to federal HIPAA privacy and security requirements. These amendments appear in the following order, on pages ii, viii, 4, and 182, 183, 184, 185, 186, 187, 188, 189, 190, 191. These pages should be removed from the existing Plan Document and replaced with the enclosed revised pages.

Thank you in advance for your cooperation.

Sincerely,

B. Keith Huffman
General Counsel

BKH/peb

Enclosures

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These were Replaced by on April 14, 2003

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*These are post-tax benefit options. Benefits for these plans are described in the Open Enrollment material mailed (annually) by the Plan Administrator.

Interpretation of Plan

The Director shall have ultimate authority to interpret the Plan for the PEIA. The Director may authorize others to interpret the Plan on the Agency's behalf, such as TPAs; however, such delegation shall not supersede the authority of the Director.

From time-to-time, this Plan may be superseded by legislation, enacted rules or regulations, court decisions, actions of the Finance Board or such other actions that may have a binding effect on the Agency. In such cases, the Plan Document will be amended, within a reasonable time, to reflect such actions.

Amendments to Plan Document

The PEIA reserves the right to amend all or any portion of this Plan Document in order to reflect changes required by court decisions, legislation, actions by the Finance Board, actions by the Director and for any other matters as are appropriate. The Plan Document will be amended within a reasonable time of any such actions. All amendments to the Plan Document must be in writing, dated and approved by the Director. The Director shall have sole authority to approve amendments to the Plan Document. The Plan Document and all approved amendments will be filed with the State of West Virginia Secretary of State's Office.

Appendices

The appendices to this Plan Document are incorporated into and made a part of this document.

Definitions

The following definitions apply to all terms used in this Plan Document, except to the extent that the definitions may be contrary to definitions contained in Section IX (Medical Reimbursement Plan) and Section X (Dependent Care Reimbursement Plan), in which case the definitions contained in Sections IX and X will apply exclusively to those sections.

Average Wholesale Price (AWP) – Average wholesale price in relation to prescription drugs.

Acordia - The Third-Party Administrator (TPA) responsible for claims processing, customer service, pre-authorizations and prior approval for out-of-network services for the PEIA PPB Plan.

WV Public Employees Insurance Agency

Plan Year 2003

Summary Plan Description

July 2002

Notice to PEIA Enrollees Concerning Election for Plan Exemption From Certain Federal Requirements

Under a 1996 Federal law, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is self-funded by the employer, rather than provided through a health insurance policy. The Public Employees Insurance Agency (PEIA) has elected to exempt the PEIA PPB Plan from item number three (3) of the following requirements:

1. Limitations on pre-existing condition exclusion periods.
2. Special enrollment periods.
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status.
4. Standards relating to benefits for mothers and newborns.
5. Parity in the application of certain limits to mental health benefits.
6. Required coverage for reconstructive surgery following mastectomies.

The PEIA PPB Plan complies with all of the other listed Federal requirements. The exemption from the Federal requirement will be in effect for the plan year beginning July 1, 2002 and ending June 30, 2003. The election may be renewed for subsequent plan years.

The only practical effect to PEIA members of this election is that the PEIA PPB Plan will make a twenty dollar reduction for family coverage and a ten dollar reduction for single coverage in premiums per month for members who certify that they and their covered dependents do not use tobacco.

The Federal law also requires the Plan to provide covered employees and dependents with a certificate of creditable coverage when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

If you have questions about this election, please call Customer Service at (304) 558-7850 or, toll-free, at 1-888-680-7342.

Bob Wise
Governor

Tom Susman
Director

Customer Service Hours: M-F 8:30 a.m. – 7:00 p.m.; Sat. 8:00 a.m. – noon • 1-304-558-7850 • 1-888-680-7342 • www.wvpeia.com

July 2002

Dear PEIA Insured:

This is your Plan Year 2003 Summary Plan Description. This booklet contains the eligibility, enrollment and benefit information you'll need to make use of your PEIA benefits for the coming year. Please take a few minutes to become familiar with this booklet so you can use it when you need it.

This book contains the medical and prescription drug information you need. Included in the prescription drug portion of the booklet is information about PEIA's new pharmacy benefit manager, Express Scripts. I encourage you to read this information carefully.

In the center of the booklet you'll find two brochures that focus on important issues in the PEIA PPB Plan. The first addresses emergency room usage, and the second gives you information about precertification and prior approval for out-of-network services. The brochures are perforated so that you can remove them and keep them close at hand throughout the plan year.

If you're a member of an HMO through PEIA, the eligibility and enrollment information in this booklet applies to you. For benefit information, you'll need to rely on the Evidence of Coverage you receive from your HMO.

PEIA continues to struggle to hold down the cost of health care for our members in the face of rising costs nationwide. We appreciate your cooperation in this effort. There are several ways you can help:

1. If you're in the PEIA PPB Plan, buy eligible maintenance prescriptions in 90-day supplies from the Retail Maintenance Network pharmacies or from the Express Scripts Mail Service program. This reduces your copayments, and reduces PEIA's costs for the drugs.
2. Take advantage of your plan's preventive care benefits, including cancer screenings, routine physicals, and immunizations.
3. If you're in the PEIA PPB Plan, review your medical bills and, if you find something questionable, participate in PEIA's Patient Audit program. The details are included in this booklet. This program identifies errors, which PEIA can then correct. There's something in it for you, too, since you can earn up to $1,000 for your efforts.

The coming year will be an exciting one at PEIA as we work to make the benefit plan serve you even better.

Sincerely,

Tom Susman
Director

Who's Who

Acordia National

Acordia National is the third party administrator that handles claim processing, customer service, preauthorizations and prior approval for out-of-network services for members of the PEIA PPB Plan.

- Preauthorization is a voluntary program that provides coverage verification for some services, like chelation therapy, vision therapy, massage therapy and accident-related dental services.
- Prior approval is the review process required for all out of state care beyond the bordering counties, and for non-network care. If you live in West Virginia or a bordering county of a surrounding state, you must have prior approval from Acordia before you seek care beyond the bordering counties or from an non- network provider. Prior approval is different from precertification, which is handled by Intracorp.

If you have questions about the payment or non-payment of a claim, need an out-of-network approval, or want to see if a service is covered, call Acordia National at 1-888-440-7342.

Intracorp

Intracorp is the utilization management company that handles precertification, medical case management and other utilization management functions for PEIA.

- Precertification is the medical necessity review process that is conducted by the nurses and physicians employed by Intracorp. Precertification is different from prior authorization for out-of-state care. Precertification looks at the medical necessity of the services being recommended by a physician and determines whether those services meet the criteria established by Intracorp based on national standards of care.
- Medical Case Management is the program that helps members with long-term or very expensive medical conditions manage and maximize their benefits. Case management nurses work with the patient, family members and providers to arrange for the best quality, most cost-effective care for the patient.

If you have questions as to whether an upcoming medical procedure is covered call Intracorp 1-888-440-7342.

Express Scripts

Express Scripts is the pharmacy benefit manager that processes drug claims through a nationwide network of pharmacies, as well as a mail service program. Express Scripts' pharmacists handle PEIA's prior authorization program for prescription drugs. If you have questions about your prescription drug benefits, call Express Scripts at 1-877-256-4680

PEIA

PEIA is the state agency responsible for the administering the PEIA PPB Plan, including contracting with all of the companies listed above. PEIA handles eligibility for both the PPB Plan and the managed care plans, and provides second-level customer service when the problem can't be resolved by Acordia, Intracorp or Express Scripts. In addition, PEIA handles appeals, oversees premium billing and collection, and administers the life insurance program. Call PEIA at 1-888-680-7342.

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Introduction

Welcome to your PEIA Summary Plan Description. This booklet replaces the white booklet you received in July 2001, and includes important information for all public employees who have ANY coverage through PEIA.

Managed Care Members

For those who are enrolled in managed care plans, this booklet provides all of the eligibility and enrollment information regarding your benefits. If you need or want to change your benefits, please refer to the information in the beginning of this booklet for details of your rights, responsibilities, and the applicable timeframes for making those changes. Information in this booklet regarding managed care plan guidelines is limited. Therefore, you should refer to your managed care Evidence of Coverage for benefit details if you are covered by one of the managed care plans offered by PEIA.

You will find information about your appeal rights in the "Appeals" section, beginning on page 52.

PPB Plan Members

For those enrolled in the PEIA PPB Plan, this booklet includes many of details of the Preferred Provider Benefit (PPB) Plan. It is important to review this information closely so that you may familiarize yourself with all aspects of PEIA's PPB Plan. Please keep this booklet close at hand and refer to it often if you have questions about your PEIA PPB Plan benefits.

This Summary Plan Description (SPD) is intended to provide PEIA PPB Plan participants with an easy-to-read description of benefits available through the PEIA Plan, and instructions on how to use these benefits. The SPD is a summarized version of a portion of PEIA's Plan Document. The Plan Document describes in detail all aspects of the operations of the Agency, and is on-file with the Secretary of State.

The PEIA PPB Plan contracts with third party administrators (TPAs) to process health, drug and fringe benefit claims. If you have a question about a specific claim or benefit, the fastest way to obtain information is to contact the TPA directly at one of the numbers listed on page 2.

For non-State agencies, PEIA offers the PEIA PPB Plan B. Plan B is similar to the standard PPB Plan A, but offers lower premiums with higher deductibles, higher out-of-pocket maximums, and higher copayments for prescription drugs. The medical coverage is the same as in PPB Plan A. The differences in deductibles, out-of-pocket maximums and drug copayments are noted in the benefit tables in the Medical Benefits section and the Prescription Drug section of this book.

Life Insurance Only

For employees who carry only life insurance with the PEIA, your eligibility and enrollment details are in this booklet. Details of the life insurance coverage are in the Life Insurance Booklet (July 1997).

Subject to Change

The benefit information in this Summary Plan Description is subject to change during the plan year, if circumstances arise which require adjustment. Plan changes will be communicated to members through PEIA News, the newsletter PEIA publishes nine times each year. The changes will be included in PEIA's Plan Document, which filed with the Secretary of State's office, and will be incorporated into the next edition of the Summary Plan Description.

Who to Call with Questions

Health Claims, Benefits, Preauthorizations and Prior Approvals for Out-of-State Care

Acordia National — 1-304-353-7820

or 1-888-440-7342 (toll-free)

Precertification and Utilization Management

Intracorp — 1-304-353-7820

or 1-888-440-7342 (toll-free)

PEIA Nurseline (Answers to medical questions from a registered nurse and medical information service)

PEIA Nurseline — 1-877-294-7342 (toll-free)

Prescription Drug Benefits and Claims

Express Scripts — 1-877-256-4680

or on the web at **www.express-scripts.com**

Subrogation and Recovery

Beacon Recovery Group — 1-800-874-0500

PEIA (Answers to questions about eligibility, life insurance and third level claim appeals)

WV Public Employees Insurance Agency — 1-304-558-7850

1-888-680-7342 (toll-free)

or on the web at **www.wvpeia.com**

Mountaineer Flexible Benefits (Dental, vision, and disability insurance and flexible spending accounts)

Fringe Benefits Management Company — 1-800-342-8017

or on the web at **www.fbmc-benefits.com**

Managed Care Plans

Carelink — 1-800-348-2922

or on the web at **www.cvty.com**

The Health Plan — 1-800-624-6961/1-740-695-3585

or on the web at **www.healthplan.org**

Important Terms

Acordia National: The third party administrator that handles claim processing, customer service, preauthorizations and prior approval for out-of-network services for the PEIA PPB Plan.

Allowed Amounts: For each PEIA covered service, the allowed amount is the lesser of the actual charge amount or the maximum fee for that service as set by the PEIA.

Alternate Facility: A facility other than an acute care hospital.

Annual Deductible: The amount you must pay each plan year before the plan pays its portion of the cost. Under the PPB Plan, office visits are not subject to the deductible. Only the Allowed Amounts for covered expenses will be applied to your deductible. The family deductible is divided up among the family members. No one member of the family will pay more than the individual deductible.

Beacon Recovery Group: The subrogation and recovery vendor for PEIA. Beacon pursues recovery of money paid for claims that were not the responsibility of the PEIA PPB Plan. For more information, read the Recovery of Incorrect Payments section beginning on page 61.

Beneficiary: The person who receives the proceeds of your PEIA life insurance policy.

Claims Administrator: Acordia National.

Coordination of Benefits: A practice insurance companies use to avoid double or duplicate payments or coverage of services when a person is covered by more than one policy.

Coinsurance: The percentage of eligible expenses that you are required to pay after the deductible has been met. This is the amount applied to your out-of-pocket maximum. You are responsible for paying the coinsurance and deductible amounts directly to the provider of services.

Copayment: This is the set dollar amount that you pay when you use the services – like the flat dollar amount you pay for an office visit in the PEIA PPB Plan. Copayments do not count toward your annual out-of-pocket maximum or your annual deductible.

Deductible: The amount of eligible expenses you are required to pay before the plan begins to pay benefits. The deductible does not apply to charges for office visits. See Annual Deductible above.

Dependent: An eligible person, as determined by the PEIA guidelines, who the policyholder has properly enrolled for coverage under the plan.

Durable Medical Equipment: Medical equipment that is prescribed by a physician which can withstand repeated use, is not disposable, is used for a medical purpose, and is generally not useful to a person who is not sick or injured.

Eligible Expense: A necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Allowable expenses under this plan are calculated according to PEIA fee schedules, policies and payment policies in effect at the time of service.

Emergency: An acute medical condition resulting from injury, sickness, pregnancy, or mental illness that arises suddenly and which a reasonably prudent layperson would believe requires immediate medical treatment to prevent the death, severe disability, or impairment of bodily function of an insured.

Exclusions: Services, treatments, supplies, conditions, or circumstances that are not covered under the PEIA PPB Plan.

Experimental, Investigational, or Unproven Procedures: Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the plan (at the time it makes a determination regarding coverage in a particular case) to be: (1) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, the United States Pharmacopeia Dispensing Information, or the American Medical Association Drug Evaluations as appropriate for the proposed use; or (2) subject to review and approval by any Institutional Review Board for the proposed use; or (3) the subject of an ongoing clinical trial that meets the definition of Phase 1, 2, 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Explanation of Benefits (EOB): A form sent to the person filing the claim after a claim for payment has been evaluated or processed by the Claims Administrator which explains the action taken on the claim. This explanation might include the amount paid, benefits available, reasons for denying payment, etc.

Inpatient: Someone admitted to the hospital as a bed patient for medical services.

Insured: Someone who is eligible for and enrolled in the PEIA PPB Plan, a managed care plan or life insurance only. Insured refers to anyone who has coverage under any plan offered by PEIA.

Intracorp: The utilization management company that handles precertification, medical case management and other utilization management functions for the PEIA PPB Plan.

Medical Case Management: A process by which Intracorp assures appropriate available resources for the care of serious long-term illness or injury. Intracorp's case management program can assist in providing alternative care plans.

Medicare Beneficiary: An individual eligible for Medicare as established by Title XVII of the Social Security Act of 1965, as amended.

Member: A policyholder or dependent enrolled in a managed care plan offered by PEIA.

Outpatient: Someone who receives services in a hospital, alternative care facility, free-standing facility, or physician's office but who is not admitted as a bed patient.

PEIA PPB Plan A: The standard PEIA PPB Plan offered to all eligible employees, regardless of employer. This plan is typically referred to as the PPB Plan.

PEIA PPB Plan B: The PPB Plan offered only to non-State agencies and deputy sheriffs who retire before age 55. Plan B offers lower premiums with higher deductibles, higher out-of-pocket maximums, and higher copayments for prescription drugs. The medical coverage is the same as in Plan A. The differences in deductibles, out-of-pocket maximums and drug copayments are noted in the benefit tables in the Medical Benefits section and the Prescription Drug section of this book. This plan is referred to as PPB Plan B.

PEIA PPO: The PEIA PPO is the network of providers from whom PEIA PPB insureds can receive care to get the highest level of benefit. This network consists of all WV providers who accept PEIA's reimbursement. For services provided outside of the State, several networks are available. In the state of Ohio,

the network is Medical Mutual of Ohio's SuperMed Plus Network. In Maryland, North Carolina and the District of Columbia (DC), the network is the Alliance Network. For all other states, the network is Beech Street. Some out-of-state providers also have direct contracts with Acordia to serve PEIA insureds.

Plan: The Preferred Provider Benefit plan of the West Virginia Public Employees Insurance Agency.

Plan Year: A 12-month period beginning July 1 and ending June 30.

Policyholder: The employee, retired employee, surviving dependent or COBRA participant in whose name the PEIA provides any health or life insurance coverage.

Preauthorization: A voluntary program that allows you to obtain prior approval for a service to assure that it will be covered by the plan. Preauthorization is handled by Acordia National.

Precertification: The **required** process of reporting any inpatient stay and certain outpatient procedures in advance to obtain approval for the admission or service. Intracorp handles precertification.

Pre-existing condition: A physical or mental condition that had been diagnosed, treated or for which the patient incurred expenses in the three months prior to becoming covered by the plan.

Preferred Provider Organization (PPO): A network of providers that have agreed to provide discounted rates for their services, thereby reducing the Plan's and the participant's expenses.

Premium: The payment required to keep a policy in force.

Prior Approval: The required process of obtaining approval from Acordia for out-of-state or out-of-network care under the PEIA PPB Plan.

Provider Discount: A previously determined percentage that is deducted from a provider's charge or payment amount and is not billable to the insured when PEIA is the primary payor and the service is provided in West Virginia or by a PPO network provider.

Reasonable and Customary: The prevailing range of charges and fees charged by providers of similar training and experience, located in the same area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill or experience to treat successfully.

Secondary Payor: The plan or coverage whose benefits are determined after the primary plan has paid. Order of payment is determined by rules described under Which Plan Pays First on page 57.

Third Party Administrator (TPA): A company with which PEIA has contracted to provide services such as customer service, utilization management and claims processing to PEIA PPB Plan insureds.

Utilization Management: A process by which PEIA controls health care costs. Components of utilization management include pre-admission and concurrent review of all inpatient stays, known as precertification; prior review of certain outpatient surgeries and services; and medical case management. Utilization management is handled by Intracorp.

Waiver of Premium: If you become disabled before age 60, and while insured, your basic life insurance coverage will continue as long as you are disabled without further payment of premium. To be considered disabled, you must be unable to do any work for pay or profit. Application for a waiver of premium must be provided to PEIA's life insurance carrier within 12 months of your last day worked. Contact your benefit coordinator or PEIA to obtain an application.

What PEIA Offers

PEIA offers the Preferred Provider Benefit (PPB) Plan, managed care plans, a life insurance plan and a fringe benefits plan. The PPB Plan includes benefits for hospital, surgical, prescription drug, and other medical expenses. Managed care plans offer comprehensive benefits, but with different cost-sharing than the PEIA PPB Plan.

For non-State agencies only, PEIA offers the PEIA PPB Plan B. Plan B is similar to the standard PPB Plan A, but offers lower premiums with higher deductibles, higher out-of-pocket maximums, and higher copayments for prescription drugs. The medical coverage is the same as in PPB Plan A. The differences in deductibles, out-of-pocket maximums and drug copayments are noted in the benefit tables in the Medical Benefits section and the Prescription Drug section of this book.

If you live in an area where PEIA offers a managed care plan, you may be eligible to enroll in a managed care plan or in the PEIA PPB Plan. You must live in the managed care plan's enrollment area to be eligible to enroll in a plan. Please consult your Shopper's Guide or contact your benefit coordinator to determine what managed care plans are offered in your area.

The PEIA PPB Plan uses a coordination of benefits provision that determines how it will pay if you have other health insurance available to you. See page 56 for a complete description of this provision. The PEIA PPB Plan may be of little or no value to you as secondary insurance.

If you enroll for any health coverage as an active employee under age 65, a basic $10,000 decreasing term life insurance policy with accidental death and dismemberment (AD&D) benefits is included. If you choose not to enroll for health benefits, you may still choose to enroll for basic life insurance. You must enroll for basic life insurance before you elect any of the optional life insurance coverages. Eligibility and enrollment details for the life insurance plans are included in this booklet. For a complete description of the life insurance benefits, please see the life insurance booklet.

Mountaineer Flexible Benefits

Mountaineer Flexible Benefits is a "cafeteria plan" which offers additional optional benefits. This plan is available to active employees of all State agencies, colleges, universities, and those county boards of education which elect to participate. This plan is not available to retired employees or non-State agency employees. If you're not sure whether you're eligible, contact your benefit coordinator.

The Mountaineer Flexible Benefits Plan enables employees to choose among several options for dental, vision and short- and long-term disability insurance, as well as medical care and dependent care flexible spending accounts, and to pay for these benefits on a pre-tax basis. A LifeEvents Plan and a Legal Plan are also available as post-tax benefit options.

Open Enrollment for Mountaineer Flexible Benefits is held each Spring, usually during April and May. The current information about these benefits is included in the enrollment materials mailed prior to the annual Open Enrollment.

If you have questions about Mountaineer Flexible Benefits, contact Fringe Benefits Management Company at 1-800-342-8017.

Mountaineer Flexible Benefits At-A-Glance	
efit	**Options**
ental Benefits	Coverage for routine dental care. Deductibles, copayments and benefits vary.
ision Benefits	Coverage for vision exams and corrective lenses.
sability Insurance	Replacement of a portion of your pay if you are disabled.
dical Flexible Spending Account	Deposit up to $3,000 for tax-free reimbursement of eligible medical expenses.
pendent Care Flexible Spending Account	Deposit up to $5,000 for tax-free reimbursement of eligible expenses.
gal Plan	Coverage for legal matters.
eEvents Plan	Benefits for critical illness, total and permanent disability, long-term care, terminal illness, and death.

*These are post-tax benefits

o Is Eligible

loyers

he PEIA offers a range of benefits through these West Virginia employers:

State government and its agencies;

State-related colleges and universities;

County boards of education;

County and municipal governments; and

Other employers as specified in W. Va. Code §5-16-2.

der West Virginia law, different types of employers may offer their employees different benefits. re, the benefits for which you are eligible may vary. If you have any questions about the benefits e to you, contact the benefit coordinator at your payroll location or call the PEIA.

Employees

public employee, you are eligible to be covered under the plans offered by your employer if you

ull-time employee (working regularly at least 20 hours per week);

elected official who works full-time in the elected position;

- a member of the West Virginia Legislature (must pay 100% of the premium);
- an elected member of a county board of education; or
- a school service employee eligible under W. Va. Code, Chapter 18A.

Temporary and part-time employees are not eligible.

Retired Employees

If you are a retired public employee, you are eligible for PEIA health and life benefits, provided you meet the minimum eligibility requirements of the applicable State retirement system and, if your last employer immediately prior to retirement is a participating employer under the State retirement system. Members of the Teacher's Defined Contribution Retirement plan must have 12 or more years of credited services to qualify to continue PEIA insurance benefits upon retirement.

Dependents

If you elect PEIA coverage, you may also enroll the following dependents:

- your legal spouse;
- your biological or adopted children under age 19;
- stepchildren who live with you and are under age 19;
- children under age 19 who are members of your household and fully dependent upon you for support and maintenance; and
- children or stepchildren over age 19 who live with you and are incapacitated and cannot support themselves due to a physical or mental disability which began before age 19 (or age 25 if a full-time student).

Coverage for dependent children may be extended to the end of the month in which they reach age 25 if they are full-time students. See page 16, "Full-time Students Over Age 19 — Student Verification," for details.

Married children are not eligible for coverage.

Surviving Dependents

If you are a surviving dependent of an active or retired public employee, and you were insured by PEIA (either in the PEIA PPB Plan or in a managed care plan) at the time of the employee's death, you may elect to continue coverage under your health plan. Surviving dependents are not eligible for life insurance coverage. Eligibility of a surviving spouse for PEIA coverage terminates upon remarriage. If a divorce occurs after the remarriage, re-enrollment as a surviving dependent is not allowed.

How To Enroll

You may enroll for PEIA health and life benefits by completing enrollment forms at your place of employment or through your retirement system. On these forms, you will select the types of coverage you want and enroll the eligible dependents you wish to cover.

Participation in PEIA benefit plans is not automatic; you must complete the proper enrollment forms. Enrollment will authorize your employer or retirement system to deduct the premiums for the coverages you select from your salary or pension.

There are restrictions on how and when you may enroll and make changes in your coverage. Please read all parts of the Eligibility Section of this booklet carefully before you enroll, so that you will fully understand your options and responsibilities.

New Employees

You may enroll for health coverage, basic life insurance and up to $200,000 of optional life insurance coverage during the calendar month you are hired and the following two calendar months. No medical information form will be required for up to $100,000 of optional life insurance. A medical information form is always required for optional life insurance in excess of $100,000.

Coverage will become effective the first day of the calendar month following enrollment. If you enroll and begin work on the first day of a month, your coverage will not be effective until the first day of the following calendar month. If you enroll before you actually start work, coverage will begin the first day of the month following your first day of active employment.

If you choose not to enroll for life insurance during this initial period, but want life coverage later (basic, optional or dependent optional) for you or your dependents, you will have to submit a medical information form and be approved by PEIA's life insurance carrier. Coverage will become effective the first day of the calendar month following approval.

If you choose not to enroll for health coverage as a new employee, you may do so later in accordance with guidelines in effect at the time you choose to enroll.

Health Coverage

For health coverage to be effective, you must be actively at work. To be considered "actively at work," you must:

1. perform the normal tasks for your job on a full-time basis on the day your coverage is to begin; and
2. perform such tasks at one of your normal places of business or at a location to which you must travel to do your job; and
3. not be absent from work because of leave of absence or temporary layoff.

If you do not meet these requirements, coverage for you and your dependents will begin on the next day on which you do meet these requirements.

Pre-existing Medical Conditions

A pre-existing medical condition is one that has been diagnosed, treated, or for which you or your dependents have incurred expenses within the three months immediately before the effective date of the PEIA PPB Plan coverage.

Any employee and/or dependent enrolling in the PEIA PPB Plan will be subject to pre-existing condition limitations.

Expenses for a pre-existing condition will not be covered by the PEIA PPB Plan for the first twelve months your coverage is in effect. This limitation is waived if you had creditable prior coverage under

another similar health plan that terminated no more than 62 days prior to the effective date of the PEIA PPB Plan coverage, and if you submit your certificate of creditable coverage from your former insurer with your Health Insurance Enrollment Form. Pregnancy and any condition meeting the definition of handicap are not considered pre-existing medical conditions.

Pre-existing condition limitations do not apply to the managed care plans.

Life Insurance Coverage

For life insurance coverage (or an increase in the amount of optional life insurance) to go into effect, you must meet the following requirements on the effective date of coverage:

a) have completed a full day of active work on that date; and

b) have completed a full day of active work on your last regularly scheduled work day and be able to work on the date you become eligible.

If you do not meet the requirements of a) and b) above, the coverage will become effective on the date you return to active work.

Active work and actively at work mean performing regular duties for a full work day for the policyholder.

Existing Employees

Existing employees may make changes in their coverage as follows:

Health Insurance

Existing employees who chose not to take PEIA health coverage at the time of employment may add health coverage through the PEIA PPB Plan at any time by completing a Health Insurance Enrollment Form. Coverage will be effective on the first day of the month following enrollment. Pre-existing condition limitations may apply. Please see the information about pre-existing condition limitations on the preceeding page.

Life Insurance

Existing employees may add or increase the amount of life insurance at any time by completing an Optional Life Insurance Enrollment Form, submitting a medical information form, and being approved by PEIA's life insurance carrier. Coverage will become effective on the first day of the month following approval by the life insurance carrier.

Newly Eligible Employees

Employees who become eligible to enroll for health coverage due to loss of other coverage may enroll for coverage during the calendar month that the previous coverage was lost or the two following calendar months. Newly eligible employees may enroll in the PEIA PPB Plan or any of the managed care plans. Employees who choose to enroll at any other time during a plan year will only be permitted to enroll in the PEIA PPB Plan. They may make another selection during the next open enrollment period.

Retired Employees

If you have PEIA coverage as an active employee, you may continue coverage into retirement without interruption. To do so, you must complete Retired Employee Enrollment Forms during the calendar month of retirement or the two following calendar months.

Continuous coverage is necessary if you wish to use your accrued sick and/or annual leave for extended employer-paid PEIA coverage. You **cannot** defer your sick and/or annual leave.

If you were not covered as an active employee or if you allow your coverage to lapse, you may choose to enroll for health coverage at the time of your retirement if your last employer immediately prior to retirement is a participating employer under the State retirement system and as long as you meet the minimum qualifications. Coverage will be effective on the first day of the month following enrollment. If you deferred your retirement from a participating employer under the State retirement plan, you may not re-enroll in PEIA if you had other (private sector) employment just prior to retirement. To be eligible to enroll in PEIA, your last employer prior to retirement must have been a public entity which participates in the State retirement system.

Employees with 20 or more years of service may defer enrollment in PEIA health benefits for up to two (2) years following separation. If and when these employees choose to enroll for health coverage, they will be required to pay 105% of the total premium for the coverage they choose. Enrollees in this category will not be eligible for PEIA's premium assistance program or retiree premium subsidy.

Medicare

When you become an eligible beneficiary of Medicare, you must enroll in Medicare Part A and Medicare Part B. Part A is an entitlement program and is available without payment of a premium to most individuals. Part B is the supplementary medical insurance program that covers physician services, outpatient laboratory and x-ray tests, durable medical equipment and outpatient hospital care. Part B is a voluntary program that requires payment of a monthly premium.

If you do not enroll in Medicare Part B, PEIA will process your claims as if you did have the Part B coverage. In other words, PEIA will pay only the amount we would have paid if Medicare had processed your claim and made a payment. If you are Medicare eligible but still and active employee, PEIA will pay as the primary plan, and Medicare will be secondary.

Insurance

If you wish to elect new or increased optional life insurance as a retired employee, you must enroll and submit a medical information form during the calendar month of retirement or the two following calendar months. Coverage will be effective pending the approval of PEIA's life insurance carrier. You may not elect or increase optional life insurance after this period.

You may continue dependent optional life insurance after retirement by completing the Retired Employee Optional Life Insurance Enrollment Form during the calendar month of retirement or the two following calendar months.

Dependents

If you enroll your dependents when you enroll, their coverage begins the same day as yours. If you enroll them at a later date, their coverage will become effective the first day of the month following enrollment. If you are enrolling a dependent for dependent optional life insurance at a date later than the first month following an enrollment event, coverage will not become effective until a medical information form has been submitted to, and approved by, PEIA's life insurance carrier.

If a dependent (except your biological newborn) is in a hospital, nursing home or other health care facility on the date coverage would otherwise begin, the effective date of coverage is delayed until the patient is discharged.

Additional Dependents

If you wish to add new dependents, such as a new spouse, your biological newborn or adopted child, you must complete enrollment forms to add them to your coverage. Coverage is not automatic.

PEIA PPB Plan

For the PPB Plan, you should enroll new dependents during the calendar month of or the two calendar months following the date they become eligible (i.e., date of marriage, date of birth or adoption) even if you already have family coverage. If you do not complete the proper enrollment forms to have your new dependent(s) added to your coverage within this timeframe, the new dependent(s) will be subject to pre-existing condition limitations.

Managed Care Plans

If you are a member of one of the managed care plans offered by PEIA, you must enroll new dependents during the calendar month of or the two calendar months following the date they become eligible (i.e., date of marriage, date of birth or adoption) even if you already have family coverage. If you fail to complete the proper enrollment forms within this timeframe, new dependents cannot be added to your coverage until the next open enrollment period. When new dependents are enrolled either the calendar month of or the two calendar months following an eligibility event or within the open enrollment period, they will not be subject to pre-existing condition limitations. Additional dependents cannot be enrolled in your managed care plan at any other time.

Life Insurance

Enroll new dependents during the calendar month of or the two calendar months following the date they become eligible (i.e., date of marriage, date of birth or adoption). Otherwise, you will have to submit a medical information form and be approved to obtain dependent optional life insurance coverage.

Newborn or Adopted Children

PEIA PPB Plan

Newborn Child

For the PPB Plan, if you enroll your biological newborn child during the calendar month of birth or the two following calendar months, coverage will be made effective retroactive to the date of birth. Otherwise, coverage will be effective on the first day of the month following the date of enrollment and the child may be subject to pre-existing condition limitations. You do not need a Social Security Number to enroll your newborn, but when you get the baby a Social Security Number, please provide it to your benefit coordinator.

Adopted Child

If you enroll an adopted child during the calendar month the child is placed in your home or the two following calendar months, coverage under the PPB Plan can be made effective retroactive to the date of placement. Otherwise, coverage will be effective on the first day of the month following the date of enrollment and the child may be subject to pre-existing condition limitations. However, coverage for an adopted infant will become effective the day the adoptive parents are legally and financially responsible for the medical expenses if bonafide legal documentation is presented to PEIA.

Managed Care Plans

Newborn Child

If you participate in one of PEIA's managed care offerings, you must enroll your biological newborn child within the calendar month of or the two calendar months following the birth and the coverage will be made effective retroactive to the date of birth. If you do not complete the proper enrollment forms to add your newborn to your coverage within this timeframe, you cannot add the newborn child until the next open enrollment period.

Adopted Child

If you enroll an adopted child into your managed care plan during the calendar month the child is placed in your home or the two following calendar months, coverage can be made effective retroactive to the date of placement. If you fail to complete the proper enrollment forms within this timeframe, the adopted child cannot be added to your coverage until the next open enrollment period.

Newborns or adopted children must be enrolled into a managed care plan in either the calendar month of or the two calendar months following an eligibility event or within the open enrollment period. They are not subject to pre-existing condition limitations. Newborns and adopted children cannot be enrolled in your managed care plan at any other time.

Life Insurance

Newborn Child

You should enroll a biological newborn child during the calendar month of or the two calendar months following the date of birth. Otherwise, you will have to submit a medical information form and be approved to obtain dependent optional life insurance coverage for your child.

Adopted Child

You should enroll an adopted child during the calendar month of or the two calendar months following the date of placement in your home. Otherwise, you will have to submit a medical information form to be approved to obtain dependent optional life insurance coverage for your adopted child.

Surviving Dependents

In the event of the death of an active or retired policyholder, dependents who were covered at the time of death are eligible to enroll for health coverage as surviving dependents. To continue coverage without interruption, surviving dependents must complete enrollment forms in the calendar month death occurs or the two following calendar months. Surviving dependents must enroll in the same plan in which they were covered at the time of the policyholder's death. During open enrollment, you may select any plan for which you are eligible.

Surviving dependents are not eligible for life insurance.

Annual Open Enrollment

Each Spring PEIA holds an open enrollment period during which PEIA insureds may choose among managed care plans and the PEIA PPB Plan. During Open Enrollment, participants may move between

plans without penalty and no pre-existing condition limitations will be applied. Choices made during the open enrollment period are effective on July 1 of that year.

During Open Enrollment, eligible policyholders who have not taken advantage of any health coverage from PEIA also have the opportunity to enroll in the PEIA PPB Plan or any managed care plan, subject to the deadlines and rules in force for that enrollment period. Pre-existing condition limitations will not apply when eligible active or retired individuals enroll in a managed care plan during open enrollment. Pre-existing condition limitations do apply to new enrollees in the PPB Plan. See "How to Enroll" on page 8 for details about life insurance in this case.

Selections made during Open Enrollment are effective on July 1 of that year, and remain in effect for a full plan year unless the member moves outside the service area of his or her managed care plan. A physician's withdrawal from a managed care plan does not qualify a member to change plans in the middle of a plan year.

Prior to the Open Enrollment, PEIA mails a *Health Care Plan Shopper's Guide* (*Shopper's Guide*) to all eligible policyholders. The *Shopper's Guide* provides a side-by-side comparison of the general attributes of all plans offered. It is intended as a general guide to the available plans. Members requiring further information about a specific plan should contact that plan directly.

Medical Identification Cards

You will receive a medical identification card within 30 days after you enroll in the PEIA PPB Plan or one of the managed care plans.

Your PEIA PPB Plan ID card verifies that you have medical and prescription drug coverage through PEIA. On the back we've listed important phone numbers you may need. One card will be issued for individual coverage, and two cards will be issued for family coverage. The policyholder's name and Social Security Number will be printed on all cards. If you want additional cards for children not residing with you, or if you need to replace a lost card, please contact Express Scripts at 1-877-256-4680.

If you enroll in a managed care plan, you will receive an identification card from that plan, not from PEIA. For additional or replacement cards, call your plan.

When Coverage Ends

Certain events will cause PEIA benefits for you and/or your covered dependents to terminate. Generally, coverage will end if you or a dependent become ineligible.

In most cases you have the option to extend health coverage under the Federal COBRA law, or convert your health and/or life benefits into private insurance policies. All of these options are at your expense and require you to act within a specified time. Please see the section on "Options After Termination of Coverage" beginning on page 19.

Voluntary Termination

PEIA coverage for an active policyholder and any covered dependents terminates at the end of the month in which the employee voluntarily ceases employment, or goes off the payroll.

Involuntary Termination

A policyholder who is terminated from employment involuntarily or through a reduction of work force may continue coverage for three additional months after the end of the month in which employment ends. The policyholder will be responsible for paying the employee's share of the premium during these three months.

If you are discharged for misconduct and you choose to contest the charge, you may extend your coverage for up to 3 months while you pursue available administrative remedies. If the charge is upheld, you must reimburse the employer's share of the premium cost of your extended coverage to your former employer.

Retired Employees

Coverage for an employee who has already retired will terminate at the end of the calendar month in which the retiree elects no longer to participate.

For retiring employees, coverage will terminate at the end of the month in which the employee goes off the payroll, unless forms have been completed to continue coverage through their retirement system.

Dependents/Surviving Dependents

Coverage for dependents terminates at the end of the calendar month in which one of the following occurs:

- policyholder (active or retired) terminates or loses coverage;
- divorce from employee;
- child reaches 19th birthday;
- child marries;
- child who has extended coverage beyond age 19 as a full-time student reaches his/her 25th birthday or ceases full-time student status;
- surviving spouse remarries;
- disabled dependent no longer meets disability guidelines; or
- policyholder voluntarily removes dependent from coverage.

ilure To Pay Premium

Your coverage as an active or retired policyholder, and coverage of your dependents, will be terminated if you fail to pay your premium contributions when due. Premiums are due by the 25th of each month. payment is not received by PEIA within 15 days following the due date, all medical claims will be pended. Additionally, the PEIA drug card will be suspended. If payment is not received within 30 days following e due date, coverage will be cancelled, and all claims incurred will be your personal responsibility.

ployer Withdrawal From The Plan

By its agreement to participate in the PEIA plan, a non-state entity is required by PEIA to stay in the n for a minimum of three years. If a participating county or municipal government or other employer hdraws or is terminated from the PEIA plan, coverage for all affected insureds ends on the effective e of that employer's withdrawal/termination.

Retirees eligible to participate in the Consolidated Public Retirement System (CPRS) may continue participation in PEIA. The withdrawn agency is billed a subsidy premium for these retirees. Retirees not eligible to participate in CPRS must look to their former employer for retiree coverage.

Your Responsibility To Make Changes

It is your responsibility to keep your PEIA enrollment records up to date. You must notify your benefit coordinator immediately of any changes in your family situation, and complete the appropriate change forms to keep your PEIA coverage up to date. Examples of such changes include a change of address, a change in your marital status, or a dependent child no longer qualifying for coverage.

You should do this whether you belong to the PEIA PPB Plan, a managed care plan or if you've elected only life insurance coverage. If you fail to notify your benefit coordinator promptly of changes in your family status, your employing agency may look to you for reimbursement of premiums your employer paid in error.

Special Eligibility Situations

If You And Your Spouse Are Both State Employees

Two public employees who are married to each other, but who are both eligible for benefits under the PEIA may elect to enroll as follows: 1) as Family with Employee Spouse in any plan; 2) as "Employee Only" and "Employee and Child(ren)" in two different plans; 3) as "Employee Only" and "Employee and Child(ren)" in the PPB Plan (remember you'll have two deductibles and two out-of-pocket maximums this way); or 4) as "Employee Only" and "Employee and Child(ren)" in the same managed care plan. All children must be enrolled under the same policyholder.

Both employees are eligible to enroll for the basic life policy, as well as optional and dependent life insurance.

Full-time Students Age 19 and Over — Student Verification

Coverage for a dependent child ceases at the end of the month in which the child reaches age 19; however, coverage may be extended (on a year-to-year basis) to age 25 if the child is unmarried, enrolled as a full-time student, and dependent on you for support and maintenance.

"Enrolled as a full-time student" means the child attends courses full-time (as determined by the institution) in a graduate or undergraduate college or university (other than a U.S. military academy when the academy considers the student to be on active duty) or attends a trade or professional school as the child's full-time occupation.

Student verification is a two-step process:

1. Verification of full-time student status will be requested by PEIA when your child turns age 19.
2. Once a year thereafter, you must verify your child's full-time student status by providing a letter from the school's registrar.

Health coverage for a dependent who is a full-time student during the Spring semester will continue through August 31 of that same year, provided the dependent is unmarried and not over age 25. If COBRA dependent coverage is elected for a student not returning to full-time status in the Fall, it will be effective September 1 of that same year.

If it becomes medically necessary for your child to withdraw temporarily from school, he or she may continue to be covered under the PEIA plan for one year under an approved medical leave. You will be asked to provide documentation from your child's physician verifying that the illness or injury prevents the student from attending college classes, and the date your child may be expected to return to school. If the medical leave extends beyond one year, you may apply to cover that child as a disabled child.

If your child loses eligibility because he or she is no longer a full-time student, you should notify your benefit coordinator promptly. If you fail to notify your benefit coordinator promptly, your employing agency may look to you for reimbursement of premiums your employer paid in error. Continued coverage under COBRA will be available, see page 19.

If your child (age 19 or over) voluntarily withdraws from school, has a lapse in coverage, and later re-enrolls as a full-time student, he or she may be reinstated for PEIA coverage. You must complete a Change-in-Status form and add this child to your list of dependents again to reinstate this coverage. This child may be subject to pre-existing condition limitations.

Disabled Child

Your dependent child may be covered after reaching age 19 if he or she is incapable of self-support because of mental or physical disability.

To be eligible:

- the disabling condition must have begun before age 19, or before age 25 if a full-time student; and
- the child must be incapable of self-sustaining employment and chiefly dependent on you for support and maintenance.

To continue this coverage, contact PEIA for an application. You will be asked to provide documentation when the child reaches age 19 and periodically thereafter.

Court-Ordered Dependent (COD)

If a PEIA-insured employee and his or her spouse divorce, and the employee is not the custodial parent for the dependent child(ren), the employee may continue to provide medical benefits for the child(ren) through the PEIA plan. If the non-custodial parent is ordered by the court to provide medical benefits for the child(ren), the custodial parent may submit medical claims for the court-ordered dependent(s), and benefits may be paid directly to the custodial parent. Special claim forms are required. The custodial parent will also receive Explanations of Benefits (EOBs) for the CODs as claims are processed. Contact PEIA to discuss this benefit.

Leaves of Absence

Medical Leave (Non-Workers' Compensation)

Any employee who is on a medical leave of absence due to an injury or illness that is not covered by Workers' Compensation is eligible to continue coverage subject to the following:

- the medical leave must be approved by the employer;
- the employee and employer must continue to pay their respective proportionate shares of the premium cost;
- the employer is obligated to pay its share only for a period of one year, after which the employee may be required to pay the full cost of coverage; and
- each month the employee must submit to the employer a physician's statement certifying that the employee is unable to return to work.

Medical Leave (Workers' Compensation)

Any employee who is on a leave of absence and is receiving temporary total disability benefits from Workers' Compensation is entitled to continue PEIA coverage until he or she returns to work.

The employer and employee must continue to pay their respective proportionate shares of the premium cost for as long as the employee receives temporary total disability benefits.

Personal Leave

An employee may continue insurance coverage while on a personal leave of absence approved by the employer. The monthly premium will be paid according to the policy or agreement established by your employer.

Family Leave

An employee may continue insurance coverage during an approved family leave. Contact your benefit coordinator for further details regarding the federal Family and Medical Leave Act (FMLA).

Military Leave

For an employee on military leave with pay, health and life insurance benefits will generally continue without interruption, as long as the employee is on the payroll.

An employee who is on an approved military leave of absence **without pay**, due to an active call of duty from the President, is entitled to continue health and life benefit coverage for as long as premium payments are made. The employee is responsible for paying their employee share of the premium costs for each month during the military leave of absence, and Governor Wise's Executive Order No. 19-01 requires the employer to pay its share. Upon return from a military leave, if there has been a lapse in coverage, the employee may generally reinstate the same health and/or life insurance benefits without penalty.

Leaves of Absence for Teachers and Service Personnel

Any teacher or school service employee who is returning from an approved leave of absence of one year or less shall be restored to the same benefits which he or she had at the time of the approved leave of absence.

Options After Termination of Coverage

If your PEIA coverage terminates, you may have a right to continue health and life coverage. Your options are explained below.

Continuing Health Coverage under COBRA

You and your enrolled dependents may have the right to continue your current health coverage for a limited time under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). PEIA's COBRA program is administered by Acordia, and all COBRA eligibility is maintained by Acordia. New enrollees in any PEIA-sponsored health plan will receive a detailed notice of their COBRA rights from Acordia.

You and/or your dependents may elect to continue coverage for up to 18 months due to termination of your employment (other than by reason of gross misconduct) or reduction in work hours.

Your dependents are eligible to continue coverage in their own right for a maximum of 36 months under COBRA in the case of:

- divorce or legal separation;
- loss of eligibility of dependent children; or
- death of employee.

An election to continue coverage under COBRA must be made within 60 days of the end of the coverage. If you elect to continue coverage under COBRA, you will be responsible for paying the full premium plus a 2% administrative fee. Please note that COBRA premiums are billed directly to you.

To enroll for COBRA benefits, contact Acordia at 1-888-440-7342.

If 18 months of COBRA coverage is provided due to termination or reduction in hours of employment, and if any COBRA beneficiary is determined to be disabled under the Social Security Act at any time during the first 60 days of this COBRA coverage, then the 18-month continuation period may be extended to 29 months for all individuals who are qualified beneficiaries. The disabled person can be a covered employee or a dependent. The disability determination must be reported to PEIA within 60 days of the determination and before the end of the original 18-month coverage period.

Under COBRA, PEIA will charge 150% of the applicable premium for coverage during the 11-month disability extension. If a second qualifying event occurs during the 11-month extension, entitling a qualified beneficiary to 36 months of coverage (an additional 7 months of coverage), then PEIA will charge 150% of the applicable premium until the end of the 36-month continuation coverage period.

Coverage under COBRA will cease under these circumstances ("you" refers to the person who elected COBRA):

- you become covered under another group plan (unless it contains a pre-existing condition exclusion that reduces your benefits);
- you become entitled to Medicare;
- you fail to pay the premium;
- the policyholder's former employer withdraws or is terminated from the PEIA plan; or
- the PEIA PPB Plan ends.

If you are covered by another health plan or Medicare before the COBRA election is made, you may make a COBRA election. In other words, your employer may end the right to COBRA continuation coverage based upon other group health plan coverage or entitlement to Medicare benefits only if the qualified beneficiary first becomes covered under the other group health plan coverage or entitled to (covered for) the Medicare benefits after the date of the COBRA election.

When coverage under COBRA ends, you have the option to convert your coverage to an individual policy.

Converting Health Coverage to an Individual Policy

If you have been covered continuously by PEIA (either under the PEIA PPB Plan or through one of the managed care plans) for at least three months and your coverage ends, you may apply for individual health coverage. Your covered dependents also have this right.

You are not eligible for an individual policy if:

- you are age 65 or older; or
- your coverage ended because you failed to pay the premium.

If you were covered under one of the managed care plans, contact the managed care plan for instructions on this conversion.

If you were covered under the PEIA PPB Plan, you must submit an application and remit the first premium within 31 days after the termination of PEIA coverage. Coverage under the individual policy will become effective the day after PEIA coverage ends. To obtain a Health Conversion Application Form, please call PEIA at 1-304-558-7850 or toll-free at 1-888-680-7342. The individual health policy is issued by Celtic Life, not PEIA. Once you have completed the application form, mail it to the address printed on the application form. Benefits under an individual policy are determined by Celtic Life, and may differ substantially from the PEIA plan. Premiums for individual policies are generally higher than rates for a group plan like the PEIA PPB Plan.

If your PEIA PPB Plan coverage has been continued under COBRA, then you may apply for an individual policy if you submit a written application within 31 days after your COBRA coverage ends.

Converting Life Insurance to an Individual Policy

When employment ends, you may convert all or part of the life insurance coverage into an individual policy. Dependents who lose eligibility for life insurance coverage may convert optional dependent life insurance to an individual policy. This provision does not apply to retired employees or their dependents.

You must submit an application and remit the first premium within 31 days after the termination of the life insurance coverage. Coverage under the individual policy will become effective the day after the group life insurance coverage ends.

To obtain a Life Insurance Conversion Application Form, call PEIA at 1-304-558-7850 or toll-free at 1-888-680-7342. The individual life insurance policy is issued by PEIA's life insurance carrier, not PEIA. Once you have completed the application form, mail it to the address printed on the application form. Premiums for individual policies are generally higher than rates for a group plan.

Paying For Benefits

Each year the PEIA Finance Board sets premium rates for the PEIA PPB Plan. PPB Plan premiums are set at a level that ensures that the premiums collected from employers and employees will pay the anticipated claims for that year. Managed care plan premiums are also set annually prior to Open Enrollment.

Your coverage as an active or retired policyholder, and coverage of your dependents, will be terminated if you fail to pay your premium contributions when due.

Tobacco-free Discount

PEIA's premiums are based on the tobacco-use status of insureds. Tobacco-free insureds will receive the preferred monthly premium rate, which is $10 lower for single coverage, and $20 lower for family coverage. Plan insureds must have been tobacco-free for 4 months prior to the beginning of the Plan Year to qualify for the discount. Newly hired PPB Plan insureds must have been tobacco-free for 4 months prior to their effective date of coverage to qualify for the discount.

Tobacco-free insureds must sign an affidavit each year and return it during Open Enrollment to receive the reduced premium rate for the following plan year. For family coverage, all enrolled family members must be tobacco-free to qualify the family for the reduced rate. PEIA reserves the right to review medical records to check for tobacco use. PEIA offers a tobacco cessation benefit. See page 47 for details.

Active Employees

If you are an active employee of a State agency, college, university or county board of education, most of your health insurance premium is paid by your employer. The amount of your contribution is determined by your salary, the type of coverage you choose, and your tobacco-use status.

If you are an active employee of a local government agency, your employer will set your health insurance premium contribution level. You may pay anywhere from 0% to 100% of the premium that PEIA charges to your employer.

Retired Employees

Premiums for most retired employees are deducted from their annuity on a monthly basis. Some retired employees pay premiums directly to the PEIA each month, and for them, premiums are due by the 25th of each month. If payment is not received by PEIA within 15 days following the due date, all medical claims will be pended. Additionally, the PEIA drug card will be suspended. If payment is not received within 30 days following the due date, coverage will be cancelled, and all claims incurred will be their personal responsibility.

Retired Employees Who Retired Before July 1, 1997

Retired employees who retired prior to July 1, 1997, pay premiums based on the plan they choose, their tobacco-use status and eligibility for Medicare. Generally, retired employees' contributions pay for about 30% of the cost of their claims. The remaining 70% of the cost is paid by employers. Eligible retired employees may use sick or annual leave to extend employer-paid health coverage.

Employees Who Retire On or After July 1, 1997

Employees who retire on and after July 1, 1997 pay premiums for their health coverage based on the plan they choose, their eligibility for Medicare, their credited years of service and their tobacco-use status. These premiums may be adjusted annually for medical inflation. Employees with 25 or more years of service will be charged the same premium as those who retired before July 1, 1997. Those with fewer than 25 years of service will pay higher premiums. If you are using accrued sick and/or annual leave or years of service to extend your employer-paid insurance, all, or a portion of this increased premium will be covered by your accrued leave. Disability retiree premiums are assessed on twenty-five (25) years of service.

Deputy Sheriffs

Deputy sheriffs who retire prior to attaining age 55 have two benefit plan options available to them. Those considering early retirement should call PEIA for details of their plans and premium requirements.

Surviving Dependents

Surviving dependents of public employees pay premiums for their health coverage based on the plan they choose, their eligibility for Medicare and their tobacco-use status. These premiums may be adjusted annually for medical inflation. Surviving dependents are considered to have 25 or more years of service, and will be charged the same premium as those who retired before July 1, 1997.

Premiums for some surviving dependents are deducted from their annuity on a monthly basis. Some surviving dependents pay premiums directly to the PEIA each month, and for them, premiums are due by the 25th of each month. If payment is not received by PEIA within 15 days following the due date, all medical claims will be pended. Additionally, the PEIA drug card will be suspended. If payment is not received within 30 days following the due date, coverage will be cancelled, and all claims incurred will be their personal responsibility.

Extending Employer-Paid Insurance Upon Retirement

You may be eligible to extend your employer-paid insurance upon retirement, but how you do that is determined by your employer. To take advantage of this benefit, you must move directly from active public employment into your respective retirement system. If you choose to defer your retirement, you cannot defer your sick and annual leave for use later. Elected public officials are not eligible for this benefit. This benefit terminates when the policyholder dies; it cannot be used by surviving dependents, who may continue coverage by paying the monthly premium.

You may also have the option to use your accrued leave to increase your retirement benefits from your retirement system. You must choose between additional retirement benefits and extended employer-paid insurance coverage. You may not use some of your accrued leave to increase your retirement benefit and the rest to extend your employer-paid insurance coverage. Once this election is made, you may not revoke the selection.

Using Accrued Sick and Annual Leave to Extend Coverage

If you are an employee of a State agency or a county board of education (or an eligible employee of a local agency) with coverage through the PEIA and have accrued sick and/or annual leave when you retire, you may use that accrued leave to extend your employer-paid insurance coverage. You must be enrolled in either the PEIA PPB Plan or a PEIA-sponsored HMO plan prior to your retirement to qualify. This extended coverage must be for full months. Employees hired on or after July 1, 2001, are not eligible for this benefit.

If the policyholder dies, the accrued sick and annual leave benefit terminates, even if the surviving dependent continues coverage.

If you and your spouse are both public employees eligible for extended employer-paid insurance coverage, you may combine your accrued leave to extend your family coverage. Certain restrictions apply. See your benefit coordinator for details.

The amount of this benefit depends on when you came into the PEIA plan as follows:

Before July 1, 1988:

If you have been continuously covered by PEIA since before July 1, 1988, then your additional coverage is calculated as follows:

2 days of accrued leave = 100% of the premium for one month of single coverage

3 days of accrued leave = 100% of the premium for one month of family coverage

After July 1, 1988:

If you were hired after July 1, 1988, or if you had a lapse in coverage after July 1, 1988, then your additional coverage is calculated as follows:

2 days of accrued leave = 50% of the premium for one month of single coverage

3 days of accrued leave = 50% of the premium for one month of family coverage

Extending Coverage for Higher Education Faculty

If you are a full-time faculty member employed on an annual contract basis for a period other than 12 months, you may extend your employer-paid insurance coverage based on your years of teaching service. Your benefit is calculated as follows:

3 1/3 years of teaching service = 1 year of single coverage

5 years of teaching service = 1 year of family coverage

Premium Assistance Program

Retired employees whose total annual income is less than 250% of the current federal poverty level may receive assistance in paying a portion of their PEIA monthly health premium based on years of active service, through a grant provided by the PEIA. Applicants must be enrolled in the PEIA PPB Plan. Managed care plan members are not eligible for this program. Retired employees using accrued sick and/or annual leave to pay their premiums are not eligible for this program until their accrued leave is exhausted. Applications are mailed to all eligible retired employees each Spring. Those who qualify for Premium Assistance also qualify for Prescription Drug Copay Assistance. See the prescription drug benefit section starting on page 63 for details.

Years of Service

The amount of assistance for which you are eligible is based on years of active service. For surviving dependents, it will be based on years of service earned by the deceased policyholder. Disabled retirees are considered to have twenty (20) years of service.

Retirees with twenty (20) or more years of service are eligible for 100% of the base assistance amount. Retirees with 10-14 years are eligible for only 60% of the base assistance amount. These figures will be

verified by the appropriate State retirement system. Below is a chart with the percentages of assistance available based on years of active service. Remember that even at the 100% level, this assistance pays only a portion of the total health insurance premium.

Years of active service	Percentage of assistance available
20 or more	100
15-19	80
10-14	60
5-9	30
Fewer than 5	0

Life Insurance Premiums

Life insurance premiums for all participants are set by PEIA's life insurance carrier. For active employees, basic life insurance premiums are paid by your employer. Retired employees must pay the basic life insurance premium to keep coverage in force. Optional life insurance premiums are paid by the employee and are based on age and amount of coverage. See your July 1997 Life Insurance Booklet for further details of the options available to you.

Life Insurance Waiver of Premium

If you are an active employee with basic life insurance, and you become totally disabled before you reach age 60, your basic life insurance may be continued at no cost to you while you remain totally disabled. To qualify for this waiver of premium, you must furnish proof of total disability within one year after the date of disability. The date of disability is considered the last day you were actively at work. You must furnish proof of total disability after you have been disabled for nine (9) months, but not later than twelve (12) months after your last day of active work. To qualify for the waiver of premium, you must have been covered under basic life insurance when your disability began.

"Total Disability" exists when you are completely unable, due to sickness or injury or both, to engage in any gainful occupation for which you are reasonably fitted by education, training or experience. You will not be considered totally disabled while working at any gainful occupation.

To apply for a disability waiver of premium, contact your benefit coordinator. Proof of continuing disability will be required three months before each anniversary of the initial date of disability. You may be asked by PEIA's life insurance carrier to submit periodic medical exams. AD&D coverage does not continue under the waiver of premium.

If your waiver of premium is approved, your basic life insurance will remain at $10,000 at no premium cost to you. At age 65, your basic life coverage decreases to $5,000, and further reduces to $2,500 at age 67. This coverage will end at the earliest of these events:

- the end of disability;
- the failure to provide proof of continued disability; or
- the failure to submit to a physical examination when required by PEIA's life insurance carrier.

See your July 1997 Life Insurance Booklet for more details.

How to Participate

If your employer offers the premium conversion plan, your premiums automatically will be deducted on a pre-tax basis. If you do not wish to participate in the premium conversion plan, you must indicate this in writing to your benefit coordinator.

Decisions regarding premium conversion must be made when you initially enroll for PEIA coverage or during the annual open enrollment period each Spring.

Limits on Benefit Changes

The premium conversion plan does not change your PEIA coverage, but it does limit your ability to make changes in your plan. Under the IRS rules, you must pay the same amount of premium each month during the year, unless you have a qualifying change in family status.

Qualifying changes in family status are:

- marriage or divorce of the employee;
- death of the employee's spouse or dependent;
- birth or adoption of the employee's child;
- commencement or termination of employment of the employee's spouse or dependent;
- a change from full-time to part-time employment status, or vice versa, by the employee or his or her spouse;
- an unpaid leave of absence taken by the employee or spouse;
- a significant change in the health coverage of the employee or spouse attributable to the spouse's employment;
- annulment;
- change in the residence or work site of the employer, spouse, or dependent;
- a dependent loses eligibility due to age or student status; or
- employment change due to strike or lock-out.

Open Enrollment Under Other Employer's Plan

You may make a change in your plan when your spouse or dependent changes coverage during Open Enrollment under his or her plan if:

- the other employer's plan permits mid-year changes under this event, and
- the other employer's plan year is different from PEIA's.

You may make a change in your coverage (add a dependent, for example) that increases your insurance premium, or that has no effect on your premium, without having one of these events, but you'll pay any resulting increased premium on an after-tax basis until the next open enrollment period.

You may not make a change in your coverage that reduces the premium you pay until the next open enrollment period unless you have a qualifying change in family status.

To make a change in your coverage, get a Change-in-Status form from your benefit coordinator. Two types of changes require additional documentation; they are detailed in the following chart.

Status Change Event	Documentation Required
Divorce	Provide a copy of the divorce decree showing that the divorce is final. Coverage for the ex-spouse will be terminated at the end of the month in which the divorce became final.
Significant Change in Health Coverage Attributable to Spouse's Employment	Documentation from the spouse's employer describing the change in health coverage.

Health Care Benefits

You may get health care benefits through PEIA from a managed care plan or from the PEIA PPB Plan. The PEIA PPB Plan replaced the PEIA Indemnity Plan on July 1, 1999.

If you choose to receive your benefits from a managed care plan, you must enroll with the PEIA and choose a plan. You must refer to the information provided by the managed care plan for details of your benefits. This next section, entitled the PEIA PPB Plan, will not apply to you.

If you choose the PEIA PPB Plan, your benefits are described on the following pages. This section describes only the benefits offered under the PEIA PPB Plan.

The PEIA PPB Plan

The PEIA PPB Plan pays for a wide range of health care services for employees and their dependents. These benefits include hospital services, medical services, surgery, durable medical equipment and supplies, and prescription drugs.

Under the plan, certain costs are your responsibility. In addition, to receive maximum benefits for some services, precertification is required or your benefits will be reduced. Please read the health care benefits section carefully so that you will have a clear understanding of your coverage under the plan.

If you have any questions about coverage or payment for health care services, please call:

Who to Call with Questions		
Medical claims, benefits, preauthorizations and prior approvals for out-of-state care	Acordia	1-888-440-7342
Prescription drug claims and benefits	Express Script	1-877-256-4680
Precertification and case management	Intracorp	1-888-440-7342

EIA's Networks

The PEIA PPB Plan provides care through several networks of providers. In West Virginia, any physician o accepts a PEIA ID card is automatically considered a member of our network. Outside West Virginia,

there are several networks available. Access to those networks depends on where you live. The available networks are:

- Medical Mutual of Ohio's SuperMed Plus Network (in Ohio only),
- the Alliance Network (in Maryland, Washington, DC, and North Carolina only), or
- the Beech Street Network in all other states.

Also, Acordia contracts with some out-of-state providers to serve PEIA members only. To locate a network provider in any of the available networks, call Acordia National at 1-888-440-7342 or 304-353-7820. Care provided by non-network providers requires prior approval, or it will be paid at the lower out-of-network benefit level (typically 60%, with the additional out-of-network deductible).

PEIA reserves the right to remove providers from the networks, so not all providers in all networks may be available to you. If you have questions about a specific network provider, please contact Acordia at 1-888-440-7342.

Resident PPB Plan Members

PEIA PPB Plan insureds who live in West Virginia or a bordering county of a surrounding state may access any West Virginia provider who accepts PEIA, or any network provider located in those bordering counties without receiving prior approval. All services, except emergency care, provided outside of West Virginia beyond the bordering counties requires prior approval.

Non-Resident PPB Plan Members

For PEIA PPB Plan insureds who reside outside the State of West Virginia (beyond the bordering counties of surrounding states), PEIA has made special arrangements. Insureds who live more than one county outside the State may seek care from any network provider. Care from network providers does not require prior approval, and that care will be covered at the in-network benefit level (typically 80%). Precertification of inpatient stays and certain outpatient procedures is still required. See page 35 for details.

What You Pay With The PEIA PPB Plan

Medical Deductible

During any plan year, if you or your eligible dependents incur expenses for covered medical services (other than office visits), you must meet a deductible before the plan begins to pay.

Medical deductibles are determined based on your salary, tier of coverage (i.e., individual or family), and whether you get your services within the PEIA network or outside of the network.

The family deductible is twice the individual deductible. The family deductible is divided up among the family members. No one member of the family will pay more than the individual deductible. Once that person has met the individual deductible, the plan will begin paying on that person. When another member of the family meets the individual deductible, then the plan will begin paying on the entire family. Alternatively, all members of the family may contribute to the family deductible with no one person meeting the individual deductible; once the family deductible is met, the plan pays on all members of the family. The deductibles are listed below according to income level and coverage tier.

PEIA PPB Plan In-Network Deductibles				
Annual Salary (state agencies, colleges, universities and county boards of education)	Employee Only	Employee & Child(ren)	Family	Family with Employee Spouse*
$0 - 20,000	$100	$200	$200	$200
$20,001 - 30,000	$150	$300	$300	$300
$30,001 - 36,000	$200	$400	$400	$400
$36,001 - 42,000	$225	$450	$450	$450
$42,001 - 50,000	$250	$500	$500	$500
$50,001 - 75,000	$375	$750	$750	$750
$75,001 - 100,000	$425	$850	$850	$850
$100,001 - 125,000	$500	$1,000	$1,000	$1,000
$125,001 +	$600	$1,200	$1,200	$1,200
Non-state Plan A	$225	N/A	$450	N/A
Non-State Plan B	$500	N/A	$1,000	N/A
Non-Medicare Retirees	$375	N/A	$750	N/A
Medicare Retirees	$150	N/A	$300	N/A

* Deductibles for Family with Employee Spouse coverage are based on the average of the two employees' salaries. This provision does not apply to local government agency or retired employees.

For inpatient admissions that span two plan years, the facility charges are paid based on the first plan year, but physician charges are paid based on the date of service, which could be in the new plan year. For example, if you go into the hospital on June 28 and are released on July 6, the hospital bill is paid based on the date of admission, so it would fall under the old plan year's deductible. Physician charges are paid based on the date of service, so if you have surgery on July 2, the surgeon's bill will be processed based on the new plan year, and the deductible for new plan year will apply to the surgeon's bill.

The out-of-network deductible satisfies the in-network deductible, but the in-network deductible does not meet the out-of-network deductible. **Please note that the amounts listed in the chart are for in-network deductibles.** Out-of-network deductibles are twice the amount of the in-network deductibles listed above.

Prescription drug benefits are subject to a separate deductible. Please see the Prescription Drug Benefit Section starting on page 63 for information.

Coinsurance for In-Network and Out-of-Network Benefits

The PEIA PPB Plan is designed to provide as much care as possible within the State of West Virginia. The PEIA Preferred Provider Organization (PPO) is made up of West Virginia providers who accept PEIA's reimbursement. For services provided outside of the State, several networks are available. In the state of Ohio, the network is Medical Mutual of Ohio's SuperMed Plus Network. For Maryland, North Carolina and the District of Columbia (DC), the network is the Alliance Network. For all other states the network is Beech Street. Acordia also has direct contracts with some providers in bordering states to serve PEIA only.

	If you live in WV, you will pay:	**If you live in a bordering county of a surrounding state, you will pay:**	**If you live out-of-state (beyond bordering counties), you will pay:**
Access care in WV or in a bordering county of a surrounding state using PPO providers	20% coinsurance	20% coinsurance	20% coinsurance
Access care outside WV (beyond bordering counties) **using PPO providers with prior approval**	20% coinsurance	20% coinsurance	20% coinsurance
Access care outside WV (beyond bordering counties) using **non-PPO providers with prior approval**	20% coinsurance	20% coinsurance	20% coinsurance
Access care outside WV (beyond bordering counties) using **PPO providers without prior approval**	40% coinsurance	40% coinsurance	20% coinsurance
Access care outside WV (beyond bordering counties) using **non-PPO providers without prior approval**	40% coinsurance	40% coinsurance	40% coinsurance

Resident PPB Plan Members

PEIA PPB Plan insureds who live in West Virginia or a bordering county of a surrounding state may access any West Virginia provider who accepts PEIA, or any network provider located in those bordering counties without prior approval. All services provided outside of West Virginia beyond the bordering counties require prior approval to be paid at the highest benefit level. For services of network providers, the plan will pay 80% of the contracted payment rate, you will be responsible for any copayments, deductible and 20% coinsurance. For services of non-network providers without prior approval, the plan will pay 60% of reasonable and customary charges; you will be responsible for any deductible, 40% coinsurance and any amount which exceeds the reasonable and customary amount. For non-network providers in bordering counties, PEIA will pay what it would have paid if the services had been provided in state. You will be responsible for any balance billing, and those amounts are considered non-covered services. They do not count toward the deductible or out-of-pocket maximum.

PPB Plan insureds traveling out-of-state have coverage for urgent and emergency care. In an emergency, seek treatment at the nearest facility that is able to provide the needed care, and that care will be paid at the in-network benefit level as an emergency. For non-emergency, urgent care, call Acordia for a referral to a network provider, or for approval to see an out-of-network provider where you are.

Non-resident PPB Plan Members

PEIA PPB Plan insureds who reside outside West Virginia and beyond the bordering counties may access care using any network provider without prior approval, and the claims will be paid at 80% of the

contracted payment rate. You will be responsible for any copayment, deductible and 20% coinsurance. Care provided by non-network providers must have prior approval. Services of non-network providers will be paid at 60% of the reasonable and customary charges, unless approved by Acordia in advance. Precertification requirements apply for inpatient stays and certain outpatient procedures.

Please consult the chart on the previous page to determine your level of coinsurance based on where you reside, where you receive your services, and whether or not you obtain prior approval.

Benefit Design

The following section provides you with a description of services and your cost-share.

Covered in Full

The following services are covered in full in-network:

Type of Service	Your In-network Cost
Routine prenatal care (physician services)	$0; Covered in full*
Well child exams and immunizations	$0; Covered in full
High risk birth score program	$0; Covered in full
Annual screening mammogram	$0; Covered in full
Annual Pap smear	$10 preventive care office visit copay
Colorectal cancer screening	$10 preventive care office visit copay
Prostate cancer screening	$10 preventive care office visit copay

* Deductible applies only if not met in hospital or other services.

Copayment Only

A copayment is a flat dollar amount you pay when you receive the service(s) from an in-network provider or an approved non-network provider. When a service is subject to a copayment only, you do not have to meet the deductible before the PEIA PPB Plan begins to pay for that service. The copayment does not count toward your deductible or your out-of-pocket maximum.

Type of Service	Your In-network Cost
Physician Office Visits - preventive care	$10 copayment per visit with no deductible
Physician Office Visits - treat illness or injury	$15 copayment per visit with no deductible
Adult Routine Physical Exams	$10 copayment per visit with no deductible
Second Surgical Opinions*	$15 copayment per visit with no deductible

*** no copayment if required by Intracorp.**

All of the services subject to a copayment only are listed in the chart above. See pages 39-48 for a detailed description of individual services.

Copayment, Coinsurance and Deductible

The services listed in the chart are subject to a copayment, annual deductible, and coinsurance.

Type of Service	Your In-network Cost
Emergency Services (including supplies) at emergency room	$25 copayment + deductible and 20% coinsurance when certified as an emergency
Non-emergency services at emergency room	$50 copayment + deductible and 20% coinsurance
Ambulatory surgery/Outpatient surgery (facility-based)	$50 copayment + deductible and 20% coinsurance

Coinsurance and Deductible

Services not listed in the three preceding charts are covered at 80% after the deductible is met for in-network care and at 60% after the out-of-network deductible is met for non-network care which is not preauthorized. You pay your deductible, coinsurance, and any charges for services not covered by the plan, directly to your health care provider.

Out-of-Pocket Maximum

The out-of-pocket maximum is the most you pay in **coinsurance** in a plan year. Amounts you pay toward your annual deductibles, for copayments, for precertification penalties, for prescription drugs, for amounts billed in excess of what PEIA pays to non-network providers, and for services that are not covered under the plan do not apply toward your annual out-of-pocket maximum. It includes only your medical charges; prescriptions are handled separately. See the prescription drug benefit section starting on page 63 for details.

The deductible chart shows the out-of-pocket maximum amount, which is the same whether you have a single plan or a family plan. It is a per-contract amount, which doesn't change regardless of whether there is just the policyholder on the contract, or the policyholder and several dependents.

Once you have met your out-of-pocket maximum, the plan will pay 100% of your covered charges (less applicable copayments) for the remainder of the plan year. Your out-of-pocket maximum amount depends on your employment status, your salary, where you receive your services, whether your provider is in the PEIA PPO network, and whether out-of-network care is preauthorized.

Amounts paid toward the out-of-network out-of-pocket maximum will also count toward the in-network out-of-pocket maximum, but in-network amounts do not count toward the out-of-network out-of-pocket maximum.

Out-of-Pocket Maximum Amounts			
Employee Status	Employee's Annual Salary	Annual In-Network Out-of-Pocket Maximum	Annual Out-of-Network Out-of-Pocket Maximum
Active, State Agency, Colleges and Universities, Boards of Education	$0 - 20,000	$800	$1,600
	$20,001 - 30,000	$1,100	$2,200
	$30,001 - 36,000	$1,250	$2,500
	$36,001 - 42,000	$1,500	$3,000
	$42,001 - 50,000	$1,750	$3,500
	$50,001 - 75,000	$1,800	$3,600
	$75,001 - 100,000	$1,900	$3,800
	$100,001 - 125,000	$2,000	$4,000
	$125,001 +	$2,250	$4,500
Non-State Plan A	Not applicable	$1,500	$3,000
Non-State Plan B	Not applicable	$1,000/single;$2,000/family	$2,000/single;$4,000/family
Retired, Non-Medicare	Not applicable	$1,500	$3,000
Retired, Medicare	Not applicable	$1,000	$1,000

Out-of-network out-of-pocket maximums are twice the amount of the in-network out-of-pocket maximums.

Benefit Maximums

For certain types of services, the plan will pay up to a set amount per plan year as shown below.

For services marked on the chart with an asterisk (*), additional benefits may be recommended by Intracorp when medically necessary and appropriate. Approval must be obtained before additional services are rendered. Seek approval for additional services at least five business days in advance to allow time for medical review. For details of these benefits, see "What Is Covered" beginning on page 39.

Annual Benefit Maximums	
Type of Service	Benefit Maximum (per member per plan year)
*Outpatient Mental Health/Chemical Dependency	20 visits
Christian Science Treatment	$1,000
*Outpatient Therapy Services: This benefit includes outpatient physical, occupational, massage, speech, and vision therapies, acupuncture and chiropractic care.	$1,000 (total amount allowed for all therapies combined)
Inpatient Rehabilitation	150 days
Skilled Nursing Facility	100 days

*may be extended if approved by Intracorp

Lifetime Maximum

The PEIA will pay a maximum of $1,000,000 in benefits per person during the person's lifetime. This maximum includes benefits paid for services rendered under the PEIA Indemnity Plan and the PEIA PPB Plan. Benefits paid under the Prescription Drug Plan are not included.

Pre-existing Medical Conditions

A pre-existing medical condition is one which has been diagnosed, treated, or for which you or your dependents have incurred expenses within the three months immediately before the effective date of the PEIA PPB Plan coverage.

Expenses for a pre-existing condition will not be covered by the PEIA PPB Plan for the first twelve months your coverage is in effect. This limitation is waived if you had creditable coverage under another health plan which terminated no more than 62 days prior to the effective date of the PEIA PPB Plan coverage. Pregnancy and any condition meeting the definition of handicap are not considered pre-existing medical conditions.

PEIA PPB Plan Fee Schedules and Rates

The PEIA PPB Plan pays health care providers according to a maximum fee schedule and rates established by the PEIA Finance Board. If a provider's charge is higher than the PEIA maximum fee for a particular service, then the plan will allow only the maximum fee. The "allowed amount" for a particular service will be the lower of the provider's charge or the PEIA maximum fee.

Physicians and other health care professionals are paid according to a Resource Based Relative Value Scale (RBRVS) fee schedule. This type of payment system sets fees for professional medical services based on the relative amounts of work, practice expense and malpractice insurance expense involved. These rates are adjusted annually. West Virginia physicians who treat PEIA patients must accept PEIA's allowed amount as payment in full; they may not bill additional amounts to PEIA patients.

Most inpatient hospital services are paid on a "prospective" basis. PEIA's reimbursement to hospitals is based on Diagnosis-Related Groups (DRGs), which is the system used by Medicare. It is a Prospective Payment System (PPS) that classifies medical cases and surgical procedures on the basis of diagnoses. Under this system, West Virginia hospitals know in advance what PEIA will pay per day or per admission. West Virginia hospitals have been provided specific information about their reimbursement rates from PEIA. These rates are also adjusted annually.

Notification Requirements

Precertification of Inpatient Admissions (Mandatory)

If you are going to be admitted to a hospital, a skilled nursing facility, or other inpatient facility, your provider must call Intracorp in advance to precertify your admission. Admissions to partial hospitalization and day programs also require precertification. Your provider must contact Intracorp five (5) business days prior to a scheduled admission or procedure.

Failure to precertify an admission within the timeframes specified in the chart below will result in a reduction of benefits under the PPB Plan of 30%. This 30% penalty will be the responsibility of network providers. For all non-network providers, this 30% penalty will be the responsibility of the insured in addition to any applicable copayment, coinsurance and deductible.

If the insured or provider feels that Intracorp inappropriately denied an admission or the extension of an admission, or that extenuating circumstances existed that prevented notification to Intracorp within the timeframes set forth, the insured or provider may file an appeal.

Exception

It is the patient's responsibility to precertify inpatient stays and outpatient procedures when these services are received out-of-network. If you do not precertify these out-of-network services, you must pay the 30% precertification penalty in addition to the out-of-network copayment, coinsurance and deductible. Prior approval to use out-of-network providers does not precertify services.

Timely Precertification Requirements	
Type of Admission	**Advance Notice Required**
Scheduled:	
Planned admission	5 business days in advance
Inpatient elective surgery or procedure	5 business days in advance
Maternity (notify Intracorp during your first trimester)	
Term pregnancy	Within 48 hours of admission
Caesarean section (planned)	5 business days in advance
Caesarean section (emergency)	Within 48 hours of admission
Urgent/Emergency	Within 48 hours of admission
Extended stay	Additional days may be recommended based on medical necessity

ecertification of Outpatient Procedures and Services (Mandatory)*

The outpatient procedures and services in the following list also require precertification. Your provider **ıst** contact Intracorp at least 5 business days in advance if you are scheduled for one of these outpa- nt surgical or diagnostic procedures:

- allergy testing
- cardiac rehabilitation
- colonoscopy (diagnostic only)
- DEXA Scan
- durable medical equipment (DME) purchase of $100 or more, or rental of more than 3 months
- magnetic resonance angiography (MRA)
- magnetic resonance imaging (MRI)
- multidisciplinary pain management services

- orthotics
- PET Scan
- sclerotherapy

Precertification does not assure eligibility or payment of benefits under this plan.

*This list is subject to change; changes will be published in the PEIA *News*.

Preauthorization (Voluntary)

Preauthorization is a program which allows you to contact Acordia National in advance of a procedure to verify that the service is covered and will be paid so that you can make an informed decision about the procedure. Obtaining preauthorization from Acordia National assures that your claim will be paid when it's submitted. To obtain preauthorization, ask your provider to send your request to:

Acordia National
P. O. Box 2451
Charleston, WV 25329-2451

Your provider should include your name, address, telephone number, your Social Security Number, and all information about the procedure that's recommended. Acordia National may contact your physician for more information. Remember, if your request for preauthorization is denied, you will be responsible for paying for the procedure if you choose to have it. Due to specific benefit criteria, preauthorization is recommended for the following procedures:

- Chelation Therapy
- Massage Therapy
- Vision Therapy
- Accident-related Dental Services

Prior Approval for Out-of-Network Services (Mandatory)

If you live in West Virginia or a bordering county of a surrounding state, all services outside of the state beyond the bordering counties must have prior approval. For services at preferred providers with prior approval, the plan will pay 80% of the contracted payment rate; you will be responsible for any deductible, copayments and 20% coinsurance.

For services of non-network providers without prior approval, the plan will pay 60% of reasonable and customary charges. You will be responsible for any deductible, copayments, and 40% coinsurance. Any amount which exceeds the reasonable and customary amount will be your responsibility. Those amounts are considered non-covered services. They do not count toward the deductible or out-of-pocket maximum.

Special arrangements have been made for insureds who live more than one county beyond the borders of West Virginia. See page 28 for more details.

Medical Case Management

If you are experiencing a serious or long-term illness or injury, Intracorp's medical case management program can help you learn about available resources, provide early support for your family, and find ways to contain medical costs, including your out-of-pocket expenses. Through medical case management Intracorp can:

- arrange home care to prevent hospitalization;
- arrange services in the home to facilitate early hospital discharge;
- obtain discounts for special medical equipment; and
- locate appropriate services to meet the patient's health care needs.

Intracorp **must** be notified for medical case management for the following services:

- home health care, including but not limited to:
  a. skilled nursing visits;
  b. I.V. therapy in the home;
  c. physical therapy, occupational therapy or speech therapy done in the home;
  d. hospice care; and
  e. medication provided or administered by a home health agency.
- skilled nursing facility services;
- rehabilitation services; and
- physical, occupational or speech therapies when proposed beyond the plan benefit maximum.

Transition of Care Program (New Members Only)

If you are new to the PEIA PPB Plan, and have been receiving medical treatment from a non-network provider, you may be concerned that your care will be interrupted in your move to the PEIA PPB Plan. To assist insureds receiving treatment for serious medical conditions from non-network providers, PEIA has a Transition of Care (TOC) program. If you qualify for TOC, you can continue to receive medical treatment from a non-network provider during a transition period specified by Acordia National and be covered at the in-network benefit level.

Following this transition period or after your treatment is complete, your medical care must be provided by a network provider to be eligible for the higher in-network level of benefits. Not all conditions will qualify for the TOC program.

Medical conditions **likely to qualify** for TOC benefits include:

- pregnancy,
- recent acute heart attack,
- newly diagnosed cancer requiring surgery, chemotherapy or radiation therapy,
- total joint replacement requiring physical therapy,
- acute trauma such as a bone fracture,

- certain psychiatric treatment or substance abuse programs, and
- recent surgical procedures with complications.

Medical conditions which are ***not likely*** to qualify for TOC benefits include:

- arthritis,
- hypertension,
- diabetes,
- asthma, and/or
- allergies.

In most cases, a network provider can successfully treat these chronic conditions. If there is not a network provider available to treat your specific illness or condition, PEIA will work with you to provide that care. Conditions limited or excluded from coverage are not eligible for TOC benefits.

To apply for the TOC program, request a copy of the TOC form by calling 1-888-440-7342 or 1-304-353-7820 and submit the completed form to Acordia National as indicated on the form. A separate form must be completed for each out-of-network provider. You will receive a written determination on your request for TOC benefits from the medical management department at Acordia National. You must apply for TOC within three months of your effective date of coverage in the PEIA PPB Plan.

PEIA Nurseline

PEIA Nurseline is your toll-free 24-hour-a-day, 7-day-a-week link to valuable medical information. You can call PEIA Nurseline from anywhere in the United States or Canada to speak with an experienced registered nurse about any health concern. You and any member of your immediate family covered through the PPB Plan may call. PEIA Nurseline nurses can help you treat minor illnesses or injuries in your home and can also provide medical information about surgeries or medications that your doctor has recommended. Call PEIA Nurseline toll-free anytime at 1-877-294-7342.

PEIA Nurseline also provides information for PPB Plan insureds considering emergency room services. If you are considering a trip to the emergency room, but don't know if you're having a true medical emergency, you can call a PEIA Nurseline nurse to discuss the symptoms. If the PEIA Nurseline nurse refers you to the emergency room, PEIA will cover the visit as an emergency.

What Is Covered

Medically Necessary Services

To be covered, services must be medically necessary or be one of the specifically listed preventive care benefits.

Medically necessary health care services and supplies are those provided by a hospital, physician or other licensed health care provider to treat an injury, illness or medical condition. A service is considered medically necessary if it is:

- consistent with the diagnosis and treatment of the illness or injury;

- in keeping with generally accepted medical practice standards;
- not solely for the convenience of the patient, family or health care provider;
- not for custodial, comfort or maintenance purposes;
- rendered in the most cost-efficient setting and level appropriate for the condition; and
- not otherwise excluded from coverage under the PEIA PPB Plan.

The fact that a physician has recommended a service as medically necessary does not make the charge a covered expense. PEIA reserves the right to make the final determination of medical necessity based on diagnosis and supporting medical data.

Who May Provide Services

The PEIA PPB Plan will pay for services rendered by a health care professional or facility if the provid- is:

- licensed or certified under the law of the jurisdiction in which the care is rendered; and
- providing treatment within the scope or limitation of the license or certification.

pes of Services Covered

Your PEIA PPB Plan covers a wide range of health care services. Some major categories are listed w. The description of each service includes the level of coinsurance and any applicable copayments must pay when the service is received from a provider who participates in the PEIA PPO within the e of West Virginia or in bordering counties of the surrounding states.

lease keep in mind that for most insureds, services you receive from non-network providers are t to higher levels of coinsurance if not prior approved by Acordia National to ensure the lowest out- ket expense. See page 30 for details. If you have questions about coverage of services, call Acordia al at 1-888-440-7342 or 1-304-353-7820. The special arrangements that have been made for in- who live more than one county beyond the borders of West Virginia are explained on page 28.

puncture. Services of a licensed acupuncturist for treatment of medical conditions are included in Outpatient Therapy Benefit (see below) and are covered at 20% coinsurance after the in-network ctible. Contact Acordia for specific benefit limitations. Combined coverage for these therapies ited to a maximum plan cost of $1,000 per person per plan year. Office visits are covered with a opayment and treatments are covered at 80% after the in-network deductible is met.

Services. Including testing and related treatment; in-network care covered at 20% coinsurance n-network deductible is met. Allergy testing requires precertification.

ance Services. Ground or air ambulance transportation, when medically necessary, to the near- lity able to provide needed emergency treatment; in-network care covered at 20% co- e after in-network deductible.

ory Surgery. This benefit is subject to a $50 copayment and 20% coinsurance. The copayment surance amounts apply after the in-network deductible has been met. (See Outpatient Sur- age 43.)

ehabilitation. Benefits are limited to 3 sessions per week for 12 weeks or 36 sessions per year lowing conditions: heart attack in the 12 months preceding treatment, heart failure, coro-

Services marked with a ★ require precertification from Intracorp.

nary by-pass surgery or stabilized angina pectoris. Covered at 20% coinsurance after in-network deductible is met.

- Chelation Therapy. Benefits for these services are limited. Contact Acordia National for preauthorization. If covered, in-network therapy is paid at 80% after the in-network deductible has been met.
- Childhood Immunizations. Immunizations for children through age 16 are covered at 100% of allowed charges, including the office visit. This benefit is not subject to deductible, coinsurance, or copayment.
- Chiropractic Services. Services of a chiropractor for treatment of neuromuscular-skeletal conditions are included in the Outpatient Therapy Benefit (see below) and are covered at 20% coinsurance after the in-network deductible. Combined coverage for these therapies is limited to a maximum plan cost of $1,000 per person per plan year. Office visits are covered with a $15 copayment and x-rays are covered at 80% after the in-network deductible is met.

★ Christian Science Treatment. Treatment for a demonstrable illness or injury if provided in a facility accredited by the Commission for Accreditation of Christian Science Nursing Facilities/Organizations, Inc. or by a practitioner accredited by the Mother Church is covered at 20% coinsurance after the in-network deductible. No benefits will be paid for the purpose of rest or study, for communication costs, or if the person requiring attention is receiving parallel medical care. Coverage is limited to a maximum cost to the plan of $1,000 per plan year. If required, this benefit may be extended for inpatient care for up to 60 days per plan year. Inpatient care must be precertified.

- Colorectal Cancer Screenings. Routine screening to detect colorectal cancer is covered at 100% in-network with no deductible or coinsurance required. The related office visit expenses are subject to the applicable preventive care office visit copayment. This benefit is covered as follows:

  Fecal-occult blood test -1 in 12 months/age 50 & over

  Flexible sigmoidoscopy -1 in 48 months/age 50 & over

  Colonoscopy for high risk -1 in 24 months/high risk patients*; 1 in 10 years/age 50 & over

  X-ray, barium enema -1 in 48 months/age 50 & over

  X-ray, barium enema -1 in 24 months/high risk patients*

  * High risk is defined as a patient who faces high risk for colorectal cancer because of family history; prior experience of cancer or precursor neo-plastic polyps; history of chronic digestive disease condition (inflammatory bowel disease, Crohn's disease, ulcerative colitis); and presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors.

- Cosmetic/Reconstructive Surgery. Services provided after trauma, illness or disease to correct conditions resulting from the trauma, illness or disease are covered at 20% coinsurance in-network after deductible is met.
- Dental Services (accident-related only). Services provided within six (6) months of an accident and required to restore tooth structures damaged due to that accident are covered at 20% coinsurance after the in-network deductible is met. Biting and chewing accidents are not covered. Services provided more than six (6) months after the accident are not covered. Contact Acordia National for more information. For children under the age of 16, the six-month limitation may be extended if an approved treatment plan is provided to Acordia National within the initial six months.
- Dental Services (impacted teeth). Medically necessary extraction of impacted teeth is covered at 20% coinsurance in-network after deductible is met. Extractions for the purpose of orthodontia are not covered.

Services marked with a ★ require precertification from Intracorp.

- Diabetes Education. Services of a diabetes education program that meets the standards of the American Diabetes Association are covered at 20% coinsurance after in-network deductible is met. Coverage is limited to six (6) visits per patient: three visits with the dietician and three visits with a registered nurse. Contact Acordia for specific benefit limitations.

★ Durable Medical Equipment (DME) and Prosthetics. Coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices, and for the rental or purchase (at the plan's discretion) of standard DME, when prescribed by a physician. Prosthetics and DME purchases of $1,000 or more, or rental for more than 3 months must be precertified by Intracorp. DME and prosthetics are covered at 20% coinsurance after the in-network deductible is met.

- Emergency Services (including supplies). Services received in an emergency room when the condition has been certified as an emergency are subject to a $25 copayment and 20% coinsurance in-network. The copayment and coinsurance amounts apply after the annual deductible has been met.

- Emergency Room Treatment. Services received in an emergency room when the condition is determined to be a non-emergency are subject to a $50 copayment and 20% coinsurance in-network. The copayment and coinsurance amounts apply after the annual deductible has been met.

★ Home Health Services. Intermittent health services of a home health agency when prescribed by a physician are covered at 20% coinsurance after the in-network deductible is met. Services must be provided in the home, by or under the supervision of a registered nurse. The home health services are covered only if they would otherwise have required confinement in a hospital or skilled nursing facility.

★ Hospice Care. When ordered by a physician; covered at 20% coinsurance after the in-network deductible is met.

- Hypertension Screening. The PEIA PPB Plan pays for diagnostic screening to determine if you are at risk for high blood pressure, heart disease or stroke. Benefits include coverage for an office visit, blood pressure check, and a blood chemistry profile. The office visit is subject to a $10 copayment and the blood chemistry is covered at 80% after the in-network deductible is met. The blood pressure check is included as part of the office visit. The plan will pay for this screening:
  - One time between the ages of 20 and 30;
  - Once every three years between ages 31 and 39; and
  - Once every two years after age 40.
- Immunizations
  - For children through age 16. The plan covers immunizations and the associated office visit with no deductible, coinsurance, or copayment required. Following is a list of immunizations and the ages at which PEIA covers them.
    - **Polio (IPV):** At 2 months, 4 months, 6 - 18 months, and 4 - 6 years.
    - **Diphtheria-Tetanus-Pertussis (DTaP):** At 2 months, 4 months, 6 months, 15-18 months, and 4-6 years.
    - **Tetanus-Diptheria (Td):** At 11-16 years.
    - **Measles-Mumps-Rubella (MMR):** At 12-15 months and EITHER 4-6 years OR 11-12 years.

Services marked with a ★ require precertification from Intracorp.

- **Haemophilus Influenzae type b (Hib):** At 2 months, 4 months, 6 months, and 12-15 months; OR 2 months 4 months, and 12-15 months, depending on the vaccine type,
- **Hepatitis B:** At birth-2 months, 1-4 months, and 6-18 months. If missed, get 3 doses starting at age 11 years.
- **Chickenpox (VZV):** At 12-18 months. If missed, get between ages 11 and 12 years.
- **Hepatitis A:** At 24 months- 12 years in selected areas.
- **Pneumococcal disease (Prevnar™):** At 2 months, 4 months, 6 months, and 12 - 15 months. If missed, talk to your health care provider.

Also see Well Child Care below.

- For adults and children over age 16. The plan covers immunizations as recommended by the American Academy of Family Physicians at 100% in-network. The associated office visit is subject to the applicable copayment. Other immunizations covered with 20% coinsurance after the in-network deductible is met.

★ Inpatient Hospital and Related Services. Confinement in a hospital including semi-private room, special care units, confinement for detoxification, and related services and supplies during the confinement are covered at 20% coinsurance after the in-network deductible is met. In addition to the penalties discussed on page 34, all unapproved out-of-network inpatient admissions are subject to a $500 deductible per admission.

★ Inpatient Rehabilitation Services. When ordered by a physician, coverage is subject to 20% coinsurance after the in-network deductible is met and is limited to 150 days per plan year. In addition to the penalties discussed on page 34, all unapproved out-of-network inpatient admissions are subject to a $500 deductible per admission.

★ Inpatient, Partial Hospitalization and Day Programs for Mental Health and Chemical Dependency. Covered at 20% coinsurance after the in-network deductible is met, when ordered by a licensed provider. In addition to the penalties discussed on page 34, all unapproved out-of-network inpatient admissions are subject to a $500 deductible per admission.

- Mammogram. An annual routine mammogram to detect breast abnormalities is covered at 100% in-network with no coinsurance or deductible required. The related office visit expenses are subject to the applicable copayment. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.
- Massage Therapy. Services of a licensed massage therapist for treatment of neuromuscular-skeletal conditions are covered under the Outpatient Therapy Benefit when ordered by a physician. Covered at 20% coinsurance after the in-network deductible is met.
- Mastectomy. If you are receiving benefits in connection with a mastectomy and elect breast reconstruction in connection with such benefits, you are entitled to the following procedures:
  - Reconstruction of the breast on which the mastectomy was performed;
  - Reconstruction surgery of the other breast to present a symmetrical appearance; and
  - Prostheses and coverage for physical complications at all stages of the mastectomy procedure including lymphedas.
- Maternity Services. See "Maternity Benefits" on page 45 for details.

Services marked with a ★ require precertification from Intracorp.

★ MRI and MRA. Magnetic Resonance Imaging and Magnetic Resonance Angiography services when performed on an outpatient basis must be precertified by Intracorp and are covered at 20% coinsurance after the in-network deductible is met.

★ Neuromuscular stimulators and bone growth stimulators when criteria are met are covered at 20% coinsurance after the in-network deductible is met.

- Oral Surgery. Only covered for extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction at 20% coinsurance after the in-network deductible is met. Preauthorization is recommended for orthognathic procedures and ridge reconstruction procedures.

★ Organ Transplants. See "Organ Transplant Benefits" on page 46 for more details.

- Outpatient Diagnostic and Therapeutic Services. Laboratory, diagnostic tests, and therapeutic treatments, when ordered by a physician, are covered at 20% coinsurance after the in-network deductible is met.

- Outpatient Mental Health and Chemical Dependency Services. Coverage is limited to a maximum of 20 visits per plan year, for short-term individual or group outpatient mental health and chemical dependency evaluation and referral, diagnostic, therapeutic, and crisis intervention services. This benefit is covered at 20% coinsurance after the in-network deductible is met. Additional visits may be covered if approved in advance and case managed by Intracorp.

★ Outpatient Surgery. This benefit is subject to a $50 copayment and 20% coinsurance in-network when performed in a hospital or alternative facility. When performed in a physician's office, the $50 copayment does not apply.

Diagnostic colonoscopy is the only outpatient surgical procedure that requires precertification by Intracorp; however, this policy is subject to change during the plan year. Changes will be communicated to members through the PEIA *News*.

- Outpatient Therapies. Coverage for the following outpatient therapies are combined into one benefit and are available at 20% coinsurance after the in-network deductible is met: physical, massage, occupational, speech, and vision therapies, acupuncture and chiropractic treatment. The benefit is limited to a maximum of $1,000 per member per plan year for all of the therapies combined. Coverage may be extended beyond the $1,000 limit if approved in advance by Intracorp.

  - Acupuncture. Services of a licensed acupuncturist for treatment of medical conditions are covered at 20% coinsurance after the in-network deductible. Contact Acordia for specific benefit limitations. Office visits are covered with a $15 copayment and treatments are covered at 80% after the in-network deductible is met.

  - Chiropractic Treatment. Services of a chiropractor for treatment of neuromuscular-skeletal conditions are included in the Outpatient Therapy Benefit (see above) and are covered at 20% coinsurance after the in-network deductible is met. Office visits are subject to the $15 copayment and x-rays are covered at 80% after deductible.

  - Massage Therapy. When ordered by a physician, services of a licensed massage therapist are covered at 20% coinsurance after the in-network deductible is met.

  - Occupational Therapy. When ordered by a physician, this benefit is included in the Outpatient Therapy Benefit and is covered at 20% coinsurance after the in-network deductible is met.

Services marked with a ★ require precertification from Intracorp.

- Outpatient Physical Therapy. When ordered by a physician, this benefit is included in the Outpatient Therapy Benefit (see above) and is covered at 20% coinsurance after the in-network deductible is met.
- Outpatient Speech Therapy. When ordered by a physician, this benefit is included in the Outpatient Therapy Benefit (see above) and is covered at 20% coinsurance after the in-network deductible is met.
- Vision Therapy. Contact Acordia for preauthorization of these services. This benefit is included in the Outpatient Therapy Benefit (see above) and is covered at 20% coinsurance after the in-network deductible is met.

★ Pain Management Services. Covered at 20% coinsurance after the in-network deductible is met. Only Multidisciplinary Pain Management services require precertification.

- Pap Smear. An annual Pap smear and the associated office visit to screen for cervical abnormalities are covered. The Pap smear is covered at 100% in-network with no deductible or coinsurance, and the office visit is subject to a $10 preventive care office visit copayment. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.
- Periodic Physicals (for Adults). The PEIA PPB Plan covers a routine physical exam once every two years for adults age 18 and over. Routine physicals are subject to a $10 copayment per visit. Exams may be provided more often if the patient's medical history indicates a need. The $10 copayment also applies to routine preventive care for adolescents age 16 through 17. (See Well Child Care below.)
- Physician's Office Visits (treatment for illness, injury, or medical condition). These visits are subject to a $15 copayment for in-network services.
- Professional Services of a physician or other licensed provider for treatment of an illness, injury or medical condition. Includes outpatient and inpatient services (such as surgery, anesthesia, radiology, and office visits). Office visits for preventive or specialty care are subject to the applicable copayment (see above) while other physician services are covered at 20% coinsurance after the in-network deductible is met.
- Prostate Cancer Screening. Coverage is provided for an annual office visit and exam to detect prostate cancer in men age 50 and over with a $10 preventive care office visit copayment. The PSA blood test associated with this screening is covered at 100% with no deductible or coinsurance in-network.
- Second Surgical Opinions. Office visits for second surgical opinions are subject to a $15 copayment per visit. Second surgical opinions are paid at 100% if required by Intracorp.

★ Skilled Nursing Facility Services. Confinement in a skilled nursing facility including semi-private room, related services and supplies is covered at 20% coinsurance after the in-network deductible is met. Confinement must be prescribed by a physician in lieu of hospitalization. Coverage is limited to 100 days per plan year. In addition to the penalties discussed on page 34, all unapproved out-of-network inpatient admissions are subject to a $500 deductible per admission.

- Smoking Cessation. See "Tobacco Cessation" on page 47 for details.
- Well Child Care. For children through age 16, the plan covers routine office visits for preventive care as recommended by the American Academy of Pediatrics. These visits are covered at 100% of allowed

Services marked with a ★ require precertification from Intracorp.

charges and are not subject to copayment or coinsurance or deductible. Covered preventive care includes, but is not limited to:

- height and weight measurement;
- blood pressure check;
- vision and hearing screening;
- developmental/behavioral assessment; and
- physical examination.

There is a $10 copayment for routine preventive care office visits for adolescents over the age of 16.

Maternity Benefits

PEIA PPB Plan provides coverage for maternity-related professional and facility services, including prenatal care, midwife services and birthing centers. Maternity related services are covered only for the employee or the employee's enrolled spouse.

Contact Intracorp during the first trimester of your pregnancy or as soon as your pregnancy is confirmed. Intracorp can assist you in identifying possible factors that may put you at risk for premature labor and delivery. If risk factors are identified, Intracorp nurses will work with you and your doctor to help safeguard the health of mother and baby.

You will need to contact Intracorp anytime you are admitted to the hospital during your pregnancy and within 48 hours of your admission for delivery, even if you are discharged in less than 48 hours.

Payment Level

Professional services for routine prenatal care, delivery and follow-up are paid at 100% of allowed charges under a global fee after the deductible has been met. An obstetrical profile and one ultrasound are also paid at 100% of allowed charges after the deductible is met. Other maternity services, including hospital charges, are paid at the regular PEIA PPB Plan level of 80% of allowed charges after the deductible is met, for in-network care.

Maternity Pre-payment Benefit

If your attending provider requests a deposit for maternity care before delivery, the PEIA PPB Plan will make an advance payment of up to $500. This will be deducted from the global fee paid after delivery. To receive this benefit, please contact Acordia and request a Maternity Pre-payment form.

High Risk Birth Score Program

For infants identified at birth as being at risk for health problems, the PEIA PPB Plan will pay for six office visits between the age of two weeks and 24 months in addition to PEIA's regular Well Child Care benefits. These additional visits are paid at 100% of allowed charges and are not subject to the deductible. Intracorp will notify those families who qualify for this benefit.

Enrolling Your Newborn

Please be sure you remember to add your newborn to your PEIA PPB Plan coverage by completing a Change-in-Status form. See the Eligibility Section at the front of this booklet for more information.

Nursery Charges

If the baby is enrolled for coverage under the PEIA PPB Plan, charges for the newborn nursery care will be paid in the baby's name. If the baby is not enrolled for coverage under the PEIA PPB Plan, charges for a normal, healthy newborn's nursery care will be covered as part of the mother's maternity benefit. If the newborn is covered under another plan, coordination of benefits rules will apply.

Organ Transplant Benefits

Organ transplants are covered when deemed medically necessary and non-experimental. They are subject to precertification and case management by Intracorp. You should contact Intracorp as soon as you learn that you or a member of your family covered by the PEIA PPB Plan may need a transplant.

All transplants require precertification for determination of medical necessity. When it is determined by your physician that you are a potential candidate for any type of transplant, Intracorp should be contacted immediately. You should advise your physician that Intracorp needs to coordinate the care from the initial phase when considering a transplant procedure, initial workup for transplant through the performance of the procedure and the care following the actual transplant.

Any services and supplies that are required for donor/procurement as a result of a surgical transplant procedure for a participant will be covered. Benefits for such charges, services and supplies are not provided under the PPB Plan if benefits are provided under another group plan or any other group or individual contract or any arrangement of coverage for individuals in a group (whether an insured or uninsured basis), including any prepayment coverage.

Organ Transplant Network (OTN)

The PEIA PPB Plan uses network providers for organ transplant services. This helps to control health care costs for both you and the plan.

PEIA uses a specialized transplant network called LifeTrac. Intracorp will work with patients and physicians to determine which network facility best serves the patient's medical needs.

OTN Benefits

Reduced Costs – Once the annual deductible and out-of-pocket maximum have been met, you will pay no more coinsurance on the negotiated fees for pre-transplant, transplant, and follow-up services. Copayments for office visits and other services described on pages 31-32 will still apply.

Travel Allowance – Because network facilities may be located some distance from the patient's home, benefits include up to $5,000 for patient travel, lodging and meals. A portion of this benefit is available to cover the travel, lodging and meals for a member of the patient's family or a friend providing support. Receipts are required for payment; mileage and cost estimates are not acceptable.

Medical Case Management – Intracorp offers support and assistance in evaluating treatment options and referrals to the prescription drug administrator. Management begins early when the potential need for a transplant is identified, and continues through the surgery and follow-up. When the need for a transplant presents itself, call Intracorp at 1-888-440-7342 or 1-304-353-7820.

You should contact Intracorp as soon as you learn that you or a member of your family covered by the PEIA PPB Plan may need a transplant. All transplants must be precertified through Intracorp.

Out-of-Network Organ Transplant Benefits

For patients who choose to use a non-network facility for transplant services, there will be a $10,000 deductible applied to the cost of the hospital admission; this is in addition to your annual deductible and out-of-pocket maximum. This deductible will be waived only if treatment at a non-network facility is approved as medically necessary in advance by Intracorp. No travel benefits will be provided for out-of-network transplants (except medically necessary ambulance transport).

Transplant-Related Prescription Drugs

The PEIA PPB Plan covers transplant-related immunosuppressant prescription drugs at 100%, after you have met your prescription drug deductible (if they are filled at a network pharmacy). These are covered through the Prescription Drug Plan and processed by the prescription drug administrator. Details of the PEIA Prescription Drug Plan are found in the Prescription Drug Benefits section starting on page 63.

Medical case management of transplant patients includes referral to the prescription drug administrator for waiver of copayment on transplant-related immunosuppressant drugs. Intracorp will make arrangements with the prescription drug administrator to waive copayments on drugs used to sustain the transplant.

obacco Cessation

PEIA PPB Plan provides benefits for insureds who wish to quit smoking or using smokeless tobacco oducts. To enroll in the tobacco cessation program, call the Quit Line at 1-877-966-8784. The Quit Line provide counseling and support, including written materials to each program enrollee. PEIA covers th prescription and non-prescription tobacco cessation products for those who have enrolled in the acco cessation program. Non-prescription drugs will be covered only if prescribed by a physician.

From time to time, PEIA may offer special limited-time benefits under this program. Contact the Quit for details.

For pregnant insureds (employees and spouses only), PEIA will provide 100% coverage for the tobacessation benefit during any pregnancy in the member's lifetime.

ent Level

PEIA will pay for an office visit, if it is required to obtain a prescription for tobacco cessation drugs. atient will pay the $10 preventive care office visit copayment. The drugs will be covered for 12 weeks. yments are as follows:

Nicotine withdrawal therapy is covered with a $5 generic copayment for a month's supply

Zyban is covered with a $15 preferred brand copayment for a month's supply.

ails, see the Prescription Drug Benefits section starting on page 63.

ean Ornish Program for Reversing Heart Disease

A is offering a short-term pilot project of the Dr. Dean Ornish Program for Reversing Heart Dislimited number of slots has been allocated for participants who have the PEIA PPB program as mary insurance. The Ornish approach does not use drugs or surgery, but relies upon diet, physical group support and counseling as part of an intensive life style change program. Applicants are by their local participating Ornish hospital to determine if they meet the medical criteria for tion: coronary artery disease, Type II diabetes, or at high risk of heart disease.

The program is covered at 100% after a member copayment of $50 per month. Members with annual household income below $20,000 per year may qualify for a copayment waiver.

For more information about this program, contact PEIA's customer service unit at 1-888-680-7342.

What Is Not Covered

Some services are not covered by the PEIA PPB Plan regardless of medical necessity. Specific exclusions are listed below. If you have questions, please contact Acordia National at 1-888-440-7342 or 1-304-353-7820. The following services are not covered:

1) Aqua therapy.
2) Birth control drugs, devices, and services for dependent children.
3) Breast pumps.
4) Chemical dependency treatments when a patient leaves the hospital or facility against medical advice.
5) Coma stimulation.
6) Cosmetic or reconstructive surgery when not medically required as the result of accidental injury or disease, or unless the surgery is performed to correct birth defects.
7) Custodial care, intermediate care, domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living, or for behavioral modification.
8) Dental services including routine dental care, x-rays, treatment of cysts or abscesses associated with the teeth, or any other dentistry and dental procedures.
9) Daily living skills training.
10) Duplicate testing, interpretation or handling fees.
11) Elective abortions.
12) Expenses for which you are not responsible, such as patient discounts and contractual discounts.
13) Experimental, investigational or unproven services, unless pre-approved by Acordia National or Intracorp.
14) Fertility drugs and services.
15) Foot care. Routine foot care including:
    - Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), hypertrophy (growth of tissue under the skin);
    - Cutting, trimming, or partial removal of toenails;
    - Treatment of flat feet, fallen arches, or weak feet; and
    - Strapping or taping of the feet.
16) Homeopathic medicine.
17) Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery.
18) Hypnosis.
19) Incidental surgery performed during medically necessary surgery.

20) Infertility and sterility services of in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, and donor semen, any other method of artificial insemination, and any other related services.

21) Marriage counseling.

22) Medical equipment, appliances or supplies of the following types:

- augmentative communication devices.
- equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs; recliners; contour chairs; adjustable beds; or tilt stands.
- exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines.
- educational equipment.
- environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors.
- equipment which is widely available over the counter such as wrist stabilizers and knee supports.
- hygienic equipment such as bed baths, commodes, and toilet seats.
- over-the-door and/or gravity traction.
- motorized scooters.
- whirlpool pumps or equipment.
- supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags.
- professional medical equipment such as blood pressure kits or stethoscopes.
- nutritional supplements, food liquidizers or food processors.
- hearing aids.
- wigs or wig styling.
- vibrators or bathroom scales.

Medical rehabilitation which is primarily educational or cognitive in nature.

Mental health services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning.

Optical services. Routine eye examinations, refractions, eye glasses, contact lenses and fittings. Glasses and/or contact lenses following cataract surgery are not covered.

Orientation therapy.

Physical examinations and routine office visits except those covered under the Periodic Physicals Benefit.

Personal comfort and convenience items or services (whether on an inpatient or outpatient basis) such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician.

Physical conditioning and work hardening. Expenses related to physical conditioning programs and work hardening such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation.

30) Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered under the plan, when such services are:

- related to employment;
- to obtain or maintain insurance;
- needed for marriage or adoption proceedings;
- related to judicial or administrative proceedings or orders;
- conducted for purposes of medical research;
- to obtain or maintain a license or official document of any type; or
- for participation in athletics.

31) Pregnancy-related conditions for dependent children.

32) Radial keratotomy and other surgery to correct vision.

33) Reversal of sterilization and associated services and expenses.

34) Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities.

35) Services rendered by a provider with the same legal residence as a participant, or who is a member of the policyholder's family. This includes spouse, brother, sister, parent, or child.

36) Services rendered outside the scope of a provider's license.

37) Sex transformation operations and associated services and expenses.

38) Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit.

39) Stimulation therapy.

40) TMJ. Treatment of temporomandibular joint (TMJ) disorders. Including intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for temporomandibular joint dysfunction not caused by documented organic disease or acute physical trauma.

41) The difference between private and semi-private room charges.

42) Therapy and related services for a patient showing no progress.

43) Therapies rendered outside the United States that are not medically recognized within the United States.

44) Transportation other than medically necessary ambulance services, or as approved under the Organ Transplant Network Benefit.

45) War-related injuries or illnesses. Treatment in a state or federal hospital for military or service-related injuries or disabilities.

46) Weight loss. Health services and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight control programs, weight control drugs, screening for weight control programs, and services of a similar nature.

47) Work-related injury or illness.

How To File A Claim

Filing A Medical Claim

Medical claims are processed by Acordia National and should be submitted to:

Acordia National
P.O. Box 2451
Charleston, WV 25329-2451

This post office box should be used only for PEIA claims. Please do not submit PEIA claims to other Acordia post office boxes. This will only delay their processing.

To process a medical claim, Acordia National requires a complete itemization of charges including:

1. the patient's name;
2. the nature of the illness or injury;
3. date(s) of service;
4. type of service(s);
5. charge for each service;
6. diagnosis and procedure codes;
7. identification number of the provider; and
8. Social Security Number of the policyholder.

If the necessary information is printed on your itemized bill, you do not need to use a PEIA claim orm to submit your charges. Cash register receipts and canceled checks are not acceptable proof of your laim.

If you have other insurance (including Medicare) which is primary, you need to submit an Explanation Benefits (EOB) from the other insurance with each claim, or ask your provider to do so if the claim is ing submitted for you.

You have six (6) months from the date of service to file a medical claim. If PEIA is your secondary urer (even if you have Medicare), you have six (6) months from the date of your primary insurer's planation of Benefits processing date to file your claim with PEIA. If you do not submit claims within period, they will not be paid, and you will be responsible for payment to the provider.

If your claim is for an illness or injury wrongfully or negligently caused by someone else, and you ect to be reimbursed by another party or insurance plan, you must file a claim with PEIA within six (6) ths of the date of service to ensure that the covered services will be paid. Later, if you receive pay- for the expenses, you will have to repay the amount you received from PEIA. See "Subrogation" on 61 for details.

dicare Crossover Claims

f you are a PEIA PPB Plan participant who has Medicare as the primary insurer, Acordia National has gram that allows providers to bill PEIA electronically as your secondary insurance after Medicare has

adjudicated the claim. This program, called Medicare Crossover, saves you the time and trouble of filing the claim yourself. At present, this program applies to West Virginia providers only. Out-of-state claims must be sent to Acordia.

Filing Claims for Court-ordered Dependents (COD)

If you are the custodial parent of a child who is covered under the other parent's PEIA plan as a result of a court order, you may submit claims directly to Acordia National using the special claim forms provided by PEIA. You can also receive all benefit information published by PEIA, and reimbursements for medical claims can be sent directly to you. For prescription drugs, you must use your I.D. card at a participating pharmacy. To make arrangements for this, please contact PEIA at 1-304-558-7850 or toll-free at 1-888-680-7342.

Claims Incurred Outside of the U.S.A.

If you or a covered dependent incur medical expenses while outside the United States, you may be required to pay the provider yourself. Request an itemized bill containing all the information listed on page 51 from your provider and submit the bill along with a claim form to Acordia National or the prescription drug administrator.

Acordia National or the prescription drug administrator will determine, through a local banking institution, the currency exchange rate and you will be reimbursed according to the terms of the PEIA PPB Plan.

Appealing A Claim

PEIA PPB Plan

If you are a PEIA PPB Plan participant or provider and think that an error has been made in processing your claim or reviewing a service, the first step is to call the Third Party Administrator to verify that a mistake has been made. (For information about prescription drug appeals, see page 75.) All appeals must be initiated within 60 days of claim payment or denial.

Type of Error	Who to Call	Phone Number
Pre-certification or case management	Intracorp	1-888-440-7342
Prescription drug claim	Express Scripts	1-877-256-4680
Medical claim or out-of-state care denial	Acordia National	1-888-440-7342

If your medical claim or service has been denied, or if you disagree with the determination made by Acordia National or Intracorp, the second step is to appeal in writing within 60 days of the denial to Acordia National or Intracorp. Explain what you think the problem is, and why you disagree with the decision. Acordia National or Intracorp will respond to you by reprocessing the claim or sending you a letter.

If this does not resolve the issue, the third step is to appeal in writing to the director of the PEIA. The member, provider or covered dependent must request a review in writing within sixty (60) days of getting the decision from Acordia National or Intracorp. Facts, issues, comments, letters, Explanations of Benefits (EOBs), and all pertinent information about the case should be included. Third step appeals should be mailed to:

Director
Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, WV 25305-0710

When your request for review arrives, the PEIA will reconsider the entire case, taking into account any additional materials which have been provided. A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the insured or his or her authorized representative.

Managed Care Plan Members

If you are a managed care plan member, and you think that an error has been made in processing your claim, the first step is to call your managed care plan to discuss the matter.

If your claim has been denied, or if you disagree with the determination made by your managed care plan, the second step is to appeal in writing within 60 days of the denial to your managed care plan. Instructions for filing that appeal are in your Evidence of Coverage provided by your managed care plan.

If you are not satisfied with the response from your managed care plan, you may appeal in writing to the director of the PEIA. You or your covered dependents must request a review in writing within sixty (60) days of getting the decision from your managed care plan. Facts, issues, comments, letters, Explanations of Benefits (EOBs), and all pertinent information about the claim and review should be included. The appeal should be mailed to:

Director
Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, WV 25305-0710

When your request for review arrives, the PEIA will reconsider the entire case, taking into account any additional materials that have been provided. A decision, in writing, explaining the reason for modifying upholding the original disposition of the claim will be sent to the insured or his or her authorized representative.

If you disagree with the decision of the PEIA director, you have one final level of appeal to the West Virginia Insurance Commissioner. Instructions for this appeal are also provided in your Evidence of Coverage from your managed care plan.

Controlling Costs

Prohibition of Balance Billing

The PEIA PPB Plan is governed in part by the Omnibus Health Care Act which was enacted by the West Virginia Legislature in April 1989. This Law requires that any West Virginia health care provider who treats a PEIA PPB Plan participant must accept assignment of benefits and cannot balance bill the participant for any portion of charges over and above the PEIA fee allowance or for any discount amount applied to a provider's charge or payment. This is known as the "prohibition of balance billing."

The prohibition of balance billing applies when services are provided in West Virginia and when the PEIA PPB Plan is the primary payor. When the PPB Plan is the secondary payor, the provider may bill you for disallowed amounts and for the provider discounts. Remember, you are always responsible for deductible, copayment, coinsurance amounts and non-covered services.

A PEIA PPB Plan participant who has Medicare as the primary payor has protection against balance billing when the provider accepts Medicare assignment. If the provider accepts Medicare assignment, you are not responsible for amounts which exceed the Medicare allowances.

Preferred Provider Organizations

For services provided outside the State of West Virginia, Acordia National utilizes several network relationships. In the state of Ohio, the network is Medical Mutual of Ohio's SuperMed Plus Network. In Maryland, North Carolina and the District of Columbia (DC), the network is the Alliance Network. For all other states the network is Beech Street. Some out-of-state providers also have direct contracts with Acordia to serve PEIA insureds. These networks review their providers for quality standards like licensing, background and treatment patterns. As part of their agreement with the network, the amount paid for services is a discounted amount. Remember, all services you receive out-of-state, other than services by a PPO provider in a county that borders West Virginia, must have prior approval in order to receive the highest level of benefit. However, if you are traveling out-of-state and you have an emergency or accident, go directly to the nearest provider for treatment without calling for approval first. Your medical identification card carries the logos for Medical Mutual of Ohio's (MMO) SuperMed Plus network, the Alliance Network, and the Beech Street network.

When receiving services always follow these important steps:

1. Always carry your most current medical identification card.
2. When seeking services outside West Virginia and beyond the bordering counties, you must call Acordia National at 1-304-353-7820 or 1-888-440-7342 for prior approval to receive the highest level of benefits.
3. **If you are experiencing an emergency or have an accident while outside of West Virginia or a bordering county, prior approval is not necessary to receive the highest level of benefits. If you are admitted to the hospital, you or your provider must call Intracorp within 48 hours of the admission.**
4. If your out-of-state service is approved as being medically necessary, please make sure your provider is a member of the Alliance, MMO or Beech Street network.
5. Call Acordia National at 1-304-353-7820 or 1-888-440-7342 for network provider information.
6. When you arrive at the doctor's office or hospital, present your ID card and the doctor or hospital will verify your membership and coverage information.

After you receive medical attention, your claim is routed to Acordia National. All PPO providers are paid directly, relieving you of any hassle and worry. You will need to pay for out-of-pocket expenses (deductible, copayments, coinsurance and non-covered services). Acordia National will send you an Explanation of Benefits (EOB).

To locate providers in the state of Ohio who participate in Medical Mutual of Ohio's (MMO) SuperMed Plus network, call 1-888-440-7342 or 1-304-353-7820, or check the internet at www.supermednetwork.com.

To locate providers in Maryland, North Carolina and the District of Columbia (DC) who participate in the Alliance Network, call 1-888-440-7342 or 1-304-353-7820, or check the internet at www.mamsi.com/directory.

To locate providers who participate in the Beech Street network, call 1-888-440-7342 or 1-304-353-7820, or check the internet at www.beechstreet.com.

Not all hospitals in these networks may participate with PEIA. PEIA reserves the right to exclude specific out-of-state facilities from its network. For Plan Year 2003, Kings Daughters Medical Center and Our Lady of Bellefont Hospital in Ashland, Kentucky, and hospitals in the UPMC Health System are not participating hospitals in the PEIA PPB Plan.

Out-of-State Provider Waiver

To assist insureds who receive medical treatment outside of West Virginia from providers who do not participate in any Preferred Provider Organization, guidelines have been established to review and approve waiver requests when you are billed for the balance not paid by PEIA and not applied to your out-of-network deductible and out-of-pocket maximum. The first $500 of expenses which exceed the allowed amount will be your responsibility. Amounts in excess of $500 may be eligible for an out-of-state provider waiver when:

1. the PEIA PPB Plan is the primary payor for the services provided; and
2. you are billed for amounts which exceed the fee allowance; and
3. you must receive out-of-state services because:
   - an emergency arises; or
   - the insured lives or is traveling out-of-state; or
   - the medically necessary service is not available in West Virginia (or within a reasonable travel time); or
   - due to geographic location, PEIA has determined that services are only available out-of-state; and
4. you do not have other insurance which will pay toward the balance.

Expenses eligible for waivers are those which exceed the maximum fee allowances. Amounts applied toward your out-of-network deductible, your out-of-network coinsurance amount, penalties, and non-covered services will not be considered for a wavier.

To request a waiver, send your balance bill from the provider, a copy of your Explanation of Benefits (EOB) indicating the amount already paid by PEIA, and a written request including the reason you chose out-of-state provider to:

Director
Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0710

You may obtain a PEIA Out-of-State Waiver Form by calling PEIA at 1-304-558-7850 or toll-free in WV at 1-888-680-7342. A waiver form is not required if you send the above requested information. The request for an Out-of-State Waiver must be submitted within six months of the processing date on the Explanation of Benefits (EOB) to be eligible for additional payments.

Patient Audit Program

The Patient Audit Program offers rewards when you help detect and correct mistakes on your health care bills. Examine your medical bills for these two types of mistakes:

- Charges for services not received; and
- Overcharges or overpayments resulting from clerical error or miscalculation.

Reported errors must be at least $50.00 to qualify for the Patient Audit Program and must be submitted within 60 days of the processing date on the Explanation of Benefits (EOB). Complete the Patient Audit Report Form from PEIA and submit it, along with an itemized bill from the provider, the corrected bill (or explanation of disagreement), and a copy of the EOB, to PEIA.

PEIA and Acordia National will investigate and recover the overpayment, if justified, from the provider of services. When the overpayment is processed you will be paid 50% of the recovered amount, up to $1,000 per plan year.

HMO members are not eligible to participate in the Patient Audit Program.

Coordination Of Benefits

In its effort to control health care costs, the PEIA PPB Plan has a coordination of benefits (COB) provision. Under this provision, when a person covered by PEIA also has coverage under another policy (or policies), there are certain rules which determine which policy is required to pay benefits first. The policy paying first is called the primary plan, and any other applicable policy is called the secondary plan.

Acordia, on PEIA's behalf, will request information about other coverage using a questionnaire mailed to the policyholder periodically. If the policyholder fails to respond to the questionnaire, claims will be denied until the information is received.

If you have health insurance coverage in addition to the PEIA PPB Plan, it is important to understand how the coordination of benefits provision works. In many instances, if the PEIA PPB Plan is secondary and your primary plan is other than Medicare, PEIA will pay little or nothing of the balance of your medical bill. An example of this situation is provided on page 59. In some cases it may be financially advisable to elect only one insurance coverage. If, after reviewing this section, you have questions concerning how PEIA's coordination of benefits provision may affect you, contact a PEIA claims representative at 1-304-558-7850 or toll-free at 1-888-680-7342.

Coordinating PEIA Benefits with Other Plans

COB will occur when an employee, retired employee or dependent has health coverage under the PEIA PPB Plan and also under:

- any government program or other coverage required or provided by law;
- any plan covering individuals as a group, including insured, uninsured and pre-payment arrangements;
- automobile insurance, medical pay provisions, whether individual or group;
- group-type hospital indemnity benefits exceeding $100 per day;
- for spouses and dependents only*, individual hospital and surgical or major medical insurance in which that spouse or dependent is the policyholder.

  * Individual and surgical or major medical insurance does not include any individual supplemental accident and sickness policy which meets the definition of a "limited benefits policy or certificate" under W. Va. Code §3-16E-2(a). These individual policies must meet all of the following conditions:

  1. the policy covers a specified disease, accident only, disability, or other limited benefits;
  2. the policy is specifically designed, represented and sold as a supplement to other basic sickness and accident coverage; and
  3. the entire premium for the policy is paid by the insured or insured's family.

Which Plan Pays First

For active employees, the PEIA PPB Plan is your primary plan in almost every circumstance. If your spouse is covered through his or her employer, that plan is usually the primary plan for your spouse. The primary plan is determined by the first of the following rules which applies:

a. any plan with no coordination of benefits provision is always primary;

b. the plan which covers the person as an active or retired employee, member or subscriber (other than as a dependent) is always primary to a plan which covers the person as a dependent. When two public employees, both eligible to enroll for PEIA coverage in their own names, are married and covered under one PEIA family plan, then the spouse, covered as a dependent, will be treated as an employee under these rules;

c. for a dependent child of parents not separated or divorced, if two or more plans cover the child as a dependent:

   1. the plan of the parent whose birthday falls earlier in the year will be primary; or
   2. if both parents have the same birthday, the plan which has covered one parent longer will be primary; or
   3. if the other plan uses the parent's gender to determine benefits, and the plans do not agree on the order of benefits, then the rule of the other plan will determine the order of benefits.

d. for a dependent child of parents who are separated or divorced, if two or more plans cover the child as a dependent, benefits are determined in this order:

1. the plan of the parent who has custody will pay first;
2. the plan of the spouse of the parent who has custody will pay next;
3. the plan of the parent who does not have custody will pay last.

Exception: If a court decree states that one of the parents is responsible for the health care expenses of the child, and the plan of that parent has knowledge of those terms, then that plan is primary. The plan of the other parent will then be secondary, and the plan of the spouse of the parent with custody of the child will pay third. For PEIA to pay according to this paragraph, you need to provide a copy of the court decree.

e. for a dependent child of divorced parents with joint custody, if the court decree does not specify which parent is responsible for health care coverage, then Rule "c." above will apply.

f. for a dependent child of separated parents with joint custody, if the court decree does not specify which parent is responsible for health care coverage, then Rule "c." above will apply.

g. a plan which covers an employee (and, consequently, his or her dependents) as an active employee, rather than as a laid-off employee or retired employee, will pay before a plan which covers a laid-off or retired employee. If the other plan does not have this rule, and the plans disagree about the order of benefits, this paragraph is disregarded.

h. if a person is covered under a right of continuation policy as required by the Consolidated Omnibus Reconciliation Act (COBRA) of 1987, as amended, and is also covered under another plan, the following rules will apply:

   1. the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent) will be primary;
   2. the benefits under the continuation coverage will be secondary.

i. if none of the above rules applies, the plan which has covered the employee, member or subscriber the longest will be primary.

How Coordination of Benefits Works

When a claim is made, the primary plan pays its benefits without regard to any other plans. Then the secondary plan pays its benefits, adjusting for the benefit paid by the primary plan. The amount that the PEIA PPB Plan will pay as a secondary plan depends on what the primary plan pays.

To calculate the amount PEIA will pay as a secondary plan, you subtract the amount your primary plan pays from the amount PEIA would have paid if there were no other insurance. If the other plan paid as much or more than PEIA would have paid as the primary plan, then PEIA will pay nothing as the secondary plan. If the other plan paid less than PEIA, then PEIA when secondary will pay the difference up to what it would have paid if there had been no other insurance.

As you can see in the following chart, the PEIA PPB Plan will pay very little or nothing as a secondary plan. For this reason, you should consider whether it makes sense to keep both plans.

"Carveout" Coordination of Benefits Example			
If PEIA is primary:		If PEIA is secondary:	
Total Charge	$120	Total Charge	$120
PEIA Allowed Amount	$100	Other Plan's AllowedtAmoun	$96
PEIA Pays	$80	PEIA Pays	$0
*You Owe	$20	*You Owe	$24

*Assumes any deductible has been met

There are several issues to consider if you are thinking about dropping one of your plans:

Prescription Drug Coverage: PEIA's coverage is generous. Compare the benefits of both plans, ding deductibles.

Mental Health Benefits: Many plans pay only 50% or limit the number of admissions per lifetime. PEIA PPB Plan pays 80% in-network with no limit when services are precertified.

Maternity Services: PEIA pays 100% of the physician's charges, after the deductible is met.

Balance Billing Prohibition: PEIA protects you from network providers billing you for amounts h exceed PEIA's allowed amounts, but only if the PEIA PPB Plan is the primary payor. In the above ple, with the PEIA PPB Plan as your primary plan, you would not be responsible for the difference een the total charge and the amount allowed by PEIA. The balance billing provision does not apply the PEIA PPB Plan is the secondary plan or when the provider is not in the PEIA PPB Plan network.

f you have questions about your coverage, or need help comparing plans, you may call the PEIA s Unit at 1-304-558-7850 or toll-free 1-888-680-7342.

care Coordination

he PEIA PPB Plan will reimburse the difference between the amount allowed by Medicare and the nt paid by Medicare if the balance is not more than the PEIA PPB Plan would have paid as the y plan, as shown in the example below.

hen Medicare is your primary insurer, all services are considered in-network and are processed at gher benefit level.

you have met your PEIA PPB Plan annual medical deductible, PEIA will usually pay the balance and ll pay nothing. This is referred to as "traditional" coordination of benefits.

Medicare Coordination of Benefits (assumes the deductible has been met)	
Total charge	$120
Medicare allowed amount	$100
Medicare pays	$80
PEIA pays	$20
You owe	$0

re Order of Determination

retirees covered by PEIA and Medicare, regardless of age (see exception below), Medicare is the nsurer and PEIA is the secondary insurer. All claims must be submitted to Medicare and then to

PEIA along with an Explanation of Medicare Benefits (EOMB). Generally claims are submitted to Medicare and then to PEIA by your provider or by Medicare through the Medicare Crossover program.

When you become an eligible beneficiary of Medicare, you must enroll in Medicare Part A and Medicare Part B. Part A is an entitlement program and is available without payment of a premium to most individuals. Part B is the supplementary medical insurance program that covers physician services, outpatient laboratory and x-ray tests, durable medical equipment and outpatient hospital care. Part B is a voluntary program that requires payment of a monthly premium.

If you do not enroll in Medicare Part B, PEIA will process your claims as if you did have the Part B coverage. In other words, PEIA will only pay the amount we would have paid if Medicare had processed your claim and made a payment.

If you or your dependents have other coverage in addition to PEIA and Medicare, contact Acordia National or PEIA to determine what coverage will be primary, secondary or tertiary (third) and whether you need to enroll in Medicare Part B.

Exception: If you are entitled to Medicare as an End Stage Renal Disease (ESRD) beneficiary, call Acordia National or PEIA to determine who the primary insurer will be.

Medicare for Active Employees

For PEIA PPB Plan active employees who are age 65 or older and eligible for Medicare, as long as you are an active employee, PEIA will be your primary insurer, except in a few rare cases. As long as you are an active employee, you do not need to sign up for Medicare Part B and pay the premium, since Medicare Part B will not pay as a secondary insurer after PEIA. When you prepare to retire, you must enroll for Medicare Part B. If you do not enroll in Medicare Part B, PEIA will process your claims as if you did have the Part B coverage. In other words, PEIA will pay only the amount we would have paid if Medicare had processed your claim and made a payment.

For PEIA PPB Plan active employees who are also eligible for Medicare, and Medicare is the **primary** payor, PEIA will use the traditional method of coordinating benefits.

Recovery Of Incorrect Payments

If PEIA discovers that a claim has been paid incorrectly, or that the charges were excessive or for non-covered services, PEIA has the right to recover its payments from any person or any entity.

You must cooperate fully with the PEIA to help it recover any such payment. The PEIA may request refunds or deduct overpayments from a provider's check in order to recover incorrect payments. This provision shall not limit any other remedy provided by law.

Subrogation and Reimbursement

PEIA may pay medical expenses on an insured's behalf in those situations where an injury, sickness, disease or disability, is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of a PEIA insured where other insurance (such as auto or homeowners) is available. As a condition of receiving such expenses, the PEIA and its agents have the right to recover the cost of such medical expenses from the responsible party directly (whether an unrelated third party or another covered insured) or from their insured, if they have already been reimbursed by another. This right is known as subrogation.

The PEIA is legally subrogated to its insured as against the legally responsible party, but only to the extent of the medical expenses paid on the insured's behalf by the PEIA attributable to such sickness, injury, disease, or disability. PEIA has the right to seek repayment of expenses from, among others, the party that caused the illness or injury, his or her liability carrier or the PEIA insured's own auto insurance carrier in cases of uninsured, underinsured motorist coverage, or medical pay provisions. Subrogation applies, but it is not limited to, the following circumstances:

a. payments made directly by the person who is liable for a PEIA insured's sickness, injury, disease or disability, or any insurance company which pays on behalf of that person, or any other payments on his or her behalf;

b. any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured, underinsured motorist policy or medical pay provisions on the insured's behalf; and

c. any payments from any source designed or intended to compensate a PEIA insured for sickness, injury, disease, or disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.

It is the obligation of the PEIA insured to:

d. notify the PEIA in writing of any injury, sickness, disease or disability for which the PEIA has paid medical expenses on behalf of a PEIA insured that may be attributable to the wrongful or negligent acts of another person;

e. notify the PEIA in writing if the insured retains services of an attorney, and of any demand made or lawsuit filed on behalf of a PEIA insured, and of any offer, proposed settlement, accepted settlement, judgment, or arbitration award;

f. provide the PEIA or its agents with information it requests concerning circumstances that may involve subrogation, provide any reasonable assistance requested in assimilating such information and cooperate with the PEIA or its agents in defining, verifying or protecting its rights of subrogation and reimbursement; and

ness, injury, disease, or disability, once they have obtained money through settlement, judgment, award, or other payment.

Failure to comply with any of these requirements may result in:

h. the PEIA's withholding payment of further benefits; and

i. an obligation by the PEIA insured to pay costs, attorneys' fees and other expenses incurred by the PEIA in obtaining the required information or reimbursement.

By acceptance of benefits paid under the plan, the PEIA insured agrees that PEIA's rights of subrogation and reimbursement shall have a priority lien and the right of first recovery against any settlement or judgment obtained by or on behalf of an insured. This right shall exist without regard to allocation or designation of the recovery.

These provisions shall not limit any other remedy provided by law. This right of subrogation shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Please note: As with any claim, the claims resulting from an accident or other incident which may involve subrogation should be submitted within the PEIA's timely filing requirement of six (6) months. It is not necessary that any settlement, judgment, award, or other payment from a third party have been reached or received before filing a claim with the PEIA or with one of the managed care plans associated with the PEIA.

Prescription Drug Benefits

Along with your PEIA PPB Plan medical coverage, you also have prescription drug coverage. The prescription drug program is administered by Express Scripts. There are two parts to the program:

- the Retail Pharmacy Program gives you access to local participating pharmacies to get your prescriptions filled.
- the Express Scripts Mail Service Pharmacy Program lets you order your prescriptions through the mail, saving you time and money by having your maintenance medications delivered to your door.

Your prescription drug benefits pay for a wide range of medications, with differing copayments depending on where you purchase those drugs, and how large a supply you buy.

Deductible

During any plan year, if you or your eligible dependents incur expenses for covered prescription drugs, you must meet a deductible before the plan begins to pay. The deductibles are:

Prescription Drug Deductibles		
	PPB Plan A	PPB Plan B (non-State agencies only)
Policyholder Only	$75	$150
Policyholder & Child(ren)	$125	$300
Family	$125	$300
Family with Employee Spouse	$125	$300

This means you will pay the first $75 or $125 (or more if you're in Plan B) of eligible charges before the plan begins to pay.

The family deductible is greater than the individual deductible. The family deductible is divided up among the family members. No one member of the family will pay more than the individual deductible. Once that person has met the individual deductible, the plan will begin paying on that person. When another member of the family meets the individual deductible, then the plan will begin paying on the entire family. Alternatively, all members of the family may contribute to the family deductible with no one person meeting the individual deductible; once the family deductible is met, the plan pays on all members of the family.

After you meet your deductible, you will pay copayments based on the amount and type of drug you're taking. The chart on the next page shows the copayments.

Prescription Drug Co-payments			
PEIA PPB Plan A			
	Up to a 34-day supply	35- to 68-day supply*	69- to 90-day supply*
Generic Drug	$5	$10	$15
Brand-name drug listed on the West Virginia Preferred Drug List	$15	$30	$45
Brand-name drug **not** listed on the West Virginia Preferred Drug List	$30	$60	$90
PEIA PPB Plan B			
Generic Drug	$10	$20	$30
Brand-name drug listed on the West Virginia Preferred Drug List	$20	$40	$60
Brand-name drug **not** listed on the West Virginia Preferred Drug List	$50	$100	$150
* For maintenance medications only. See pages 74-75 for the maintenance drug list. You may be able to get a discount on your maintenance medications through a Retail Maintenance Network pharmacy or through Mail Service. Read on for details.			
Should your doctor prescribe or you request the brand-name drug when a generic drug is available, you must pay the difference in price, plus the applicable generic co-payment.			

What You Pay

Under your prescription drug plan, once you meet your deductible, you pay a copayment to obtain drugs. Copayments are the portion of the cost that, under your plan, you are required to pay per new or refill prescription. The rest of the cost is paid by PEIA. Several factors determine your copayment.

Generic Drugs

The brand name of a drug is the product name under which the drug is advertised and sold. Generic medications have the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs. Please ask your doctor to prescribe generic drugs whenever possible.

West Virginia Preferred Drug List (WVPDL)

The West Virginia Preferred Drug List (WVPDL) is a list of carefully selected medications that can assist in maintaining quality care while providing opportunities for cost savings to the PEIA PPB Plan. Under this program, your plan requires you to pay a lower copayment for medications on the WVPDL and a higher copayment for medications **not** on the WVPDL. By asking your doctor to prescribe WVPDL medications, you can maintain high quality care while you help to control rising health-care costs.

Here's how the copayment structure works:

- **Highest Copayment:** You will pay the highest copayment for brand-name drugs that are **not** listed on the WVPDL.
- **Middle Copayment:** You will pay a mid-level copayment for brand-name drugs that are listed on the WVPDL.

- **Lowest Copayment:** You will pay the lowest copayment for all generic drugs. Generic drugs are subject to the same rigid U.S. Food and Drug Administration standards for quality, strength and purity as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs. Please ask your doctor to prescribe generic medications for you whenever possible.

Sometimes your doctor may prescribe a medication to be "dispensed as written" when a WVPDL and name or generic alternative drug is available. As part of your plan, an Express Scripts pharmacist or ur retail pharmacist may discuss with your doctor whether an alternative formulary or generic drug might appropriate for you. Your doctor always makes the final decision on your medication, and you can ways choose to keep the original prescription at the higher copayment.

Drugs on the WVPDL are determined by the Express Scripts Pharmacy and Therapeutics Committee. e committee is made up of pharmacists and physicians, meets quarterly to review the medications rrently on the Formulary, and to evaluate new drugs for addition to the Formulary. The Formulary may ange periodically, based on the recommendations adopted by the committee.

If you have any questions about the copayment structure or about your WVPDL, please call Express ipts Member Services at 1-877-256-4680.

escription Out-of-Pocket Maximum

PEIA has added an out-of-pocket maximum on drugs. The maximum is $1,750 for an individual and 500 for a family. Once you have met the out-of-pocket maximum, PEIA will cover the entire cost of your scriptions for the balance of the plan year. The out-of-pocket maximum only includes actual copays, t deductibles or other charges, and is separate from your medical plan out-of-pocket maximum.

escription Drug Copayment Assistance Program

PEIA offers a program to assist retired employees who struggle to deal with increasing prescription g costs in the PEIA PPB Plan. This assistance reduces prescription drug copayments for those who alify.

o Qualifies?

Retired employees whose annual household income falls below 250% of the federal poverty level, d who are members of the PEIA PPB Plan can qualify for assistance. Retired employees who receive mium Assistance from PEIA are automatically enrolled in this program. Retired employees who are ng sick or annual leave or years of service to extend their employer-paid insurance qualify for this gram if their annual income meets the guidelines.

at is Available?

If you qualify for assistance, PEIA will provide you with the reduced prescription copayments based your years of service as shown in the chart on page 66. These reduced copayments are available to you our local pharmacy or through the Express Scripts mail service program. To take full advantage of the scription Drug Copayment Assistance program, it is best to get your maintenance medications in 90- supplies. When you fill a 90-day prescription through mail order or at a retail maintenance network rmacy, you'll only pay for two thirty-day supplies -- you get one thirty-day supply for no copayment. page 66 for details of the Retail Maintenance Network benefits, and page 67 for information about Express Scripts Mail Service Pharmacy program.

Years of active service	New Brand-Preferred Co-payment		New Brand Non-preferred Co-payment	
	30-day supply at a Retail Pharmacy	Up to 90-day supply by mail or at a Retail Maintenance Network Pharmacy	30-day supply at a Retail Pharmacy	Up to 90-day supply by mail or at a Retail Maintenance Network Pharmacy
20 or more	$6	$12	$21	$42
10 through 19	$9	$18	$29	$58
5 through 9	$12	$24	$30	$60
less than 5	$15	$30	$30	$60

How Do You Apply?

If you believe you qualify, contact PEIA for an application.

The Retail Network Pharmacy Program

Express Scripts has a nationwide network of pharmacies. To get a prescription filled, simply present your medical/prescription drug ID card at a participating Express Scripts pharmacy. You can purchase both acute and maintenance medications at an Express Scripts network pharmacy.

Your ID card contains personalized information that identifies you as a PEIA PPB Plan member, and ensures that you receive the correct coverage for your prescription drugs.

If you use an Express Scripts pharmacy, you do not have to file a claim form. The pharmacist will file the claim for you online, and will let you know your portion of the cost.

To find the participating pharmacies nearest you, call Express Scripts Member Services at 1-877-256-4680 and use the voice-activated Pharmacy Locator System. If you have Internet access, you can find a pharmacy online at **www.express-scripts.com**.

Retail Maintenance Network

If you take a drug on a long-term basis, you may be able to purchase a 90-day supply of that drug if it is on the maintenance list (see pages 73-74 for the maintenance drug list). PEIA offers a Retail Maintenance Network of pharmacies that will fill your 90-day prescription for just two copayments. You can buy two months and get one month free. Check with your local pharmacist to verify participation.

Non-Network Pharmacies

If you use a non-participating pharmacy, you will pay 100% of the prescription price at the time of purchase, and submit a completed claim form to Express Scripts. The prescription receipt must be attached to the form. You will usually be reimbursed within 21 days from receipt of your claim form. You will be reimbursed the amount PEIA would have paid at a participating pharmacy, less your required copayment, your deductible (if applicable), and a $3 fee. This reimbursement may be less than you paid for the prescription.

If you need claims forms, call Express Scripts Member Services at 1-877-256-4680 or visit their website at **www.express-scripts.com**.

he Express Scripts Mail Service Pharmacy Program

Express Scripts provides a convenient mail service pharmacy program for PEIA PPB Plan insureds. You ay use the mail service pharmacy if you're taking medication to treat an ongoing health condition, such s high blood pressure, asthma, or diabetes.

When you use the mail service pharmacy, you can order up to a 90-day supply* of a medication on the aintenance list, as prescribed by your doctor, and pay only two copayments. Express Scripts' licensed ofessionals fill every prescription following strict quality and safety controls. If you have questions about ur prescription, registered pharmacists are available around the clock to consult with you.

Maintenance Drug Co-payments				
	PEIA PPB Plan A		PEIA PPB Plan B (non-State agencies only)	
	Up to 34-day supply	35 to 90-day supply*	Up to 34-day supply	35 to 90-day supply*
Generic medication	$5	$10	$10	$20
Brand-name medication listed on the National Preferred Formulary	$15	$30	$20	$40
Brand-name medication **not** listed on the National Preferred Formulary	$30	$60	$50	$100
* For maintenance medications only. See pages 74-75 for the maintenance drug list.				
Should your doctor prescribe or you request the brand-name drug when a generic drug is available, you must pay the difference in price, plus the applicable generic co-payment.				

ew Prescriptions

If you want to use the mail service pharmacy, the first time you are prescribed a medication that you ll need on an ongoing basis, ask your doctor for two prescriptions: the first for a 14-day supply to be led at a participating retail pharmacy; the second, for up to a 90-day supply, to be filled through the mail rvice pharmacy. There are several ways to submit your mail service prescriptions. Just follow the steps elow. *Some restrictions apply.*

Ordering new prescriptions. Ask your doctor to prescribe your medication for up to a 90-day supply for maintenance medications, plus refills if appropriate. Mail your prescription and required copayment along with an order form in the envelope provided. Or ask your doctor to fax your order to 1-800-636-9494. You will need to give your doctor your member ID number located on your ID card.

Refilling your medication. A few simple precautions will help ensure you don't run out of your prescription. Remember to reorder on or after the refill date indicated on the refill slip. Or reorder when you have less than 14 days of medication left.

- Refills online — Log on to Express Scripts' website at www.express-scripts.com. Have your member ID number, the prescription number (it's the 9-digit number on your refill slip), and your credit card ready when you log on.

- Refills by phone — Call 1-877-256-4680 and use the automated refill system. Have your member ID number, refill slip with the prescription number, and your credit card ready.
- Refills by mail — Use the refill and order forms provided with your medication. Mail them with your copayment.

3. **Delivery of your medication.** Prescription orders receive prompt attention and, after processing, are usually sent to you by U.S. mail or UPS within two weeks. Your enclosed medication will include instructions for refills, if applicable. Your package may also include information about the purpose of the medication, correct dosages, and other important details.

4. **Paying for your medication.** You may pay by check, money order, VISA, MasterCard, Discover or American Express. Debit cards are not accepted for payment.

Please note: The pharmacist's judgment and dispensing restrictions, such as quantities allowable, govern certain controlled substances and other prescribed drugs. Federal law prohibits the return of any dispensed prescription medicines.

Other Important Features of Your Prescription Drug Program

Your prescription drug program is designed to provide the care and service you expect, whether it's keeping a record of your medication history, providing toll-free access to a registered pharmacist, or keeping you in touch with any changes to your program.

Express Scripts uses the health and prescription information about you and your dependents to administer your benefits. They also use information and prescription data from claims submitted nationwide for reporting and analysis without identifying individual patients.

When your prescriptions are filled at one of Express Scripts' mail service pharmacies or at a participating retail pharmacy, pharmacists use the health and prescription information on file for you to consider many important clinical factors including drug selection, dosing, interactions, duration of therapy and allergies. Express Scripts' pharmacists may also use information received from your network retail pharmacy.

Express Scripts may contact your doctors to discuss these clinical factors and benefit management matters, including the "preferred" medication list. The results of these discussions sometimes lead to changes in your prescription. If your doctor authorizes a change in your prescription, Express Scripts will send a confirmation letter to you. Express Scripts, however, will only dispense the medication authorized by your doctor.

Drug Utilization Review

Under the drug utilization review program, prescriptions filled through the mail service pharmacy and participating retail pharmacies are examined by Express Scripts for potential drug interactions based on your personal medication profile. The drug utilization review is especially important if you or your covered dependents take many different medications or see more than one doctor. If there is a question about your prescription, your pharmacist may notify your doctor before dispensing the medication.

Education and Safety

You will receive information about critical topics like drug interactions and possible side effects with every new prescription Express Scripts mails. Your retail pharmacy may also provide you with drug information.

By visiting **www.express-scripts.com**, you also can access other health-related information. Click on Drug Information or Health Information to browse information relative to specific health interests, get

safety tips and answers to the most commonly asked medication questions, or just keep up with timely health issues. To view health information personalized to fit your interests, register with **www.express-scripts.com**. Any written health information cannot replace the expertise and advice of health care practitioners who have direct contact with a patient. All Express Scripts health information is designed to help you communicate more effectively with your doctor and, as a result, understand more completely your situation and choices.

Health Management

Based on your prescription and health information, Express Scripts may provide information to you on one or more of Express Scripts' Care Management programs, provided as a service to you by PEIA. Program participants generally receive educational mailings and may receive a follow-up call from an Express Scripts pharmacist or nurse. Express Scripts develops these programs to support your doctor's care, and they may contact your doctor regarding your participation in these programs.

Coordination of Benefits

If another insurance carrier is the primary insurer for a policyholder or a dependent, or if you are Medicare-eligible, PEIA will pursue coordination of benefits.

1. **Commercial Insurance**: As a secondary payor, PEIA will pay only if the other insurance plan's benefit is less than what PEIA would have provided as the primary insurer.
2. **Medicare**: PEIA will pay what Medicare does not pay for prescription drugs, up to the amount that PEIA would have paid if you had no other coverage.

Prior Authorization

Your prescription drug program provides coverage for some drugs **only** if they are prescribed for certain uses and amounts, so those drugs require prior authorization for coverage. If your medication must be authorized, your pharmacist or physician can initiate the review process for you. The prior authorization process is typically resolved over the phone; if done by letter it can take up to one business day. If your medication is not approved for plan coverage, you will have to pay the full cost of the drug.

PEIA will cover, and your pharmacist can dispense, up to a five-day supply of a medication requiring prior authorization for the applicable copayment. This policy applies when your doctor is either unavailable or temporarily unable to complete the prior authorization process promptly. If the prior authorization is ultimately approved, your pharmacist will be able to dispense the remainder of the approved amount with no further copayment for that month's supply if you have already paid the full copayment.

The medications listed below require prior authorization:

- CNS stimulants for adults*
- erythroid stimulants (Epogen, Procrit)
- fluconazole (Diflucan)
- growth hormones
- itraconazole (Sporanox)

- legend oral contraceptives for dependents (covered for treatment of medical conditions only)
- leuprolide (Lupron, Lupron Depot)
- modafinil (Provigil) for adults*
- oxycodone hydrochloride (Oxycontin) beginning 10/1/02
- terbinafine (Lamisil)
- tramadol (Ultram)
- tretinoin cream (e.g. Retin-A) for individuals 27 years of age or older

* For pharmacy benefits, PEIA defines "adults" as 19 years of age or older

This list is subject to change during the plan year if circumstances arise which require adjustment. Changes will be communicated to members through the PEIA *News*, the newsletter PEIA publishes nine times each year. The changes will be included in PEIA's Plan Document, which filed with the Secretary of State's office, and will be incorporated into the next edition of the Summary Plan Description.

Drugs with Special Limitations

Step Therapy

Step Therapy promotes appropriate utilization of first line drugs and/or therapeutic categories. Step Therapy requires that participants receive one or more first-line drug(s), as defined by program criteria before prescriptions are covered for second-line drugs in defined cases where a step approach to drug therapy is clinically justified. Patients currently taking a second-line drug will be able to continue therapy without interruption.

To promote use of cost-effective first line therapy, PEIA will implement step therapy in the following therapeutic classes:

- Non-Steroidal Anti-inflammatory Drugs (brand-name NSAID e.g. Celebrex, Vioxx),
- Proton Pump Inhibitors (e.g. Prilosec, Prevacid, Nexium),
- H2 Antagonists (e.g. Axid),
- Disease-modifying Antirheumatic Drugs (e.g. Enbrel, Kineret), and
- Prozac Weekly.

This list is subject to change during the plan year, if circumstances arise which require adjustment. Changes will be communicated to members through the PEIA *News*, the newsletter PEIA publishes nine times each year. The changes will be included in PEIA's Plan Document, which filed with the Secretary of State's office, and will be incorporated into the next edition of the Summary Plan Description.

Quantity Limits

Under the PEIA PPB Plan Prescription Drug Program, certain drugs have preset coverage limitations (quantity limits). Quantity limits ensure that the quantity of units supplied in each prescription remains consistent with clinical dosing guidelines and PEIA's benefit design. Quantity limits encourage safe, effective and economic use of drugs and ensure that members receive quality care. Select medications from the quantity limit list are provided below. If you are taking one of the medications listed below and

need to get more of the medication than the plan allows, ask your pharmacist or doctor to call Express pts to discuss your refill options.

Anzemet, Kytril, Zofran. Coverage Limitations:

- Anzemet is limited to 1 tablet per prescription
- Kytril is limited to 2 tablets per prescription
- Zofran 24 mg is limited to 1 tablet per prescription
- Zofran 4 mg and 8 mg are limited to 12 tablets per prescription
- Zofran Solution is limited to 3 bottles per prescription

Brand name medically necessary prescriptions. If the medication your doctor prescribes is a multi-source drug (that is, more than one manufacturer markets the drug), and there is an FDA-approved – or "A-B rated" – generic on the market, then PEIA will pay only for the generic version. Medical justification is required for prior authorization. If prior authorization is granted, these drugs will be covered as non-preferred brand-name drugs.

Diflucan 150 mg. Coverage is limited to two tablets per prescription.

Migraine medications. Coverage is limited to quantities listed on the chart below:

Generic name	Brand name	Quantity Limit Per dispensing	Total Quantity Level Limit within a 28-Day Period
Almotriptan tablets 6.25 mg, 12.5 mg	Axer® - Pharmacia	6	18 tablets
Dihydroergotamine nasal spray	Migranal® - Novartis	4	2 kits = 8 unit dose sprays
Naratriptan tablets 1 mg, 2.5 mg	Amerge®- Glaxo Wellcome	9	18 tablets
Rizatriptan tablets 5 mg, 10 mg, orally disintegrating tablets	Maxalt-MLT®- Merck	6	24 tablets
Rizatriptan tablets 5 mg, 10 mg	Maxalt®- Merck	6	24 tablets
Sumatriptan injection syringes	Imitrex®- Glaxo Wellcome	1 Kit (2 syringes)	8 kits = 16 injections
Sumatriptan injection vials	Imitrex®-Glaxo Wellcome	2 Vials	16 vials
Sumatriptan nasal spray 20 mg	Imitrex®-Glaxo Wellcome	6 spray devices	3 boxes = 18 unit dose spray devices
Sumatriptan nasal spray 5 mg	Imitrex®- Glaxo Wellcome	6 spray devices	6 boxes = 36 unit dose spray devices
Sumatriptan tablets 25 mg, 50 mg, 100 mg	Imitrex®-Glaxo Wellcome	9 tablets	18 tablets
Zolmitriptan tablets 2.5 mg and 5 mg, orally disintegrating	Zomig-ZMT®-AstraZeneca	6 tablets for 2.5 mg 3 tablets for 5 mg	18 tablets
Zolmitriptan tablets 2.5 mg, 5 mg	Zomig®- AstraZeneca	6 tablets for 2.5 mg 3 tablets for 5 mg	18 tablets

- **New drugs** approved by the FDA that have not yet been reviewed by Express Scripts' Pharmacy and Therapeutics Committee will have a non-preferred status.
- **Non-sedating antihistamines (Allegra, Claritin, Zyrtec).** PEIA will cover 30 days of therapy in a 180-day period. Therapy beyond 30 days requires prior authorization from Express Scripts.
- **Toradol**. Coverage is limited to one course of treatment (5 days) per 90-day period.
- **Tamiflu and Relenza**. Coverage is limited to one course of treatment within 180 days. Additional quantities require prior authorization from Express Scripts.

Diabetes Management

Blood Glucose Monitors — Covered diabetic insureds can receive a free Bayer Glucometer Elite®, Elite® XL or Glucometer® DEX® blood glucose monitor with a current prescription. Simply ask your pharmacist, and he or she will contact Bayer by fax or mail to request the monitor.

Glucose Test Strips — The plan covers only Bayer Glucometer Elite® test strips and Glucometer® DEX® sensor cartridges at the preferred copayment of $15. Other brands on the WVPDL require a 100% copayment.

Needles/Syringes and Lancets — You can obtain a supply of disposable needles/syringes and lancets for the copayments listed below:

Coverage	Needles/Syringes	Lancets
At the retail pharmacy:		
Up to a 34-day supply	$10	$5
35- to 68-day supply	$20	$10
69- to 90-day supply	$30	$15
Through the mail service and retail maintenance network pharmacies:		
Up to a 34-day supply	$10	$5
35- to 90-day supply	$20	$10

Tobacco Cessation Program

PEIA has a tobacco cessation program that includes coverage for Zyban and nicotine withdrawal drugs. The drugs are covered under your prescription drug program after a call is made to the PEIA Quit Line: 1-877-966-8784. The program also includes phone coaching services and printed information.

Coverage

After the Quit Line is contacted, PEIA will cover prescription and over-the-counter (OTC) tobacco cessation products only if they are dispensed with a prescription. Coverage is limited to one twelve-week cycle per plan year, two cycles per lifetime. Zyban is available for the Brand-preferred copayment of $15 for up to a 34-day supply. Nicotine withdrawal therapy is available for the generic copayment of $5 for up to a 34-day supply.

From time to time PEIA may offer special discounts on nicotine withdrawal therapy. Call the Quitline at 1-877-966-8784 for details.

ho is Eligible?

PEIA PPB Plan insureds will be screened for eligibility and readiness. Pregnant women will be offered 0% coverage during any pregnancy.

laintenance Medications

You may receive up to a 90-day supply of the following medications and classes listed below:

- alendronate sodium (Fosamax)
- antiarthritics
- anticoagulants
- anticonvulsants
- antineoplastics
- antiparkinsonism agents
- antispasmodics: urinary tract
- benign prostatic hypertrophy/micturation
- bronchodilators
- calcitonin (Miacalcin)
- cardiovascular agents
- copaxone
- corticosteroids, bronchial
- cromolyn sodium (Intal)
- diabetic therapies
- digestants
- disposable needles and syringes
- diuretics
- enzymes, systemic
- estrogens & progestins
- gastrointestinal, colitis
- glaucoma agents
- gout medications
- hormones, misc.
- immunosuppressive agents
- interferon beta (i.e. Avonex, Betaseron)
- legend vitamins (including legend hematinics, vitamin K)
- leukotriene receptor antagonists (asthma agents)
- lipotropics (cholesterol lowering agents)
- mucolytics (pulmonary agents)
- oral contraceptives

- legend potassium
- raloxifene (Evista)
- risedronate (Actonel)
- thyroid medications
- tuberculosis medications
- xanthines (asthma agents)

Drugs or Services That Are Not Covered

Your plan does not cover the following medications or services:

- Anorexients (any drug used for the purpose of weight loss) *Exceptions*: Amphetamines are covered for individuals through the age of 18
- Anti-wrinkle agents (e.g. Renova)
- Birth control drugs for dependent children
- Charges for the administration or injection of any drug
- Contraceptive devices and implants
- Hair growth stimulants
- Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs not approved by the FDA, even though a charge is made to the individual
- Drugs requiring a prescription by state law, but not by federal law (state controlled) are not covered
- Erectile dysfunction medications
- Fertility drugs
- Homeopathic medications
- Immunizations, biological sera, blood or blood products, Hyalgan, Synvisc, Remicade, Synagis (these are covered under the medical plan)
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, sanitarium, or extended care facility
- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member
- Non-legend drugs (except when included in a compound with a legend drug)
- Pentazocine/Acetaminophen (Talacen)
- Prescription drug charges not filed within 6 months of the purchase date, if PEIA is the primary insurer, or within 6 months of the processing date on the Explanation of Benefits (EOB) from the other plan, if PEIA is secondary
- Replacement medications for lost or stolen drugs

- Requests for more than a 90-day supply of maintenance medications, or requests for more than a 34-day supply of short-term medications
- The following narcotic analgesics:
    - Fioricet with Codeine
    - Fiorinal with Codeine
    - Stadol Nasal Spray
- Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those listed above
- Vacation supplies, unless leaving the country.

Appealing a Claim

If you think that an error has been made in processing your prescription drug claim or in a prescription benefit determination or denial, first call Express Scripts at 1-877-256-4680 to ask for details. If you are not satisfied with the outcome of your telephone inquiry, the second step is to appeal to Express Scripts in writing. Please have your physician provide any additional relevant clinical information to support your request. Mail your request with the above information to:

Express Scripts, Inc.
Clinical Appeals - (Client-WVA)
BW1041
6625 W. 78th Street
Bloomington, MN 55439

Express Scripts will respond in writing to you and your physician with a letter explaining the outcome of the appeal. If this does not resolve the issue, the third step is to appeal in writing to the director of PEIA. You or your covered dependents must request a review in writing within sixty (60) days of receiving the decision from Express Scripts. Mail third step appeals to:

Director
Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, WV 25305-0710

Facts, issues, comments, letters, Explanations of Benefits (EOBs), and all pertinent information about the claim and review should be included. When your request for review arrives, PEIA will reconsider the entire case, taking into account any additional materials that have been provided. A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the covered person or his or her authorized representative. For more information about your drug coverage, please contact Express Scripts at 1-877-256-4680.

How to Reach Express Scripts

On the Internet

Reach Express Scripts at: **www.express-scripts.com**. Visit Express Scripts' website anytime to learn about patient care, refill your mail service prescriptions, check the status of your mail service pharmacy order, request claim forms and mail service order forms or find a participating retail pharmacy near you.

By Telephone

For those insureds who do not have access to Express Scripts via the Internet, you can learn more about your program by calling Express Scripts Member Services at 1-877-256-4680, 24 hours a day, 7 days a week.

Special Services

Express Scripts continually strives to meet the special needs of PEIA's insureds:

You may call a registered pharmacist at any time for consultations at **1-877-256-4680.**

PEIA's hearing-impaired insureds may use Express Scripts's TDD number at **1-800-972-4348**.

Visually impaired insureds may request that their mail service prescriptions include labels in Braille by calling **1-877-256-4680.**

Amending the Benefit Plan

The West Virginia Public Employees Insurance Agency reserves the right to amend all or any portion of this Summary Plan Description in order to reflect changes required by court decisions, legislation, actions by the Finance Board, actions by the Director or for any other matters as are appropriate. The Summary Plan Description will be amended within a reasonable time of any such actions. All amendments to the Summary Plan Description must be in writing, dated and approved by the Director. The Director shall have sole authority to approve amendments. The Summary Plan Description and all approved amendments will be filed with the office of the West Virginia Secretary of State.

Who to Call with Questions

Health Claims, Benefits, Preauthorizations and Prior Approvals for Out-of-State Care

Acordia National ..... 1-304-353-7820 or 1-888-440-7342 (toll-free)

Precertification and Utilization Management

Intracorp ..... 1-304-353-7820 or 1-888-440-7342 (toll-free)

PEIA Nurseline (Answers to medical questions from a registered nurse and medical information service)

PEIA Nurseline ..... 1-877-294-7342 (toll-free)

Prescription Drug Benefits and Claims

Express Scripts 1-877-256-4680

..... or on the web at **www.express-scripts.com**

Subrogation and Recovery

Beacon Recovery Group 1-800-874-0500

PEIA (Answers to questions about eligibility, life insurance and third level claim appeals)

WV Public Employees Insurance Agency ..... 1-304-558-7850 or 1-888-680-7342 (toll-free)

..... or on the web at **www.wvpeia.com**

Mountaineer Flexible Benefits (Dental, vision, and disability insurance and flexible spending accounts)

Fringe Benefits Management Company 1-800-342-8017

..... or on the web at **www.fbmc-benefits.com**

Managed Care Plans

Carelink 1-800-348-2922

..... or on the web at **www.cvty.com**

The Health Plan ..... 1-800-624-6961 or 1-740-695-3585

..... or on the web at **www.healthplan.org**

Public Employees Insurance Agency

State Capitol Complex, Bldg. 5, Rm. 1001,
1900 Kanawha Blvd., E., Charleston, WV 25305-0710

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