Public Employees Insurance Agency

State Capitol Complex
Building 5, Room 1001
1900 Kanawha Blvd., E.
Charleston, WV
25305-0710
(304) 558-7850
Fax (304) 558-2516

Gaston Caperton
Governor

David P. Lambert
Director

September 1, 1994

The Honorable Ken Hechler
Secretary of State
State Capitol Complex
Building 1, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find two replacement pages for filing in the Public Employees Insurance Agency Benefit Plan Document notebook, already on file with your Office.

The replacement pages are Pages AC-6 and AC-6.1 (Revised September 1, 1994). They replace Page AC-6 (Revised 5/1/90). These pages are found in the Accounting Section of the Plan Document notebook, and pertain to billing non-participating local agencies an employer premium contribution for their retirees and surviving dependents who participate in the PEIA health benefit plan.

Your assistance in filing these pages is appreciated.

Sincerely,

David P. Lambert
Director

DPL/lq

Enclosure

cc: All PEIA Staff
Agency Insurance Coordinators

c:\linda\notice.sos

both the insured and the employing payroll location are protected:

1) Upon notification by PEIA of a check returned for insufficient funds, closed account, etc., notify the insured by certified mail (return receipt requested) that a replacement postal money order or cashier's check is to be remitted within 15 days or subsequently his/her insurance coverage will be terminated for failure to pay premium.

2) Inform insured that if PEIA coverage is terminated for failure to pay premium, the termination date will be retroactive to the last day of the month for which premium was received. Any claims incurred after the effective date of termination will be the sole financial responsibility of the insured.

D. NON-PARTICIPATING LOCAL GOVERNMENT AGENCY

During its 1992 regular session, the West Virginia Legislature amended the Public Employees Insurance Agency governing statute to require all non-State (local government) agencies to contribute toward the cost of their retired employees who participate in the PEIA. The new law applies to all non-State agencies with retirees in the PEIA plan, whether the agency itself participates as a group with the PEIA or not.

Specifically, a new paragraph was added to W.Va. Code 5-16-22 which reads:

> Any employer, whether such employer participates in the public employees insurance agency insurance program as a group or not, which has retired employees, their dependents or surviving dependents of deceased retired employees who participate in the public employees insurance agency insurance program as authorized by this article, shall pay to the agency the same contribution toward the cost of coverage for its retired employees, their dependents or surviving dependents of deceased retired employees as the state of West Virginia, its boards, agencies, commissions, departments, institutions, spending units, or a county board of education pay for their retired employees, their dependents, and surviving dependents of deceased retired employees, as determined by the finance board. Each employer is hereby authorized and required to budget for and make such payments.

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Gaston Caperton
Governor

Sally K. Richardson
Director

February 4, 1993

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Re: **PEIA Plan Document; Pre-Existing Condition Limitation**

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Benefit Plan Document notebook a new provision setting forth the statutory "pre-existing condition limitation." The statute, W. Va. Code §5-16-17, was amended by the West Virginia Legislature during its last regular session.

Please file this letter and new provision at the front of the Plan Document. It replaces the pre-existing condition language in the January 1, 1991 benefit summaries, as well as the earlier language on page PT-17 of the Plan Document.

We are in the process of totally revising the Plan Document which will enable us to incorporate all of the changes which have occurred over the past three years into a more readable format. Until these revisions are completed, your cooperation is appreciated in filing benefit changes as they are made.

Sincerely,

Sally K. Richardson
Director

SKR:DPL:trs

Enclosure

PRE-EXISTING CONDITION LIMITATION

Any employee, retired employee or dependent who enrolls in the PEIA health plan is subject to the pre-existing condition limitation set forth in W. Va. Code §5-16-17.

A pre-existing condition is an injury, or sickness, or any condition relating to that injury or sickness, for which a PEIA participant is diagnosed, receives treatment, or incurs expenses within three months prior to the effective date of PEIA coverage. "Pre-existing condition" does not include pregnancy, nor does it include a condition which meets the definition of handicap set forth in W. Va. Code §5-11-3.

Effective March 7, 1992, if a new PEIA participant was covered under a previous employer-based health benefit plan, comparable individual health plan, or self-insured plan, then the pre-existing condition limitation will not apply if the participant's previous coverage was in effect on a date not more than thirty days prior to the effective date of PEIA coverage, excluding any applicable waiting period under the prior plan. A new participant will be asked to identify previous coverage at the time of enrollment with PEIA, and provide documentation, if requested.

Unless a new PEIA participant receives credit for previous coverage as specified above, the PEIA, by law, cannot make payment for any expenses incurred for or in connection with a pre-existing condition until the participant has been enrolled in the PEIA health plan continuously for a period of one year.

Public Employees Insurance Agency

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Gaston Caperton
Governor

Sally K. Richardson
Director

November 5, 1991

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Benefit Plan Document notebook a copy of a Memorandum, to All Insurance Coordinators, from Sally K. Richardson, Director, dated October 25, 1991, regarding Insurance Plan Changes and Section 125 Program.

This memorandum announces changes to the PEIA benefit plan regarding removal of impacted wisdom teeth and hospice care. The memorandum also discusses the expanded Section 125 plan to be implemented in 1992.

Please file the memorandum together with this letter at the front of the Plan Document. As always, your cooperation and assistance are appreciated.

Sincerely,

Sally K. Richardson
Director

SKR:DPL:trs

cc: David P. Lambert, Esq.
Gloria Long
Stephen F. Coady, Health Economics Corporation
John Mobley, Prescription Reimbursement Network
Wayne Boggess, Prescription Reimbursement Network
Joyce A. Kenny, Healthmarc

Public Employees Insurance Agency

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Gaston Caperton
Governor

Sally K. Richardson
Director

MEMORANDUM

To: **All Insurance Coordinators**

From: **Sally K. Richardson** SKR
Director

Date: **October 25, 1991**

Subject: **Insurance Plan Changes and Section 125 Program**

PEIA has recently made several changes in the benefit plan which you need to be aware of:

Removal of Impacted Wisdom Teeth. Effective August 14, 1991, the PEIA will provide reimbursement for the surgical removal of impacted wisdom teeth.

Hospice Care. PEIA provides coverage for Hospice Care when ordered by a physician. There is no longer a maximum dollar amount on this benefit.

Mountaineer Flexible Benefits. As you may have already heard, PEIA will be sponsoring an enhanced Section 125 plan in 1992 called Mountaineer Flexible Benefits which will include optional dental, vision and disability coverage, and medical and dependent care reimbursement accounts. This plan will be available to all State employees. County Boards of Education have the option of choosing to participate. Non-State agencies will be eligible to buy the three insurance coverages we're offering on a post-tax basis, but cannot participate in the reimbursement accounts because we have no tie-in with their payroll systems.

The implementation date for the plan was to have been January 1, 1992, with enrollment in October and November of this year, but due to the lack of availability of the disability insurance component, we have delayed implementation until March 1, 1992. Enrollments will take place beginning January 13, 1992. This additional time will allow us to seek alternative bids on the disability insurance component, and to educate employees on the benefits of this type of plan.

As an insurance coordinator, you will not be responsible for any enrollment or changes in this program. Fringe Benefits Mangement Company, the group administering this program for PEIA, will conduct training sessions with you regarding the payroll matters involved in this program. These will be held in early January. Fringe Benefits Management Company will also hold individual enrollment meetings with employees who are interested in participating in the plan.

We will be sending you further information on this program, including individual enrollment booklets for your employees, as soon as it becomes available. We'll keep you posted!

SKR:JEL

Public Employees Insurance Agency

Capitol Complex
Building 5
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FAX: 304-348-2516

Gaston Caperton
Governor

Sally K. Richardson
Director

June 13, 1991

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Benefit Plan Document notebook the following documents:

1. Memorandum to Non-State Agency Employees and All PEIA-Insured Retired Employees, from Sally K. Richardson, dated June 1, 1991, entitled: "1992 Financial Plan."

2. Memorandum to All PEIA Insureds of State Agencies and County Boards of Education, from Sally K. Richardson, dated June 1, 1991, entitled: "1992 Financial Plan."

These memoranda provide notice of changes to the PEIA benefit plan, made by the PEIA Finance Board, effective July 1, 1991. The memoranda should be filed with the Summary Plan Descriptions filed earlier this year.

Your cooperation and assistance in filing these documents are appreciated.

Sincerely,

Sally K. Richardson
Director

SKR:DPL:trs

Enclosures

Public Employees Insurance Agency

Gaston Caperton

Sally K. Richardson

MEMORANDUM

TO: Non-State Agency Employees and **All** PEIA-insured Retired Employees

FROM: Sally K. Richardson
Director

DATE: June 1, 1991

SUBJECT: 1992 Financial Plan

Following are the changes which constitute the PEIA Financial Plan for Fiscal Year 1992. These changes will apply to the PEIA benefit plan effective July 1, 1991. These changes are to be read with the Summary Plan Description you received December 1, 1990.

Well-Child Care and Immunizations. Office visits and immunizations for children as determined by the Plan (see Summary Plan Description Appendix B) are paid at 90%.

Maternity services. Physicians' fees for prenatal and delivery care paid at 100%. **Retroactive to January 1, 1991.** (Hospital costs are not included in this change.) Pregnancies must be reported to Healthmarc within the first trimester, or as soon as the pregnancy is confirmed. If more than one sonogram (ultrasound) is required during your pregnancy, each additional sonogram must be precertified by Healthmarc.

Outpatient Mental Health and Chemical Dependency Services. Coverage to a maximum of 26 visits per calendar year of individual and/or group outpatient mental health and chemical dependency evaluations and referral services, diagnostic, crisis intervention and therapeutic services. All 26 visits in a calendar year paid at 80%. No coverage after 26 visits. Apply 20% co-payment on outpatient mental health and chemical dependency services to annual out-of-pocket maximum.

Chiropractic Services. Apply 20% co-payment on chiropractic services to annual out-of-pocket maximum.

Inpatient and/or Partial Hospitalization Mental Health and Chemical Dependency Services. Coverage is limited to a maximum cost to the Plan of $10,000 per calendar year, unless extended through pre-certification and individual case management by the utilization management firm to cover necessary and efficient services.

Out of State Provider Waiver. Guidelines for a system to make exceptions in payments to out-of-state providers of health care have been approved. An employee may request an exception to PEIA's policy of discounting providers' fees in cases where:

1. an emergency arises and out-of-state care can be reached more quickly;

2. the insured lives or is traveling out of state;

3. the medically necessary service is not available in West Virginia, or is not available within reasonable travel time in West Virginia; or

4. due to the geographic location, PEIA has determined that services are only available out of state.

The written request for exception and supporting explanation and justification must be sent to the director of PEIA, State Capitol Complex, Building 5, Room 1025, Charleston, WV 25305.

Claim Denial Appeal Procedure. The procedure for appealing a denied claim has not been changed, but it bears repeating.

Level 1: Insured (or his/her authorized representative) appeals the denial, in writing, to the claims administrator (or to the utilization management firm if denial was for lack of precertification). Appeal must be made within ninety (90) days following the date of the Explanation of Benefits.

Level 2: If the appeal is not resolved at level 1, the insured may request a review of the denial (or the declination of appeal) by the Director of PEIA. This request for review must be made within sixty (60) days from the date of the declination of appeal. The Director of PEIA will make a final decision and notify the insured of the outcome of the review.

If you have questions about any of these benefit issues, please contact your payroll location or PEIA.

PEIA
State Capitol Complex
Building 5, Room 1025
Charleston, WV 25305

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Notice of Benefit Changes

Public Employees Insurance Agency

MEMORANDUM

Gaston Caperton

Sally K Richardson

TO: All PEIA Insureds of
State Agencies and County Boards of Education

FROM: Sally K. Richardson
Director

DATE: June 1, 1991

SUBJECT: 1992 Financial Plan

Following are the changes which constitute the PEIA Financial Plan for Fiscal Year 1992. These changes will apply to the PEIA benefit plan effective July 1, 1991. These changes are to be read with the Summary Plan Description you received December 1, 1990.

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1. an emergency arises and out-of-state care can be reached more quickly;
2. the insured lives or is traveling out of state;
3. the medically necessary service is not available in West Virginia, or is not available within reasonable travel time in West Virginia; or
4. due to the geographic location, PEIA has determined that services are only available out of state.

The written request for exception and supporting explanation and justification must be sent to the director of PEIA, State Capitol Complex, Building 5, Room 1025, Charleston, WV 25305.

Employee Premium Contributions. The active employee premium rates for State employees and County Board of Education employees have been adjusted to include a category for "Spouse Only". The new active employee premium contribution rates (including the new "Spouse Only" category) are printed on the next page. These replace the rates printed in your Summary Plan Description as Appendix A.

Claim Denial Appeal Procedure. The procedure for appealing a denied claim has not been changed, but it bears repeating.

Level 1: Insured (or his/her authorized representative) appeals the denial, in writing, to the claims administrator (or to the utilization management firm if denial was for lack of precertification). Appeal must be made within ninety (90) days following the date of the Explanation of Benefits.

Level 2: If the appeal is not resolved at level 1, the insured may request a review of the denial (or the declination of appeal) by the Director of PEIA. This request for review must be made within sixty (60) days from the date of the declination of appeal. The Director of PEIA will make a final decision and notify the insured of the outcome of the review.

If you have questions about any of these benefit issues, please contact your payroll location or PEIA.

Appendix A
Monthly Premiums

Annual Salary			Child(ren) only	Spouse Only	Full Family	Annual Out-of-pocket Maximum
$0	to	$ 8,000	$10.66	$18.66	$21.32	$750
8,001	**to**	**8,500**	**11.00**	**19.26**	**22.00**	**750**
8,501	to	9,000	11.68	20.44	23.36	750
9,001	**to**	**9,500**	**12.34**	**21.60**	**24.68**	**750**
9,501	to	10,000	13.00	22.76	26.00	750
10,001	**to**	**10,500**	**13.68**	**22.76**	**27.36**	**750**
10,501	to	11,000	14.34	25.10	28.68	750
11,001	**to**	**11,500**	**15.00**	**26.26**	**30.00**	**750**
11,501	to	12,000	15.68	27.44	31.36	750
12,001	**to**	**12,500**	**16.34**	**28.60**	**32.68**	**750**
12,501	to	13,000	17.00	29.76	34.00	750
13,001	**to**	**13,500**	**17.68**	**30.94**	**35.36**	**750**
13,501	to	14,000	18.34	32.10	36.68	750
14,001	**to**	**14,500**	**19.00**	**33.26**	**38.00**	**750**
14,501	to	15,000	19.68	34.44	39.36	750
15,001	**to**	**30,000**	**20.00**	**35.00**	**40.00**	**1,000**
30,001	to	30,500	20.18	35.32	40.36	1,250
30,501	**to**	**31,000**	**20.50**	**35.88**	**41.00**	**1,250**
31,001	to	31,500	20.84	36.48	41.68	1,250
31,501	**to**	**32,000**	**21.18**	**37.08**	**42.36**	**1,250**
32,001	to	32,500	21.50	37.64	43.00	1,250
32,501	**to**	**33,000**	**21.84**	**38.22**	**43.68**	**1,250**
33,001	to	33,500	22.18	38.82	44.36	1,250
33,501	**to**	**34,000**	**22.50**	**39.38**	**45.00**	**1,250**
34,001	to	34,500	22.84	39.98	45.68	1,250
34,501	**to**	**35,000**	**23.18**	**40.58**	**46.36**	**1,250**
35,001	to	35,500	23.50	41.14	47.00	1,250
35,501	**to**	**36,000**	**23.84**	**41.72**	**47.68**	**1,250**
36,001	to	36,500	24.18	42.32	48.36	1,250
36,501	**to**	**37,000**	**24.50**	**42.88**	**49.00**	**1,250**
37,001	to	37,500	24.84	43.48	49.68	1,250
37,501	**to**	**38,000**	**25.18**	**44.08**	**50.36**	**1,250**
38,001	to	38,500	25.50	44.64	51.00	1,250
38,501	**to**	**39,000**	**25.86**	**45.26**	**51.72**	**1,250**
39,001	to	39,500	26.18	45.82	52.36	1,250
39,501	**to**	**40,000**	**26.50**	**46.38**	**53.00**	**1,250**
40,001	to	40,500	26.84	46.98	53.68	1,500
40,501	**to**	**41,000**	**27.18**	**47.58**	**54.36**	**1,500**
41,001	to	41,500	27.50	48.14	55.00	1,500
41,501	**to**	**42,000**	**27.84**	**48.72**	**55.68**	**1,500**
42,001	to	42,500	28.18	49.32	56.36	1,500
42,501	**to**	**43,000**	**28.50**	**49.88**	**57.00**	**1,500**
43,001	to	43,500	28.84	50.48	57.68	1,500
43,501	**to**	**44,000**	**29.18**	**51.08**	**58.36**	**1,5**
44,001	to	44,500	29.50	51.64	59.00	1,500
44,501	**to**	**45,000**	**29.84**	**52.22**	**59.68**	**1,500**
45,001	to	45,500	30.18	52.82	60.36	1,500
45,501	**to**	**46,000**	**30.50**	**53.38**	**61.00**	**1,500**
46,001	to	46,500	30.84	53.98	61.68	1,500
46,501	**to**	**47,000**	**31.18**	**54.58**	**62.36**	**1,500**
47,001	to	47,500	31.50	55.14	63.00	1,500
47,501	**to**	**48,000**	**31.84**	**55.72**	**63.68**	**1,500**
48,001	to	48,500	32.18	56.32	64.36	1,500
48,501	**to**	**49,000**	**32.50**	**56.88**	**65.00**	**1,500**
49,001	to	49,500	32.84	57.48	65.68	1,500
49,501	**to**	**50,000**	**33.18**	**58.08**	**66.36**	**1,500**
50,001	and	above	33.34	58.36	66.66	1,500

PEIA
State Capitol Complex
Building 5, Room 1025
Charleston, WV 25305

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Notice of Benefit Changes

Public Employees Insurance Agency

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1991 JUN 13 PM 3:43

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850
FAX: 304-348-2516

Gaston Caperton
Governor

Sally K. Richardson
Director

June 13, 1991

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Rate Schedule notebook copies of the following documents:

1. Memorandum to Benefit Coordinators/Payroll Clerks of County Commission, Cities and Towns, and Other Political Subdivisions, from Sally K. Richardson, dated May 22, 1991, entitled: "Premium Rate Schedule for FY-92." This memo includes the new PEIA rate schedules for non-State agencies effective July 1, 1991.

2. Memorandum to Benefit Coordinators/Payroll Clerks of State Agencies, Colleges and Universities, and County Boards of Education, from Sally K. Richardson, dated May 22, 1991, entitled: "Premium Rate Schedule for FY-92." This memo includes new PEIA rate schedules for State agencies and county boards of education effective July 1, 1991.

Thank you for your cooperation and assistance in filing these documents.

Sincerely,

Sally K. Richardson
Director

SKR:DPL:trs

Enclosures

Public Employees Insurance Agency

[illegible]
304 348-[illegible]
Fax 304 348-[illegible]

Gaston Caperton
Governor

Sally K. Richardson
Director

MEMORANDUM

TO: Benefit Coordinators/Payroll Clerks of County Commissions, Cities and Towns, and other Political Subdivisions

FROM: Sally K. Richardson SKR
Director

SUBJECT: Premium Rate Schedule for FY-92

DATE: May 22, 1991

Enclosed is the Non-State premium rate schedule to be effective July 1, 1991. In addition, an administrative expense fee of $20.00, which is billed annually on July 1 for each employee, and monthly as new employees are enrolled after July 1, is also effective July 1, 1991.

Please note any adjustments to the premium rates and make the proper payroll deductions for the July 1991 remittance.

Thank you for your cooperation. If you have any questions, please contact the Premium Accounts Section at 348-7850.

Enclosure

SKR/DE/de
E:\NSRS92

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees of
County Commissions, Municipalities and other
Political Subdivisions

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	TOTAL PREMIUM
EMPLOYEES UNDER AGE 65; AMOUNT OF LIFE INSURANCE $10,000.00	ASN	SINGLE COVERAGE	$195.00
	AFN	FAMILY COVERAGE	$411.00
	LA	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL COVERAGE	$ 4.34
	LAD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 4.34
	MS	LIFE INSURANCE ONLY - HMO SINGLE	$ 4.34
	MF	LIFE INSURANCE ONLY - HMO FAMILY	$ 4.34
EMPLOYEES AGES 65 THRU 69; AMOUNT OF LIFE INSURANCE $6,500.00	BSN	SINGLE COVERAGE	$194.00
	BFN	FAMILY COVERAGE	$410.00
	LB	LIFE INSURANCE ONLY - MUST BE COVERED AS A DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.82
	LBD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.82
	MA	LIFE INSURANCE ONLY - HMO SINGLE	$ 2.82
	MB	LIFE INSURANCE ONLY - HMO FAMILY	$ 2.82
EMPLOYEES AGES 70 AND OLDER; AMOUNT OF LIFE INSURANCE $5,000.00	CSN	SINGLE COVERAGE	$193.00
	CFN	FAMILY COVERAGE	$409.00
	LD	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.17
	LDD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.17
	MC	LIFE INSURANCE ONLY - HMO SINGLE	$ 2.17
	MD	LIFE INSURANCE ONLY - HMO FAMILY	$ 2.17
COBRA	NES	COBRA EMPLOYEE - SINGLE COVERAGE	$195.00
	NEF	COBRA EMPLOYEE - FAMILY COVERAGE	$415.00
	NDS	COBRA DEPENDENT - SINGLE COVERAGE	$195.00
	NDF	COBRA DEPENDENT - FAMILY COVERAGE	$415.00
	NSD	COBRA EMPLOYEE - SINGLE DISABLED	$289.00
	NFD	COBRA EMPLOYEE - FAMILY DISABLED	$614.00
	NMO	COBRA - HEALTH MAINTENANCE ORGANIZATION	$000.00

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WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
RETIREE UNDER AGE 65; AMOUNT OF LIFE INSURANCE $5,000.00	GSPN	SINGLE COVERAGE	$119.00
	GSAM1	SINGLE COVERAGE WITH MEDICARE	$ 42.00
	GSBPN*	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$117.00
	GSCM1*	SINGLE COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM	$ 40.00
	GFPN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$238.00
*AMOUNT OF LIFE INSURANCE $10,000.00	GFAM1	FAMILY COVERAGE WITH MEDICARE AND DEPENDENT(S) UNDER AGE 65	$164.00
	GFBPN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$236.00
	GFCM1*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	GWPN	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$151.00
	GWAM1	FAMILY COVERAGE WITH MEDICARE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 69.00
	GWBPN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$149.00
	GWCM1*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 67.00
	LG	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LGB*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LGD	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LGE*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
RETIREE AGE 65 - 65 AMOUNT OF LIFE INSURANCE $5,000.00	HSM1	SINGLE COVERAGE	$ 42.00
	HSBM1	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 40.00
	HFM1	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 69.00
	HFBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUMS AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 67.00
	HWPN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$164.00
	HWBPN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	LH	LIFE INSURANCE ONLY - MUST BE COVERED AS A DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LHB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LHD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LHE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
RETIREE AGE 67 OR OVER AMOUNT OF LIFE INSURANCE $2,500.00	ISM1	SINGLE COVERAGE	$ 41.00
	ISBM1	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 40.00
	IFM1	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 68.00
	IFBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 67.00
	IWPN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$163.00
	IWBPN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	LI	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 1.00
	LIB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LID	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 1.00
	LIE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
RETIREE ANY AGE HEALTH INSURANCE ONLY	ZSPN	SINGLE COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$117.00
	ZSAM1	SINGLE COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 40.00
	ZFPN	FAMILY COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$236.00
	ZFAM1	FAMILY COVERAGE - RETIREE MEDICARE AND DEPENDENT NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$162.00
	ZWPN	FAMILY COVERAGE - RETIREE NON-MEDICARE AND DEPENDENT MEDICARE - NO LIFE INSURANCE BENEFITS	$149.00
	ZWAM1	FAMILY COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 67.00
BASIC PLAN SURVIVING DEPENDENT RATE SCHEDULE	WS	SURVIVING SPOUSE UNDER AGE 65	$117.00
	WOM1	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$162.00
	WWM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$ 40.00
	WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$236.00
	WXM1	SURVIVING SPOUSE OVER AGE 65	$ 40.00
	WMM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$162.00
	YS	SURVIVING CHILD W/NO PARENTS	$117.00
	YF	SURVIVING CHILDREN W/NO PARENTS	$236.00

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
CATASTROPHIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTRO-PHIC PLAN
RETIREE UNDER AGE 65; AMOUNT OF LIFE INSURANCE $5,000.00	QSCN	SINGLE COVERAGE	$ 91.00
	QSAM2	SINGLE COVERAGE WITH MEDICARE	$ 30.00
	QSBCN*	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 89.00
	QSCM2*	SINGLE COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM	$ 28.00
	QFCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$176.00
*AMOUNT OF LIFE INSURANCE $10,000.00	QFAM2	FAMILY COVERAGE WITH MEDICARE AND DEPENDENT(S) UNDER AGE 65	$149.00
	QFBCN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$174.00
	QFCM2*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	QWCN	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$111.00
	QWAM2	FAMILY COVERAGE WITH MEDICARE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 49.00
	QWBCN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$109.00
	QWCM2*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 47.00
	LQ	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNVER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LQB*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LQD	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LQE*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
RETIREE AGE 65 - 65 AMOUNT OF LIFE INSURANCE $5,000.00	HSM2	SINGLE COVERAGE	$ 30.00
	HSBM2	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 28.00
	HFM2	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 49.00
	HFBM2	FAMILY COVRRAGE WITH WAIVER OF PREMIUMS AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 47.00
	HWCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$149.00
	HWBCN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	LH	LIFE INSURANCE ONLY - MUST BE COVERED AS A DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LHB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LHD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LHE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-

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WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
CATASTROPHIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTRO-PHIC PLAN
RETIREE AGE 67 OR OVER AMOUNT OF LIFE INSURANCE $2,500.00	ISM2	SINGLE COVERAGE	$ 29.00
	ISBM2	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 28.00
	IFM2	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 48.00
	IFBM2	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 47.00
	IWCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$148.00
	IWBCN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	LI	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 1.00
	LIB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LID	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 1.00
	LIE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
RETIREE ANY AGE HEALTH INSURANCE ONLY	ZSCN	SINGLE COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$ 89.00
	ZSAM2	SINGLE COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 28.00
	ZFCN	FAMILY COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$174.00
	ZFAM2	FAMILY COVERAGE - RETIREE MEDICARE AND DEPENDENT NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$147.00
	ZWCN	FAMILY COVERAGE - RETIREE NON-MEDICARE AND DEPENDENT MEDICARE - NO LIFE INSURANCE BENEFITS	$109.00
	ZWAM2	FAMILY COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 47.00
CATASTROPHIC SURVIVING DEPENDENT RATE SCHEDULE	WS	SURVIVING SPOUSE UNDER AGE 65	$117.00
	WCM2	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$147.00
	WWM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$ 28.00
	WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$236.00
	WXM2	SURVIVING SPOUSE OVER AGE 65	$ 28.00
	WMM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$147.00
	YS	SURVIVING CHILD W/NO PARENTS	$117.00
	YF	SURVIVING CHILDREN W/NO PARENTS	$236.00

Public Employees Insurance Agency

Gaston Caperton
Governor

Sally K. Richardson
Director

MEMORANDUM

TO: Benefit Coordinators/Payroll Clerks of
State Agencies, Colleges and Universities, and
County Boards of Education

FROM: Sally K. Richardson
Director

SUBJECT: Premium Rate Schedule for FY-92

DATE: May 22, 1991

Enclosed is the State premium rate schedule to be effective July 1, 1991. In addition, an administrative expense fee of $20.00, which is billed annually on July 1 for each employee, and monthly as new employees are enrolled after July 1, is also effective July 1, 1991.

Please note any adjustments to the premium rates and make the proper payroll deductions for the July 1991 remittance.

Thank you for your cooperation. If you have any questions, please contact the Premium Accounts Section at 348-7850.

Enclosure

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WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
MONTHLY PREMIUM

INDEX CODE	ANNUAL SALARY	TYPE OF FAMILY			ANNUAL OUT-OF-POCKET MAXIMUM	BENEFIT CODE
		CHILD(REN) ONLY	2 ADULT FAMILY	FULL FAMILY		
1	$ 0 - $ 8,000	$10.66	$18.66	$21.32	$ 750.00	A1
2	$ 8,001 - $ 8,500	$11.00	$19.26	$22.00	$ 750.00	A1
3	$ 8,501 - $ 9,000	$11.68	$20.44	$23.36	$ 750.00	A1
4	$ 9,001 - $ 9,500	$12.34	$21.60	$24.68	$ 750.00	A1
5	$ 9,501 - $10,000	$13.00	$22.76	$26.00	$ 750.00	A1
6	$10,001 - $10,500	$13.68	$23.94	$27.36	$ 750.00	A1
7	$10,501 - $11,000	$14.34	$25.10	$28.68	$ 750.00	A1
8	$11,001 - $11,500	$15.00	$26.26	$30.00	$ 750.00	A1
9	$11,501 - $12,000	$15.68	$27.44	$31.36	$ 750.00	A1
10	$12,001 - $12,500	$16.34	$28.60	$32.68	$ 750.00	A1
11	$12,501 - $13,000	$17.00	$29.76	$34.00	$ 750.00	A1
12	$13,001 - $13,500	$17.68	$30.94	$35.36	$ 750.00	A1
13	$13,501 - $14,000	$18.34	$32.10	$36.68	$ 750.00	A1
14	$14,001 - $14,500	$19.00	$33.26	$38.00	$ 750.00	A1
15	$14,501 - $15,000	$19.68	$34.44	$39.36	$ 750.00	A1
16	$15,001 - $30,000	$20.00	$35.00	$40.00	$1,000.00	A2
17	$30,001 - $30,500	$20.18	$35.32	$40.36	$1,250.00	A3
18	$30,501 - $31,000	$20.50	$35.88	$41.00	$1,250.00	A3
19	$31,001 - $31,500	$20.84	$36.48	$41.68	$1,250.00	A3
20	$31,501 - $32,000	$21.18	$37.08	$42.36	$1,250.00	A3
21	$32,001 - $32,500	$21.50	$37.64	$43.00	$1,250.00	A3
22	$32,501 - $33,000	$21.84	$38.22	$43.68	$1,250.00	A3
23	$33,001 - $33,500	$22.18	$38.82	$44.36	$1,250.00	A3
24	$33,501 - $34,000	$22.50	$39.38	$45.00	$1,250.00	A3
25	$34,001 - $34,500	$22.84	$39.98	$45.68	$1,250.00	A3
26	$34,501 - $35,000	$23.18	$40.58	$46.36	$1,250.00	A3
27	$35,001 - $35,500	$23.50	$41.14	$47.00	$1,250.00	A3
28	$35,501 - $36,000	$23.84	$41.72	$47.68	$1,250.00	A3
29	$36,001 - $36,500	$24.18	$42.32	$48.36	$1,250.00	A3
30	$36,501 - $37,000	$24.50	$42.88	$49.00	$1,250.00	A3
31	$37,001 - $37,500	$24.84	$43.48	$49.68	$1,250.00	A3
32	$37,501 - $38,000	$25.18	$44.08	$50.36	$1,250.00	A3
33	$38,001 - $38,500	$25.50	$44.64	$51.00	$1,250.00	A3
34	$38,501 - $39,000	$25.86	$45.26	$51.72	$1,250.00	A3
35	$39,001 - $39,500	$26.18	$45.82	$52.36	$1,250.00	A3
36	$39,501 - $40,000	$26.50	$46.38	$53.00	$1,250.00	A3
37	$40,001 - $40,500	$26.84	$46.98	$53.68	$1,500.00	A4
38	$40,501 - $41,000	$27.18	$47.58	$54.36	$1,500.00	A4
39	$41,001 - $41,500	$27.50	$48.14	$55.00	$1,500.00	A4
40	$41,501 - $42,000	$27.84	$48.72	$55.68	$1,500.00	A4
41	$42,001 - $42,500	$28.18	$49.32	$56.36	$1,500.00	A4
42	$42,501 - $43,000	$28.50	$49.88	$57.00	$1,500.00	A4
43	$43,001 - $43,500	$28.84	$50.48	$57.68	$1,500.00	A4
44	$43,501 - $44,000	$29.18	$51.08	$58.36	$1,500.00	A4
45	$44,001 - $44,500	$29.50	$51.64	$59.00	$1,500.00	A4
46	$44,501 - $45,000	$29.84	$52.22	$59.68	$1,500.00	A4
47	$45,001 - $45,500	$30.18	$52.82	$60.36	$1,500.00	A4
48	$45,501 - $46,000	$30.50	$53.38	$61.00	$1,500.00	A4
49	$46,001 - $46,500	$30.84	$53.98	$61.68	$1,500.00	A4
50	$46,501 - $47,000	$31.18	$54.58	$62.36	$1,500.00	A4
51	$47,001 - $47,500	$31.50	$55.14	$63.00	$1,500.00	A4
52	$47,501 - $48,000	$31.84	$55.72	$63.68	$1,500.00	A4
53	$48,001 - $48,500	$32.18	$56.32	$64.36	$1,500.00	A4
54	$48,501 - $49,000	$32.50	$56.88	$65.00	$1,500.00	A4
55	$49,001 - $49,500	$32.84	$57.48	$65.68	$1,500.00	A4
56	$49,501 - $50,000	$33.18	$58.08	$66.36	$1,500.00	A4
57	$50,001 - $++.+++	$33.34	$58.36	$66.68	$1,500.00	A4

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WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC INSURANCE RATE SCHEDULE FOR ACTIVE EMPLOYEES OF
STATE AGENCIES, COLLEGES AND UNIVERSITIES, AND
COUNTY BOARD OF EDUCATION

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	AGENCY PREMIUM
EMPLOYEES UNDER AGE 65; AMOUNT OF LIFE INSURANCE $10,000.00	AS	EMPLOYEE ONLY	$177.00
	ASC	EMPLOYEE WITH CHILD(REN) ONLY	$279.00
	AF	EMPLOYEE WITH SPOUSE AND CHILD(REN)	$381.00
	AFF	EMPLOYEE WITH EMPLOYEE SPOUSE, WITH CHILD(REN)	$381.00
	AFX	EMPLOYEE WITH EMPLOYEE SPOUSE, NO CHILD(REN)	$339.00
	AFY	EMPLOYEE WITH SPOUSE, NO CHILD(REN)	$339.00
	LA	LIFE INSURANCE ONLY - EMPLOYEE COVERED AS DEPENDENT UNDER SPOUSE'S AFX/AFF COVERAGE FOR MEDICAL BENEFITS	$ 4.34
	LAD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 4.34
	MS	LIFE INSURANCE ONLY - HMO SINGLE	$ 4.34
	MF	LIFE INSURANCE ONLY - HMO FAMILY	$ 4.34
EMPLOYEES AGES 65 THRU 69; AMOUNT OF LIFE INSURANCE $5,500.00	BS	EMPLOYEE ONLY	$176.00
	BSC	EMPLOYEE WITH CHILD(REN) ONLY	$278.00
	BF	EMPLOYEE WITH SPOUSE, AND CHILD(REN)	$380.00
	BFF	EMPLOYEE WITH EMPLOYEE SPOUSE, WITH CHILD(REN)	$380.00
	BFX	EMPLOYEE WITH EMPLOYEE SPOUSE, NO CHILD(REN)	$338.00
	BFY	EMPLOYEE WITH SPOUSE, NO CHILD(REN)	$338.00
	LB	LIFE INSURANCE ONLY - EMPLOYEE COVERED UNDER AS DEPENDENT UNDER SPOUSE'S BFX/BFF COVERAGE FOR MEDICAL BENEFITS	$ 2.82
	LBD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.82
	MA	LIFE INSURANCE ONLY - HMO SINGLE	$ 2.82
	MB	LIFE INSURANCE ONLY - HMO FAMILY	$ 2.82
EMPLOYEES AGES 70 AND OLDER; AMOUNT OF LIFE INSURANCE $5,000.00	CS	EMPLOYEE ONLY	$175.00
	CSC	EMPLOYEE WITH CHILD(REN) ONLY	$277.00
	CF	EMPLOYEE WITH SPOUSE, AND CHILD(REN)	$379.00
	CFF	EMPLOYEE WITH EMPLOYEE SPOUSE, WITH CHILD(REN)	$379.00
	CFX	EMPLOYEE WITH EMPLOYEE SPOUSE, NO CHILD(REN)	$337.00
	CFY	EMPLOYEE WITH SPOUSE, NO CHILD(REN)	$337.00
	LD	LIFE INSURANCE ONLY - EMPLOYEE COVERED AS DEPENDENT UNDER SPOUSE'S CFX/CFF COVERAGE FOR MEDICAL BENEFITS	$ 2.17
	LDD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.17
	MC	LIFE INSURANCE ONLY - HMO SINGLE	$ 2.17
	MD	LIFE INSURANCE ONLY - HMO FAMILY	$ 2.17

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN.
RETIREE UNDER AGE 65; AMOUNT OF LIFE INSURANCE $5,000.00	GSPN	SINGLE COVERAGE	$119.00
	GSAM1	SINGLE COVERAGE WITH MEDICARE	$ 42.00
	GSBPN*	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$117.00
	GSCM1*	SINGLE COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM	$ 40.00
	GFPN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$238.00
	GFAM1	FAMILY COVERAGE WITH MEDICARE AND DEPENDENT(S) UNDER AGE 65	$164.00
*AMOUNT OF LIFE INSURANCE $10,000.00	GFBPN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$236.00
	GFCM1*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	GWPN	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$151.00
	GWAM1	FAMILY COVERAGE WITH MEDICARE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 69.00
	GWBPN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$149.00
	GWCM1*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 67.00
	LG	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LGB*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LGD	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LGE*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
RETIREE AGE 65 - 66 AMOUNT OF LIFE INSURANCE $5,000.00	HSM1	SINGLE COVERAGE	$ 42.00
	HSBM1	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 40.00
	HFM1	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 69.00
	HFBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUMS AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 67.00
	HWPN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$164.00
	HWBPN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	LH	LIFE INSURANCE ONLY - MUST BE COVERED AS A DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LHB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LHD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LHE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-

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WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
RETIREE AGE 67 OR OVER AMOUNT OF LIFE INSURANCE $2,500.00	ISM1	SINGLE COVERAGE	$ 41.00
	ISBM1	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 40.00
	IFM1	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 68.00
	IFBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 67.00
	IWPN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$163.00
	IWBPN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	LI	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 1.00
	LIB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LID	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 1.00
	LIE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
RETIREE ANY AGE HEALTH INSURANCE ONLY	ZSPN	SINGLE COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$117.00
	ZSAM1	SINGLE COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 40.00
	ZFPN	FAMILY COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$236.00
	ZFAM1	FAMILY COVERAGE - RETIREE MEDICARE AND DEPENDENT NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$162.00
	ZWPN	FAMILY COVERAGE - RETIREE NON-MEDICARE AND DEPENDENT MEDICARE - NO LIFE INSURANCE BENEFITS	$149.00
	ZWAM1	FAMILY COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 67.00
BASIC PLAN SURVIVING DEPENDENT RATE SCHEDULE	WS	SURVIVING SPOUSE UNDER AGE 65	$117.00
	WOM1	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$162.00
	WWM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$ 40.00
	WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$236.00
	WXM1	SURVIVING SPOUSE OVER AGE 65	$ 40.00
	WMM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$162.00
	YS	SURVIVING CHILD W/NO PARENTS	$117.00
	YF	SURVIVING CHILDREN W/NO PARENTS	$236.00
COBRA RATE SCHEDULE	CES	COBRA EMPLOYEE - SINGLE COVERAGE	$176.00
	CEC	COBRA EMPLOYEE - WITH CHILD(REN) ONLY	$300.00
	CEF	COBRA EMPLOYEE - FAMILY COVERAGE	$424.00
	CDS	COBRA DEPENDENT - SINGLE COVERAGE	$176.00
	CDC	COBRA DEPENDENT - WITH CHILD(REN) ONLY	$300.00
	CDF	COBRA DEPENDENT - FAMILY COVERAGE	$424.00
	CSD	COBRA EMPLOYEE - SINGLE DISABLED	$259.00
	CSC	COBRA EMPLOYEE - DISABLED - WITH CHILD(REN) ONLY	$432.00
	CFD	COBRA EMPLOYEE - FAMILY DISABLED	$605.00
	CEY	COBRA EMPLOYEE - WITH SPOUSE, NO CHILD(REN)	$376.00
	CFY	COBRA DEPENDENT - WITH SPOUSE, NO CHILD(REN)	$376.00
	CDY	COBRA WITH SPOUSE	

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
CATASTROPHIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTRO-PHIC PLAN
RETIREE UNDER AGE 65; AMOUNT OF LIFE INSURANCE $5,000.00	GSCN	SINGLE COVERAGE	$ 91.00
	GSAM2	SINGLE COVERAGE WITH MEDICARE	$ 30.00
	GSBCN*	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 89.00
	GSCM2*	SINGLE COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM	$ 28.00
	GFCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$176.00
*AMOUNT OF LIFE INSURANCE $10,000.00	GFAM2	FAMILY COVERAGE WITH MEDICARE AND DEPENDENT(S) UNDER AGE 65	$149.00
	GFBCN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$174.00
	GFCM2*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	GWCN	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$111.00
	GWAM2	FAMILY COVERAGE WITH MEDICARE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 49.00
	GWBCN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$109.00
	GWCM2*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 47.00
	LG	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNVER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LGB*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LGD	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LGE*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
RETIREE AGE 65 - 65 AMOUNT OF LIFE INSURANCE $5,000.00	HSM2	SINGLE COVERAGE	$ 30.00
	HSBM2	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 28.00
	HFM2	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 49.00
	HFBM2	FAMILY COVERAGE WITH WAIVER OF PREMIUMS AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 47.00
	HWCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$149.00
	HWBCN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	LH	LIFE INSURANCE ONLY - MUST BE COVERED AS A DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LHB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LHD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LHE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-

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WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY CATASTROPHIC PLAN RATE SCHEDULE FOR RETIREES			
EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTRO-PHIC PLAN
RETIREE AGE 67 OR OVER AMOUNT OF LIFE INSURANCE $2,500.00	ISM2	SINGLE COVERAGE	$ 29.00
	ISBM2	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 28.00
	IFM2	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 48.00
	IFBM2	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 47.00
	IWCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$148.00
	IWBCN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	LI	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 1.00
	LIB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LID	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 1.00
	LIE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
RETIREE ANY AGE HEALTH INSURANCE ONLY	ZSCN	SINGLE COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$ 89.00
	ZSAM2	SINGLE COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 28.00
	ZFCN	FAMILY COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$174.00
	ZFAM2	FAMILY COVERAGE - RETIREE MEDICARE AND DEPENDENT NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$147.00
	ZWCN	FAMILY COVERAGE - RETIREE NON-MEDICARE AND DEPENDENT MEDICARE - NO LIFE INSURANCE BENEFITS	$109.00
	ZWAM2	FAMILY COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 47.00
CATASTROPHIC SURVIVING DEPENDENT RATE SCHEDULE	WS	SURVIVING SPOUSE UNDER AGE 65	$117.00
	WOM2	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$147.00
	WWM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$ 28.00
	WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$236.00
	WXM2	SURVIVING SPOUSE OVER AGE 65	$ 28.00
	WMM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$147.00
	YS	SURVIVING CHILD W/NO PARENTS	$117.00
	YF	SURVIVING CHILDREN W/NO PARENTS	$236.00

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850
FAX: 304-348-2516

Gaston Caperton
Governor

Sally K. Richardson
Director

March 22, 1991

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Benefit Plan Document notebook the following four publications (the "Summaries"):

1. Public Employees Insurance Agency Summary Plan Description For Active [State] Employees and Their Dependents;

2. PEIA Summary Plan Description For Active Employees of Non-State Agencies and Their Dependents;

3. PEIA Summary Plan Description For Employees and Their Dependents, and Surviving Dependents; and

4. West Virginia Public Employees Insurance Agency Prescription Drug Program, Effective January 1, 1991.

These documents summarize the benefit plan changes adopted by the PEIA Finance Board as part of its initial financial plan. The Summaries all became effective on January 1, 1991. Copies were mailed to all insureds.

Please file the four Summaries together with this letter at the front of the Plan Document. Notwithstanding statements in the Summaries to the contrary, until comprehensive revisions to the Plan Document are completed and filed with your office, the Summaries shall govern in the case of any conflict between the provisions of the Summaries and those contained in the Plan Document.

As always, thank you for your cooperation and assistance with this request.

Sincerely,

Sally K. Richardson
Director

SKR:DPL:trs

Enclosures

West Virginia Public Employees Insurance Agency

Prescription Drug Program

Effective January 1, 1991

Beginning January 1, 1991, the PEIA Prescription Drug Program is being administered by The Computer Company through PRN, the Prescription Reimbursement Network. Their system will be in full operation and processing Prescription Drug Program claims by the end of February.

OVERVIEW

The new program will consist of an annual deductible and set co-payment amounts which are determined by:

1. whether a generic or brand name drug is dispensed;
2. whether a Network or non-Network pharmacy is used;
3. whether a 90-day supply of a maintenance medication is dispensed; and
4. the net (after deductible) cost of the prescription.

NETWORK

Preferred Pharmacy Network of West Virginia will remain the pharmacy network for PEIA insureds. Network pharmacies may be identified by the PPNWV signs on doors or windows. PEIA insureds are encouraged to use only Network pharmacies whenever possible. Non-Network pharmacies may charge higher prices and your co-payment, i.e., the amount you pay in cooperation with the amount the PEIA Program pays, will be $3.00 higher for each prescription.

Members either choosing not to use or unable to use Network pharmacies, e.g., retirees living out of West Virginia, MUST use the PEIA Member Prescription Drug Claim Form to file their claims. Members may also ask their preferred pharmacies - including those out of State - to contact PRN regarding joining the PEIA Prescription Drug Program Network.

ANNUAL DEDUCTIBLE

The PEIA Prescription Drug Program annual deductible has not changed. It is $50.00 per person per calendar year up to a maximum of $100.00 per family per calendar year for all persons within a covered family.

CO-PAYMENTS

After the annual deductible is satisfied, the patient's co-payment amount for each prescription is as follows:

NET (AFTER DEDUCTIBLE) PRESCRIPTION COST

DRUG TYPE	$0.00 Thru 9.99	$10.00 Thru 19.99	$20.00 Thru 29.99	Each Additional $10.00
Generic Drug	**$1.00**	**$2.00**	**$3.00**	**$1.00**
Brand Name Drug (Brand necessary or generic not available)	**2.00**	**4.00**	**6.00**	**2.00**
Brand Name Drug (Patient request)	**2.50**	**5.00**	**7.50**	**2.50**

NOTE 1: If a 90-day supply of a maintenance medication is dispensed, the above co-payments are cut in half.

NOTE 2: An additional $3.00 is added to each calculated prescriptio co-payment if dispensing is by a non-Network pharmacy.

NOTE 3: The co-payment amount as calculated above will never exceed the net cost of the prescription.

DISPENSING LIMITS (EFFECTIVE MAY 1, 1991)

As a method to control possible waste and, therefore, unnecessary cost to both you

and the PEIA Prescription Drug Program, the Program will limit its reimbursement of acute medication prescriptions to a maximum 34-day supply per fill or refill effective May 1, 1991.

REMEMBER: IF MORE THAN A 34-DAY SUPPLY OF AN ACUTE MEDICATION IS PRESCRIBED AND DISPENSED AT ONE TIME, YOUR REIMBURSEMENT WILL BE BASED ON ONLY THE MAXIMUM 34-DAY AMOUNT. YOU WILL BE RESPONSIBLE FOR THE DIFFERENCE.

For maintenance medications you should ask your physician to prescribe a 90-day supply and you should then get that 90-day supply dispensed at one time. All 90-day-supply maintenance medication prescriptions have a co-payment which is one-half of the usual co-payment amount for that particular drug and cost. Effective May 1, 1991, maintenance medications dispensed at less than the standard 90-day supply will be treated as acute medications, i.e., subject to the same 34-day-supply maximum in calculating Program reimbursement for these prescriptions.

If your pharmacist does not have on hand enough of a particular maintenance drug to fill your 90-day-supply prescription, you should either (1) go to another pharmacy, or (2) work out an agreement with your pharmacist to let you take the available quantity, return later for the balance of the 90-day supply, and then treat the two transactions as if a single transaction for purposes of calculating your co-payment and submitting of only one claim (for the 90-day supply) to PRN.

REMEMBER: YOU WILL BE SUBJECT TO THE SAME 34-DAY-SUPPLY MAXIMUM AS FOR AN ACUTE MEDICATION AND WILL PAY A HIGHER CO-PAYMENT AMOUNT WHENEVER YOU OBTAIN LESS THAN A 90-DAY SUPPLY OF A MAINTENANCE DRUG. ...GET YOUR PRESCRIBING PHYSICIAN AND YOUR DISPENSING PHARMACIST TO COOPERATE IN REDUCING YOUR MAINTENANCE DRUG COSTS WITH THE 90-DAY SUPPLY!

FILING CLAIMS

The Member must file claims prior to satisfaction of the patient's annual deductible and/or any time a prescription is filled by a non-Network pharmacist. Network pharmacists will file claims for you after the patient's deductible is met.

1. Before the deductible is met, a PEIA Prescription Drug Claim Form is required for all Member-submitted claims. A copy of the form is printed at the end of this memo for your use.

2. Be sure you provide the following information on the PEIA Prescription Drug

Claim Form:

a. the MEMBER'S Social Security number,

b. the patient information (filled out by the Member), and

c. the MEMBER'S signature, or that of the dependent patient of legal age.

3. Be sure the pharmacist has either:

a. completed the prescription data section of the PEIA Prescription Drug Claim Form, including pharmacy name, address, telephone number, National Association of Boards of Pharmacy (NABP) number, and pharmacist's signature, or

b. provided a completed Universal Claim Form (your pharmacist has these forms on hand) which must include member and patient information as well as all required pharmacy and drug information. The Member must attach this form to the PEIA Prescription Drug Claim Form and submit both to PRN.

4. First Prescription(s) of the Year:

a. **If one or more prescriptions being filled at the same time cost less than $50.00** (your individual prescription drug deductible), pay for the prescription(s), but keep the PEIA Member Prescription Drug Claim Form(s) filled out by the pharmacist or the Universal Claim Form(s) until you have purchased $50.00 worth of prescriptions for the same individual or $100 for the entire family. When you feel that you have met your deductible, submit the claim forms to PRN for processing and issuance of your Explanation of Claim Processed (ECP) verifying your deductible status.

b. **If one or more prescriptions being filled for the same patient at the same time cost more than $50.00** (your individual prescription drug deductible), follow the same instructions as for prescriptions less than $50.00 or you may inquire if your Network pharmacy would file the claim for you. If the pharmacy agrees to filing your claim, pay the $50.00 deductible plus the correct co-payment for the total cost of the drug. PRN will receive this claim form directly from the pharmacist, apply the $50 of the drug cost toward your deductible, and issue to you the required ECP for deductible satisfaction verification for your future drug purchases.

5. Be sure you include information on any other group insurance coverage and attach an Explanation of Benefits from the other group insurance carrier with your claims (if applicable).

6. After the deductible is met, you will receive an Explanation of Claims Processed (ECP) from PRN. You should keep this ECP to show your Network pharmacy that such deductible has been met the next time that you get a prescription (re)filled. (As soon as your Network pharmacy is electronically "on line" with PRN - about April or May - you will no longer need to show the ECP with each prescription (re)fill.) Once a participating Network pharmacy can verify - either electronically or manually via the ECP - that the patient's deductible has been met, that pharmacy will submit all future claims for that patient for the rest of that year.

7. Your deductible status makes no difference to non-Network pharmacies: you pay the entire cost up front and then send your properly completed claim to PRN for reimbursement.

MAILING ADDRESS FOR CLAIMS

When you believe you have reached your deductible and/or if you use non-Network pharmacies, send your claim forms to:

Prescription Reimbursement Network
P. O. Box C-85042
Richmond, VA 23261-5042

OTHER DETAILS AND REMINDERS

1. Please do **NOT** re-submit claims already filed with the previous administrator, Erisco. These claims were automatically transferred and will be processed for you by PRN in the near future according to guidelines being provided by PEIA. Please do not call PRN (or PEIA) on the status of these claims until March.

2. All incomplete claim forms will be returned to the Member.

3. Universal Claim Forms not attached to PEIA Member Prescription Drug Claim Forms will be reimbursed to pharmacies. PEIA Member Prescription Drug Claim Forms (with or without attached Universal Claim Forms) will be reimbursed to Members.

4. Cash register receipts and cancelled checks are not acceptable proof of claim.

5. Do not submit either Network or non-Network prescription drug claims for reimbursement until you believe that you have reached your annual deductible. Once you have reached your deductible, submit all claims to PRN for verification. PRN will then provide you with an ECP to be shown to Network pharmacists to allow them to begin billing PRN directly for your future prescriptions.

6. There is a one-year filing limit from the date the prescription was filled; therefore, claims should be submitted as soon as the deductible has been met.

7. Always ask if generic drugs are available. Drug costs will be lower and a lower co-payment amount will also apply.

8. Always ask for 90-day-supply prescriptions and fills for maintenance drugs. Your co-payment amount will be considerably lower.

9. If available in your area, always use a Network pharmacy. Drug costs will usually be lower and a lower co-payment amount will also apply. Recommend that your non-Network pharmacy join the Network!

10. Never obtain at one time more than a 34-day supply of an acute medication. You will pay the entire difference between the actual cost and the 34-day-supply cost for any acute drug prescription.

QUESTIONS

If you have questions related to prescription drug claim payments, you may call the Prescription Drug Program Customer Service Hotline at (800) 669-0776. The hotline is available Monday through Friday (except holidays) from 8:00 a.m. to 9:00 p.m. Eastern Time. Please do not use this hotline number for benefit questions unrelated to the Prescription Drug Program.

WEST VIRGINIA
PUBLIC EMPLOYEES INSURANCE AGENCY
PRESCRIPTION DRUG CLAIM FORM

Mail to:
Prescription Reimbursement Network
P.O. Box C-85042
Richmond, VA 23261-5042

IMPORTANT—I certify that the information entered on this form is correct, that the patient named is eligible for the benefits and that I have received the medication described. I also certify that the medication received is not for treatment of an on-the-job injury. I also authorize release of all information pertaining to this claim to the plan administrator, the PEIA, the member, and the employer.

PLEASE SIGN CERTIFICATION FOR PRESCRIPTION(S) RECEIVED _____
SIGNATURE

MUST BE COMPLETED BY MEMBER

SOCIAL SECURITY NUMBER	MEMBER NAME	DATE

PRESCRIPTIONS WERE FOR: (PLEASE PRINT) Last Name	First Name	MI	PATIENT SEX (Circle One)	RELATIONSHIP (Circle One)	PATIENT DATE OF BIRTH Mo. Day Year
			M F	Self Spouse Dependent Other	

Is this medication covered under any other group insurance plan? (Circle One) Yes No If Yes, name:

PRESCRIPTION DETAIL MUST BE COMPLETED BY PHARMACY

DATE Rx WRITTEN	PRESCRIBER NAME	PRESCRIBER DEA NO.	PRESCRIPTION NO.
DATE Rx FILLED	NATIONAL DRUG CODE	DRUG NAME	
DISPENSED AS WRITTEN CODE:	METRIC QUANTITY	DAYS SUPPLY	NEW OR REFILL ☐N ☐R / AMOUNT PAID BY PATIENT:

DATE Rx WRITTEN	PRESCRIBER NAME	PRESCRIBER DEA NO.	PRESCRIPTION NO.
DATE Rx FILLED	NATIONAL DRUG CODE	DRUG NAME	
DISPENSED AS WRITTEN CODE:	METRIC QUANTITY	DAYS SUPPLY	NEW OR REFILL ☐N ☐R / AMOUNT PAID BY PATIENT:

TE Rx WRITTEN	PRESCRIBER NAME	PRESCRIBER DEA NO.	PRESCRIPTION NO.
DATE Rx FILLED	NATIONAL DRUG CODE	DRUG NAME	
DISPENSED AS WRITTEN CODE:	METRIC QUANTITY	DAYS SUPPLY	NEW OR REFILL ☐N ☐R / AMOUNT PAID BY PATIENT:

DATE Rx WRITTEN	PRESCRIBER NAME	PRESCRIBER DEA NO.	PRESCRIPTION NO.
DATE Rx FILLED	NATIONAL DRUG CODE	DRUG NAME	
DISPENSED AS WRITTEN CODE:	METRIC QUANTITY	DAYS SUPPLY	NEW OR REFILL ☐N ☐R / AMOUNT PAID BY PATIENT:

DATE Rx WRITTEN	PRESCRIBER NAME	PRESCRIBER DEA NO.	PRESCRIPTION NO.
DATE Rx FILLED	NATIONAL DRUG CODE	DRUG NAME	
DISPENSED AS WRITTEN CODE:	METRIC QUANTITY	DAYS SUPPLY	NEW OR REFILL ☐N ☐R / AMOUNT PAID BY PATIENT:

PHARMACY INFORMATION

MEMBER ADDRESS _____

_____

_____

NAME _____

ADDRESS _____

TELEPHONE _____

NABP NUMBER _____

_____
PHARMACIST'S SIGNATURE DATE

WV Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1025
Charleston, WV 25305

Bulk Rate
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Permit # 271
Charleston, WV

Public Employees Insurance Agency
Summary Plan Description

For Active Employees and Their Dependents

To have coverage under the PEIA Health Benefit Plan after January 1, 1991, you must re-enroll by December 15, 1990. Pay close attention to the ENROLLMENT Section for details.

This Summary Plan Description describes the Benefit Plan of the West Virginia Public Employees Insurance Agency ("PEIA"), which is effective on January 1, 1991.

The PEIA is a self-insured health insurance trust fund which offers hospital, surgical, major medical, prescription drug and other medical care benefit coverage, as well as basic and optional life insurance, to employees and retirees of all state agencies, organizations, universities and colleges, county boards of education and those county and municipal agencies and organizations which elect to participate. This represents 12% of West Virginia's population.

The increasing cost of health care is an economic fact of life for all employers and employees and retirees. The revised PEIA Benefit Plan seeks to maintain an equitable balance between the State's responsibility to adequately fund its insurance benefit, the responsibility of providers to offer cost-effective services and the insureds' responsibility to use the Plan in a cost-saving manner. Following are some important features which assist PEIA in attaining these balanced goals.

Read this document carefully so that you will have a clear understanding of your coverage under the Plan.

The Plan provides coverage for health services to members and their covered dependents as described in this Summary Plan Description and as set forth in greater detail in the Plan Document. Coverage for some health services is subject to prior approval of the Plan. No coverage is provided for health services rendered after coverage under the Plan terminates.

Only medically necessary health services are covered under the Plan. The fact that a physician has performed or prescribed a procedure or treatment does not mean that the procedure or treatment is covered under the Plan. The Plan has sole discretion in interpreting the benefits covered under the Plan and the other terms, conditions, limitations and exclusions set out in the Plan and the Summary Plan Description. The Summary Plan Description is subject to the Plan Document and, if there is a conflict between the documents, the Plan Document shall govern.

ASSIGNMENT OF BENEFITS

State law requires health care providers (except pharmacies and dental surgeons) to "accept assignment" of the PEIA member's right to receive payment for covered health services. Consequently, you have the right to request the physician or other provider to seek payment directly from Plan instead of from you. This provision means that physicians practicing in West Virginia can request, but cannot require PEIA members to pay for their care at the time of service. Unless the member wishes to pay at the time of service, physicians must first bill the Plan for covered services, be paid by the Plan directly, and then bill the member for the member's portion. The member's portion will be reflected on the Explanation of Benefits.

If the Plan pays the provider directly, you will still be responsible for making payment to the provider for any deductible amount, any Copayment and any amount for a non-covered service. You may decide to pay for the provider's care at the time of service and then to submit a claim to the Plan for reimbursement. If you wish to be reimbursed for covered health services, you must give the Plan all the information required to process the claim. If you do not provide the required information, you may not be reimbursed.

PROHIBITION AGAINST BALANCE BILLING

State law prohibits health care providers (other than pharmacies and dental surgeons) from billing PEIA members for any portion of their charges not paid by the Plan (other than for applicable deductibles, copayments and services not covered by the Plan).

The Plan pays health care providers according to maximum fee schedules established by PEIA. If the provider's charge is higher than the Plan maximum fee for a particular service, then the Plan will pay only the maximum fee. The provider cannot collect the unpaid portion from the member.

New fee schedules taking effect on January 1, 1991, will further reduce fees, increasing the likelihood that a provider's charges may be higher than the fee which the Plan will pay. You should monitor your provider's bills and your Explanation of Benefits statements carefully to insure that you have not been billed improperly. If you have been, you should first contact the provider and ask for a refund. If this does not resolve the situation, you should contact the PEIA.

The PEIA will be notifying providers located outside West Virginia that the agency expects them not to bill the member for the balance of any charges not paid by the Plan. However, it has not yet been determined by a court of law that State law can be enforced outside this State. You may wish to take this into consideration before deciding to seek care outside West Virginia. If you do obtain care out of State, and are balance billed by the provider, please contact the PEIA and we will request the Attorney General's Office to take whatever actions are possible.

ELIGIBILITY

Active Employees:

All elected and regular, full-time employees of the State of West Virginia, the State colleges and universities, County Boards of Education, Counties, Cities or Towns, and other individuals and

Government Bodies so specified in the West Virginia State Code, Chapter 5, Article 16 are eligible for enrollment in the PEIA Benefit Plan.

The term "full-time" shall mean a permanent position that is considered full-time by the participating agency and that requires at least twenty hours per week, or 1,040 hours per year in that position, unless otherwise exempt from this requirement by the Code. PEIA reserves the right to make the final determination on these matters.

Temporary, substitute, and other part-time employees who do not meet the definitions as stated in this summary are excluded with the exception of those school service employees made eligible by Section 18A-4-15 of the Code.

Legislative Participation:

Members of the Legislature may participate in and be covered under any and all plans established by the PEIA. All Legislative members must enroll and pay the full cost for all group coverage on themselves, their spouses and dependents so that there will be no cost to the State of West Virginia. Enrollment period for Legislature is December next succeeding their election and the following January. (West Virginia Constitution, Article 4, Section 7)

Dependent:

A member's dependents shall only include:

a. Spouse (if legally married);

b. Natural child who has not reached its nineteenth birthday;

c. Legally adopted child (including a child living with the member during the period of probation) who has not reached its nineteenth birthday;

d. Stepchild who has not reached its nineteenth birthday and is living with the member;

e. Child who has not reached its nineteenth birthday, is fully dependent upon the member for support and maintenance, and is living with the member; and

f. Child of divorced parents when the divorce decree stipulates that the member is responsible for health insurance coverage.

PEIA reserves the right to request proof of marriage, copies of birth certificates and legal documents indicating responsibility for child support and/or showing legal custody.

Full-time Unmarried Student:

Children are considered to be dependents until they reach their twenty-fifth birthday if they are enrolled as full-time students, are unmarried and are fully dependent upon the member for support and maintenance.

Mentally Retarded/Physically Disabled Dependent Children:

A dependent child may be covered after reaching its nineteenth birthday while incapable of self-support because of mental retardation, mental illness, or a physical disability. The child must have been a dependent and covered by the plan at the onset of the mental retardation, mental illness or physical disability. The member shall contact the PEIA office within 31 days before coverage terminates for the appropriate form to request continuation of the child's coverage.

ENROLLMENT

To have coverage with PEIA after January 1, 1991, the member must complete an enrollment form which will be available through the payroll locations and return it to his/her payroll location no later than December 15, 1990.

Premiums and "Out-of-Pocket Maximums" are based on the member's annual salary. Two married eligible employees will always be considered as one family unit with one eligible employee being designated as the member, and the other being designated as the spouse dependent, and salary for the purpose of determining such member premium and/or out-of-pocket maximum will be the sum of the couple's separate annual salary amounts. The chart in **Appendix A** shows the premium rates and the out-of-pocket maximums for each individual or combined salary range.

The enrollment categories and premium levels are:

Eligible single employee ---------- No premium

Eligible employees married to each other (no dependent children) ---------- No Premium

Eligible employee with dependent child(ren) ---------- Children Only Premium

Eligible employees married to each other with child(ren)---------- Children Only Premium

Eligible employee with full family coverage ---------- Full Family Premium

TERMINATION OF COVERAGE

Active Employee:

The coverage for the employee terminates when the employee is no longer eligible or when group coverage terminates, whichever happens first.

a. Voluntary Termination: The basic medical coverage for the employee terminates at the end of the month in which the employee voluntarily ends his/her employment.

b. Involuntary Termination: The employee who is terminated from employment involuntarily or through a reduction of work force may continue coverage for 3 additional months after the end of the month in which the employee goes off of the payroll. Eligible dependent(s) who have been properly enrolled by the employee are included in the 3 months extension. This extension of basic coverage is provided at no additional cost to the employee.

Mentally Retarded/Physically Disabled Dependent Children:

A dependent child may be covered after reaching its nineteenth birthday while incapable of self-support because of mental retardation, mental illness, or a physical disability. The child must have been a dependent and covered by the plan at the onset of the mental retardation, mental illness or physical disability. The member shall contact the PEIA office within 31 days before coverage terminates for the appropriate form to request continuation of the child's coverage.

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Misconduct Discharge: The employee who is discharged for misconduct is not entitled or eligible for the 3 months extension of coverage as mentioned above. However, basic coverage may be extended to the employee and/or eligible dependent(s) up to the maximum period of 3 months, while administrative remedies contesting the charge of misconduct are pursued by the employee. If the misconduct is upheld, the full premium cost of the extended basic coverage must be reimbursed by the employee through his/her respective payroll location.

Dependents:

The coverage for dependent(s) terminates at the end of the month in which one of the following occur:

1. Employee terminates or loses coverage;
2. Divorce from member (at the end of the month in which the divorce is final);
3. Child reaches nineteenth birthday;
4. Child marries;
5. Child is no longer a full-time student or reaches twenty-fifth birthday.

TIMELY SUBMISSION OF CLAIMS

All claims must be submitted to the Plan within 12 months of the date the health service is rendered. The only exception that will be made to this requirement is the submission of Medicare claims, which must be submitted to the Plan within 18 months of the date health services were rendered.

APPEALS PROCESS

The appeals process is as follows:

Step 1: Appeal in writing to the claims administrator or utilization management firm for determination of a processing error or reconsideration of a decision.

Step 2: Appeal to PEIA for review. Must be submitted in writing within sixty (60) days of final disposition of the claim by the claims administrator or utilization management firm .

Step 3: Review and determination by PEIA.

A claim may be settled at any point in the appeals process. Further information about the process will be provided to the member when an appeal is filed

PATIENT AUDIT PROGRAM

The Patient Audit Program rewards members for helping to control the rising cost of health care in West Virginia. It is becoming increasingly clear that errors may occur in the billing or payment of

health care services. These errors are unintentional, but costly. The Patient Audit program has been designed to help detect and correct these errors. All PEIA members who have Public Employees health insurance may submit Patient Audit reports.

Reported errors must be at least $50.00 to qualify for this program. Participants in HMO's are not eligible to participate, although it still makes sense to check hospital bills to see that they are correct.

Types of errors which qualify for this program are:

1. Charges for services you did not receive; and
2. Overcharges or overpayments resulting from clerical error or miscalculation.

The member must initiate the Patient Audit report for any overpayments prior to the receipt of any recovered amounts by the Claims Administrator. If the claims administrator detects and corrects an error before the member has made the Patient Audit Report, the report will be invalid.

When an error is detected, please contact the PEIA Patient Audit Coordinator for a report form and further instructions.

COORDINATION OF BENEFITS

The Plan, as secondary payor, will pay only its usual benefits less any amount already paid by the primary payor(s).

Following is an illustration of coordination of benefits:

Total Charges	$100.00
PEIA Plan's Usual Benefits	$ 80.00
Other Plan Pays	$ 60.00
PEIA Plan Pays	$ 20.00
Member's Payment	$ 20.00
Total Percentage of Claim Charges Paid	80%
Amount Paid in Excess of PEIA Benefits	$ 0.00

SUBROGATION

To the extent that benefits for covered services are provided or paid by the Plan, the Public Employees Insurance Agency shall be subrogated and succeed to all rights of a member to recover such paid expenses from any person or entity which may be liable for expenses incurred for covered services.

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SUBROGATION

To the extent that benefits for covered services are provided or paid by the Plan, the Public Employees Insurance Agency shall be subrogated and succeed to all rights of a member to recover such paid expenses from any person or entity which may be liable for expenses incurred for covered services.

This right of subrogation shall constitute a lien against any settlement or judgment obtained by or on behalf of a member for recovery of such expenses. A member shall, upon request, execute and deliver to the PEIA such documents and information which the PEIA may require to define, verify or protect its right of subrogation. Benefits may be withheld pending receipt of necessary documents from the member. In addition, the member shall be responsible for making prompt reimbursement to the PEIA from any settlement or judgment obtained.

Failure by the member to provide any requested documents or information, or to otherwise cooperate with the PEIA in protecting or securing its right, or to make prompt reimbursement from any settlement or judgment, shall not affect the PEIA's right of subrogation, but shall render the member liable to the PEIA for any expenses, including reasonable attorney's fees, incurred in obtaining any such requested information, or any reimbursement to which it is entitled.

RIGHT OF RECOVERY

The Public Employees Insurance Agency shall have the right to recover from any member or other person or entity to whom benefits have been paid for payments subsequently determined to be excessive, for noncovered services, or otherwise improperly or incorrectly made. The member shall cooperate fully with the PEIA to secure recovery of any such overpayments. The PEIA may, after making reasonable attempts to collect from the member or other person or entity to whom such overpayment has been made, deduct the amount of the overpayment from other benefits which are or may become payable to or on behalf of the member.

This provision shall not limit any other remedy provided by law.

UTILIZATION MANAGEMENT

Managing health care dollars is the responsibility of both PEIA and its insureds. Utilization Management is a process by which PEIA helps its insureds to receive the most appropriate types of medical care in the most cost-effective manner. Alternative care can shorten a hospital stay or eliminate a hospital stay altogether when appropriate, and utilization management can coordinate alternative care for insureds.

Utilization management also can help the member maximize health care benefits, since the staff is familiar with the PEIA benefit plan and can provide guidance in using benefits wisely. A helath service advice line with nurses answering questions is available.

To provide the best possible prenatal care for all PEIA insureds, PEIA requires that all pregnancies be reported to the utilization management firm during the first trimester, or as soon as the pregnancy is confirmed.

The member must contact the utilization management firm as soon as a hospital admission becomes necessary, or as soon as one of the specific outpatient procedures/services requiring precertification is prescribed. The utilization management firm will contact the doctor to discuss the

treatment plan, evaluate the need for a second opinion, and discuss the appropriate level of care. The member will be informed of the outcome of this discussion to assist him/her in making an informed decision.

The member must contact the utilization management firm:

- At least seven days prior to any scheduled inpatient admission.
- Within 48 hours following any emergency inpatient admission.
- At least seven days prior to any of the specified outpatient procedures or services.
- During the first trimester of pregnancy or as soon as it is confirmed.

The ultimate responsibility for precertification lies with the member or dependent or designee. Consult the PEIA medical identification card for the telephone number of the utilization management firm.

STATEMENT OF RIGHTS

The West Virginia Public Employees Insurance Agency, reserves the right to change, increase, decrease and/or alter the content of the policy provisions and procedures by giving written notice to policyholders and the Third Party Claims Administrator.

CONTRACT

The PEIA Director is authorized to pursue selective contracting with health care providers, including hospitals, physicians and pharmacies, and organizations comprised of such providers. The Director shall, through provider contracts, endeavor to reduce total costs to the PEIA by seeking price discounts in exchange for structuring benefit plan incentives to encourage PEIA insureds to use the contracting providers. The PEIA shall structure these incentives in such a way that members may incur reduced costs if they use contract providers. These contracts will be presented to the Finance Board and must be consistent with the financial plan adopted by it.

EMPLOYEE OR PROVIDER MISREPRESENTATION

"Any person who shall knowingly secure or attempt to secure benefits payable under this article to which the person is not entitled, or who shall knowingly secure or attempt to secure greater benefits than those to which the person is entitled, by willfully misrepresenting the presence or extent of benefits to which the person is entitled under a collateral insurance source, or by willfully misrepresenting any material fact relating to any other information requested by the Director of PEIA, or by willfully overcharging for services provided, or by willfuily misrepresenting the diagnosis or nature of the service provided, may be found to be overpaid and shall be civilly liable for any overpayment.

In addition to the civil remedy provided herein, PEIA shall withhold payment of benefits due to

treatment plan, evaluate the need for a second opinion, and discuss the appropriate level of care. The member will be informed of the outcome of this discussion to assist him/her in making an informed decision.

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In addition to the civil remedy provided herein, PEIA shall withhold payment of benefits due to

that person until any overpayment has been recovered or may directly set off, after holding internal administrative proceedings to assure due process, any such overcharges or improperly derived payment against benefits due such person hereunder. Nothing in this section shall be construed to limit any other remedy or civil or criminal penalty provided by law." W.Va. Code 5-16-11a.

DEFINITIONS

"Alternate Facility" - a non-hospital health care facility, or an attached facility designated as such by a hospital, which provides one or more of the following services on an outpatient basis pursuant to the law of jurisdiction in which treatment is received: prescheduled surgical services, emergency health services, or prescheduled rehabilitative, laboratory or diagnostic services, mental health or chemical dependency services.

"Annual Out-of-Pocket Maximum" - the ceiling on the amount of copayments that a member pays in a plan year before the Plan payment/member copayment ratio goes from 80/20 to 100/0, i.e., the plan thereafter for the remainder of the plan year pays at 100% for those payments and copayments not excluded from this annual out-of-pocket copayment maximum provision.

"Chemical Dependency Services" - services and supplies for the diagnosis and treatment of alcoholism and chemical dependency, whether having a physiological or psychological origin.

"Confined" or "Confinement" - an uninterrupted stay following formal admission to a hospital, a skilled nursing facility or other inpatient facility..

"Copayment" - the percentage of eligible expenses (after deductibles) which the member is required to pay for health services covered under the Plan. The member is responsible for paying the copayment (and deductible amounts) directly to the provider of the health services.

"Coverage" or "Covered" - the entitlement by a member to have the Plan pay for health services, subject to all the terms, conditions, limitations and exclusions of the Plan.

"Deductible" - any initial portion of a covered health service eligible expense which a member is responsible for paying and which is, therefore, subtracted — i.e. deducted — from that eligible expense before the plan payment (typically at 80%) and member copayment (typically at 20%) are calculated. There are two types of deductibles:

"Per-service Deductible" - the initial amount of eligible expense that the member must pay for each covered health service for which prior approval or precertification was required by the Plan, but not obtained by the member.

"Annual Deductible" - the initial amount, after any applicable per-service deductible, of each insured's cumulative plan year eligible expenses which the member must pay.

"Detoxification" - those health services which are required for the physical withdrawal and stabilization from alcohol and/or addictive drugs.

"Durable Medical Equipment" - medical equipment which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of a sickness or injury.

"Eligible Expenses" - for each PEIA covered health service is the lesser of the actual charge amount and the PEIA maximum allowable charge amount for that service. (PEIA maximum allowable charges are set by the Director of the PEIA in consultation with the Finance Board and its consulting actuarial firm in consideration of both State of West Virginia providers' usual and customary charges and the actuarially projected financial status of the Plan.)

"Emergency" - a serious medical condition resulting from injury, sickness, pregnancy or mental illness which arises suddenly and requires immediate care and treatment to avoid jeopardy to the life or health of an insured.

"Emergency Health Services" - those health services necessary for the treatment of an emergency.

"Enrolled Dependent" - a dependent who is properly enrolled for coverage under the Plan.

"Experimental, Investigational or Unproven Procedures" - medical, surgical, psychiatric or drug procedures, treatments and devices (including investigational drugs and drug therapies) not generally accepted by the medical community or approved by federal authorizing agencies.

"Health Services" - any health care services and supplies.

"Home Health Care Services" - those services including nursing, IV therapy, etc., provided by a properly licensed home health care program.

"Hospice Care" - medical, palliative, supportive procedures necessary for pain control and acute and chronic symptom management provided to a terminally ill insured through a Medicare certified hospice agency, counseling services for the insured and bereavement counseling for any of the insured's immediate family members.

"Annual Deductible" - the initial amount, after any applicable per-service deductible, of each insured's cumulative plan year eligible expenses which the member must pay.

"Detoxification" - those health services which are required for the physical withdrawal and stabilization from alcohol and/or addictive drugs.

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"Hospital" - a properly licensed institution which is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities, by, or under the supervision of, a staff of physicians, and has 24 hour nursing services.

"Insured" - an eligible person, as determined by Plan, who is properly enrolled for coverage under the Plan.

"Lifetime Maximum Benefit" - the maximum amount which will be paid by Plan for certain health services provided to each member during the member's lifetime.

"Medically Necessary Health Services" - health care services and supplies provided with respect to the insured's condition, which are determined by Plan to be (1) consistent with the diagnosis of, and prescribed course of treatment for the condition; (2) necessary to treat the Insured's condition; (3) required for reasons other than the convenience of either the insured or his or her physician, or not to be required solely for custodial, comfort or maintenance reasons; (4) rendered in the most cost-efficient setting appropriate for the condition; (5) rendered at a frequency which is medically appropriate; and (6) likely to be effective in treating the condition.

"Member" - an eligible person, as determined by the Plan, who is properly enrolled for coverage under the Plan. The Member is the person (who is not a dependent) on whose behalf coverage under the Plan is provided.

"Mental Health Services" - those health care services and supplies for the diagnosis and treatment of mental illnesses, whether having a physiological or psychological origin.

"Health Care Professional" - any doctor of medicine, "M.D.," or doctor of osteopathy, "D.O.," or other health care professional who is licensed and qualified under the law of the jurisdiction in which treatment is received and who is providing treatment within the scope or limitation of his or her professional license.

"Plan" - the benefit plan of the West Virginia Public Employees Insurance Agency.

"Plan Year" - a calendar year period beginning January 1 and ending December 31.

"Pregnancy" - includes prenatal and postnatal care, childbirth, early termination of pregnancy and any associated complications.

"Rehabilitation Hospital" - a facility primarily engaged in providing medical rehabilitation care services to those disabled by disease or injury to be able to achieve the highest practicable level of functional ability. Such services are provided by, or under the supervision of, an organized staff of physicians with continuous nursing services provided under the supervision of a registered graduate nurse (R.N.).

"Reconstructive Surgery" - surgery which is incidental to an injury, sickness, or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, which defect is determined by a physician to have been present at the time of birth.) For the purpose of coverage under the Plan, this definition shall also include breast reconstruction following mastectomy.

"Salary" - for all salary-related plan provisions, a single salary amount will apply to coverage within any portion of each plan year, and that amount will be the employee's annualized salary as of the later of January 1 or the first date of employment within that plan year.

"Skilled Nursing Facility" - a properly licensed hospital, or other nursing facility, which is Medicare approved as a skilled nursing facility.

BENEFITS

The "Lifetime Maximum Benefit" is $1,000,000.00.

The "Annual Deductible" (without pharmacy) is $100.00 in a calendar year, and will not exceed $200.00 per family.

The "Annual Out-of-Pocket Maximum" is based on the member's ability to pay. The schedule of out-of-pocket maximums is printed in Appendix A. Any amount a member pays for annual deductibles, per-service deductibles, specifically excluded copayments or non-covered services will not be counted toward meeting the "Annual Out-of-Pocket Maximum."

Coverage for the treatment of a **Pre-existing Medical Condition** which has been diagnosed or treated or that existed within the 3 months immediately preceding the effective date of coverage is excluded and will be provided only after a period of 12 consecutive months following the effective date of coverage.

Health services covered under the Plan are described below, along with the level of coverage provided by the Plan. Members are required to pay, directly to the provider, any deductibles, and copayments or full charges for any services not covered.

"Rehabilitation Hospital" - a facility primarily engaged in providing medical rehabilitation care services to those disabled by disease or injury to be able to achieve the highest practicable level of functional ability. Such services are provided by, or under the supervision of, an organized staff of physicians with continuous nursing services provided under the supervision of a registered graduate nurse (R.N.).

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Health services covered under the Plan are described below, along with the level of coverage provided by the Plan. Members are required to pay, directly to the provider, any deductibles, and copayments or full charges for any services not covered.

Beginning January 1, 1991, and continuing through the remainder of Fiscal Year 1991, PEIA will pay amounts significantly lower than the providers' charges. Providers of service practicing within the State of West Virginia will be prohibited from collecting amounts exceeding the PEIA maximum (at this lower rate) from PEIA insureds. Hospitals located outside, and other providers practicing outside the State of West Virginia may collect these additional amounts from PEIA members.

Stars (★) mark those services for which prior approval must be obtained. If the prior approval is not obtained, a separate 30% per-service deductible will be required (prior to and in addition to consideration of any applicable annual deductible).

Unless otherwise noted, all PEIA covered health services are reimbursed at 80%, i.e., with 20% member copayment, of net eligible expenses remaining after first deducting any applicable per-service and annual deductible amounts. Moreover, unless otherwise noted, these same net eligible expenses are reimbursed at 100% after the member's 20% copayment total for the calendar year reaches the applicable out-of-pocket copayment maximum.

HEALTH SERVICE DESCRIPTIONS

Medical services and supplies in a physician's or other provider's office for treatment of a sickness or injury. Covered health services also include well-child care and immunizations for children (as determined by Plan — see Appendix B), pap smears and mammogram screening, and allergy services, testing, injections, extract, serum, and venoms.

Other Medical Services or Physician-related Surgical Services, not including office visits, but including inpatient hospital visits.

★Inpatient Hospital and Related services. Confinement in a hospital including semi-private room, special care units, confinement for detoxification, related services and other supplies, provided during confinement in a hospital.

Emergency Outpatient Services and Supplies. Stabilization or initiation of treatment of emergency conditions provided on an outpatient basis at either a hospital or an alternate facility.

★Outpatient Surgery. Services and supplies for prescheduled outpatient surgery provided at a hospital, an alternate facility or a physician's office. Prior approval must be obtained for certain procedures listed below.

★Outpatient diagnostic and therapeutic services for pre-scheduled laboratory and diagnostic tests and therapeutic treatments, when ordered by a physician. Prior approval must be obtained for certain outpatient diagnostic and therapeutic services listed below.

The following outpatient procedures require precertification:

arthroscopy of the knee,
hammertoe,
cataract extraction,
laparoscopy,
osteotomy of the foot,
tonsillectomy.
bunionectomy,
hallux valgus,
colonoscopy,
MRI,
septoplasty,

★**Maternity Services.** Maternity-related medical, hospital and other covered health services, as well as birthing centers and midwife services. Prior approval must be obtained during the first trimester of pregnancy or as soon as the pregnancy is confirmed. Maternity-related services are covered only for the member or the member's enrolled dependent spouse.

Outpatient Mental Health and Chemical Dependency Services. Coverage to a maximum of 26 visits per calendar year of short-term individual and/or group outpatient mental health and chemical dependency evaluations and referral services, diagnostic, crisis intervention and therapeutic services. First 5 visits paid at 80%; visits 6-26 paid at 50%. No coverage after 26 visits. The Plan's annual out-of-pocket maximum provision does not apply to either the 20% or 50% copayment amounts.

★**Inpatient and/or Partial Hospitalization Mental Health and Chemical Dependency Services.** Coverage is limited to a maximum cost to Plan of $10,000 per calendar year.

★**Home Health Services.** Intermittent health services of a Home Health Agency and private duty nursing when prescribed by a physician and provided by or under the supervision of a registered nurse, in a member's home, required for care and treatment which otherwise would require confinement in a hospital or skilled nursing facility.

★**Skilled Nursing Facility Services.** Confinement in a skilled nursing facility including semi-private room, related services and other supplies. Confinement must be prescribed by a physician in lieu of hospitalization, and is limited to 180 days per calendar year.

Ambulance Services. Emergency ground ambulance transportation by a licensed ambulance service to the nearest hospital where emergency health services can be rendered. Air ambulance, when medically necessary, is covered when moving the patient to the nearest facility providing necessary treatment.

★**Medically Necessary Dental Surgery**

The following outpatient procedures require precertification:

arthroscopy of the knee,
hammertoe,
cataract extraction,
laparoscopy,
osteotomy of the foot,
tonsillectomy.
bunionectomy,
hallux valgus,
colonoscopy,
MRI,
septoplasty,

★**Maternity Services.** Maternity-related medical, hospital and other covered health services, as well as birthing centers and midwife services. Prior approval must be obtained during the first trimester of pregnancy or as soon as the pregnancy is confirmed. Maternity-related services are covered only for the member or the member's enrolled dependent spouse.

Outpatient Mental Health and Chemical Dependency Services. Coverage to a maximum of 26 visits per calendar year of short-term individual and/or group outpatient mental health and chemical dependency evaluations and referral services, diagnostic, crisis intervention and therapeutic services. First 5 visits paid at 80%; visits 6-26 paid at 50%. No coverage after 26 visits. The Plan's annual out-of-pocket maximum provision does not apply to either the 20% or 50% copayment amounts.

★**Inpatient and/or Partial Hospitalization Mental Health and Chemical Dependency Services.** Coverage is limited to a maximum cost to Plan of $10,000 per calendar year.

★**Home Health Services.** Intermittent health services of a Home Health Agency and private duty nursing when prescribed by a physician and provided by or under the supervision of a registered nurse, in a member's home, required for care and treatment which otherwise would require confinement in a hospital or skilled nursing facility.

★**Skilled Nursing Facility Services.** Confinement in a skilled nursing facility including semi-private room, related services and other supplies. Confinement must be prescribed by a physician in lieu of hospitalization, and is limited to 180 days per calendar year.

Ambulance Services. Emergency ground ambulance transportation by a licensed ambulance service to the nearest hospital where emergency health services can be rendered. Air ambulance, when medically necessary, is covered when moving the patient to the nearest facility providing necessary treatment.

★**Medically Necessary Dental Surgery**

★**Accident-Related Dental Services** to repair sound natural teeth.

★**Prosthetics and Durable Medical Equipment.** Coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices and for the rental or purchase (at Plan's discretion) of standard Durable Medical Equipment when prescribed by a physician. Certain specific items are excluded from coverage, refer to Appendix C.

★**Inpatient Rehabilitation Services** when ordered by a physician limited to 150 days per plan year.

★**Outpatient Speech Therapy** when ordered by a physician. Limited to $750.00 each year for each therapy unless further therapy is prior approved and case managed.

★**Outpatient Occupational Therapy** when ordered by a physician. Limited to $750.00 each year for each therapy unless further therapy is prior approved and case managed.

★**Outpatient Physical Therapy.** Physical therapy is limited to $750.00 each year unless further therapy is prior approved and case managed. After the first 5 physical therapy visits, physical therapy must be prescribed by a physician.

Chiropractic Services. Health services provided by a chiropractor in the chiropractor's office for the treatment of neuro-muscular-skeletal conditions, limited to a maximum cost to Plan of $750.00 per calendar year. The Plan's annual out-of-pocket maximum provision does not apply to the 20% copayment amount.

★**Hospice Care.** Hospice Care when ordered by a physician. Hospice Care is limited to a total insured lifetime cost to Plan of $3,000.

Outpatient Prescription Medication Benefit. There will be a change to the prescription medication benefit as of January 1, 1991, however the specific coverage for outpatient prescription medications has not yet been determined. Coverage under the revised benefit will not cost members (in the aggregate) any more than does the current drug benefit.

GENERAL EXCLUSIONS

The following are not covered:

(a) Chemical dependency treatments when patient leaves against medical advice.

(b) Cosmetic or reconstructive surgery unless such charges are incurred as the result of accidental bodily injury or disease, or unless the surgery is performed to correct birth defects.

(c) Custodial care, intermediate care, domiciliary care, respite care or rest cures.

(d) Devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, diversion or general motivation.

(e) Diagnosis and/or treatment by any method of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint, with the exception of Class III and Class IV oral and maxillofacial surgery after medical record review by the American Board of Dental Examiners.

(f) Duplicate testing or handling fee for laboratory test.

(g) Health services and associated expenses for infertility services, including in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, donor semen, and non-medically necessary ultrasound screening and non-medically necessary amniocentesis.

(h) Health services and associated expenses for procedures intended primarily for the treatment of morbid obesity, including gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, and health services of a similar nature.

(i) Health services and associated expenses for sex transformation operations and for reversal of voluntary sterilizations.

(j) Health services otherwise covered under the Plan, but rendered after the date individual coverage under the Plan terminates, including health services for medical conditions arising prior to the date individual coverage under the Plan terminates.

(k) Hospital days associated with weekend admissions or other unauthorized admissions prior to scheduled surgery..

(l) Hypnosis.

(m)Incidental surgery performed through the course of a medically necessary surgery.

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The following are not covered:

(a) Chemical dependency treatments when patient leaves against medical advice.

(b) Cosmetic or reconstructive surgery unless such charges are incurred as the result of accidental bodily injury or disease, or unless the surgery is performed to correct birth defects.

(c) Custodial care, intermediate care, domiciliary care, respite care or rest cures.

(d) Devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, diversion or general motivation.

(e) Diagnosis and/or treatment by any method of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint, with the exception of Class III and Class IV oral and maxillofacial surgery after medical record review by the American Board of Dental Examiners.

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(j) Health services otherwise covered under the Plan, but rendered after the date individual coverage under the Plan terminates, including health services for medical conditions arising prior to the date individual coverage under the Plan terminates.

(k) Hospital days associated with weekend admissions or other unauthorized admissions prior to scheduled surgery..

(l) Hypnosis.

(m) Incidental surgery performed through the course of a medically necessary surgery.

(n) Injury or sickness connected with employment with any employer.

(o) Marital counseling.

(p) Medical rehabilitation which is educational/cognitive only.

(q) Mental health services for the treatment of mental illnesses which will not substantially improve beyond the current level of functioning.

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

(s) Physical, psychiatric, or psychological examinations or testing, or vaccinations, immunizations, or treatments not otherwise covered under the Plan, when such services are for purposes of obtaining, maintaining or otherwise relating to employment, insurance, marriage or adoption, or relating to judicial or administrative proceedings or orders, or which are conducted for purposes of medical research, or to obtain or maintain a license or official document of any type.

(t) Pregnancy related conditions for dependent children.

(u) Prosthetic devices, durable medical equipment and appliances, and personal comfort items, including air conditioners, even though prescribed by a physician, except as otherwise provided in this Summary Plan Description.

(v) Radial keratotomy.

(w)Routine dental and optical work, dental x-rays, routine eye examinations, routine office visits, routine physical examinations (except pap smears and mammograms).

(x) Services rendered outside the scope of a provider's license or rendered by a provider with the same legal residence as an insured or rendered by a person who is a member of an insured's family including spouse, brother, sister, parent or child.

(y) Therapy for a patient showing no progression.

(z) Transportation other than local ambulance service as provided elswhere in this Summary Plan Description, and air ambulance not deemed medically necessary.

(aa)Treatment (including cutting or removal by any method) of toe nails or of superficial lesions of the feet including corns, callouses, pedicures and hyperkeratoses, other than the removal of nail matrix or root. Treatment of weak, strained, or flat feet or instability or imbalance of the feet, or any tarsalgia, metatarsalgia or bunion, other than surgery involving the exposure of bones, tendons or ligaments.

(bb)Treatment in a federal hospital for service related injuries/disabilities or on account of war or for treatment in any state-supported institution.

YOUR RIGHTS UNDER COBRA

Legal Requirements:

Federal law entitles the employee and covered dependents under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue medical coverage only in certain cases when coverage would otherwise terminate, provided the employee and/or dependent(s) pay the full group premiums.

Enrollment Guidelines:

Active Employees:

A covered active employee who would lose eligibility for coverage because of voluntary or involuntary termination (except for gross misconduct) or reduction in work hours to part-time status may elect to continue medical coverage for himself and his dependents at his own expense for up to 18 months from the date coverage would have terminated. It will be the responsibility of the employing agency to notify the Program of termination or reductions in hours within 60 days of date coverage would ordinarily have terminated under the Plan. The Program will then notify the employee within 14 days of his right to continue coverage. Coverage may be continued for up to 18 months, but will end earlier if he becomes covered under another group health plan, fails to pay the required premium, or becomes covered by Medicare.

Surviving Spouse and Dependents:

Upon the death of a covered employee or retiree, the surviving legal spouse and dependents may elect to continue medical coverage at their own expense. For the surviving spouse, coverage may be continued for up to 36 months, unless they become covered under another group health plan. For surviving dependent children, coverage may continue for up to 36 months beyond the termination date for children as set forth in the Plan Document, but will end earlier if the child becomes covered in another group health plan. Either the agency or surviving spouse must notify the Program within 60 days of the death of the employee or retiree; the Program will then notify the spouse within 14 days of his or her right to continue coverage.

Divorced Spouse:

In the event of divorce from a covered active or retired employee, the divorced spouse may elect to continue medical coverage at his or her own expense for up to 36 months from the date coverage would have terminated. Coverage will end earlier if the spouse remarries and becomes covered under another group plan or becomes covered by Medicare. It will be the responsibility of the divorced spouse to notify the Program of the divorce within 60 days from the date coverage would terminate, and the Program will notify the spouse of his or her option to continue coverage within 14 days. (Legal

(bb)Treatment in a federal hospital for service related injuries/disabilities or on account of war or for treatment in any state-supported institution.

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In the event of divorce from a covered active or retired employee, the divorced spouse may elect to continue medical coverage at his or her own expense for up to 36 months from the date coverage would have terminated. Coverage will end earlier if the spouse remarries and becomes covered under another group plan or becomes covered by Medicare. It will be the responsibility of the divorced spouse to notify the Program of the divorce within 60 days from the date coverage would terminate, and the Program will notify the spouse of his or her option to continue coverage within 14 days. (Legal separation is treated the same as a divorce).

Dependent Children:

A covered employee or retiree may elect to continue coverage on a dependent child, if the child no longer meets the definition of a covered dependent as defined in the Plan Document. Loss of eligibility may result from marriage, attainment of age 19 (or 25, if a full-time student), failure to maintain student status, etc. Coverage may be continued for up to 36 months following the date coverage would have terminated, but will end earlier if the dependent child becomes covered under another group health plan or becomes covered by Medicare. It will be the responsibility of the covered employee or retiree to notify the Program within 60 days of loss of the dependent's eligibility; the Program will then notify the employee within 14 days of his right to elect continued coverage on that dependent.

Further details of this program are available from your payroll location or the PEIA.

Conversions after COBRA:

Conversion Privileges

When a person's eligibility for continued group coverage ends because he/she has continued coverage for 18 or 36 months, that person has the right to apply for the individual conversion coverage available under the PEIA plan.

HMO Conversion Options after COBRA

If the member is enrolled in a Health Maintenance Organization (HMO), the member will be given the opportunity to convert to either the PEIA or the HMO conversion plan.

For further information on conversion privileges, contact the PEIA office at least thirty days prior to the end of continuation coverage.

HEALTH MAINTENANCE ORGANIZATIONS

The Federal Health Maintenance Organization (HMO) Act of 1973 provides a system for delivering a broad scope of specified comprehensive health care services to its members for a fixed, pre-negotiated fee, 24 hours each day, 7 days each week. The HMO removes the barrier which usually causes individuals to wait until an illness becomes severe before seeking medical care and emphasizes outpatient and preventive care to reduce the need for hospitalization.

All HMO's must be certified by the Department of Health and Human Services and licensed by the West Virginia Insurance Commission.

Solicitation by an HMO:

Any agency in a HMO service area and currently enrolled in the Public Employees Insurance Program may be solicited by an HMO. Employees are given the option of remaining with the PEIA or joining the HMO plan for a contract period of one year. Since the HMO's do not have life insurance coverage as provided by the PEIA, if an individual wishes to enroll for health coverage with an HMO, the life insurance coverage as well as the optional life insurance coverage would be continued with the PEIA

Open enrollment or solicitation by the HMO is done only once a year (in May and June), to be effective July 1.

Eligibility:

Eligibility for enrollment in an HMO is based on the same eligibility guidelines used for enrollment in the PEIA insurance program. Members must meet minimum eligibility and participation requirements.

Contact your payroll location for further information about HMO enrollment and coverage.

Solicitation by an HMO:

Any agency in a HMO service area and currently enrolled in the Public Employees Insurance Program may be solicited by an HMO. Employees are given the option of remaining with the PEIA or joining the HMO plan for a contract period of one year. Since the HMO's do not have life insurance coverage as provided by the PEIA, if an individual wishes to enroll for health coverage with an HMO, the life insurance coverage as well as the optional life insurance coverage would be continued with the PEIA.

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Eligibility for enrollment in an HMO is based on the same eligibility guidelines used for enrollment in the PEIA insurance program. Members must meet minimum eligibility and participation requirements.

Contact your payroll location for further information about HMO enrollment and coverage.

Appendix A

Monthly Premiums

Annual Salary	Type of Family: Child(ren) only	Full Family	Annual Out-of-pocket Maximum
$0 to $ 8,000	$10.66	$21.32	$750
8,001 to 8,500	**11.00**	**22.00**	**750**
8,501 to 9,000	11.67	23.33	750
9,001 to 9,500	**12.33**	**24.67**	**750**
9,501 to 10,000	13.00	26.00	750
10,001 to 10,500	**13.67**	**27.33**	**750**
10,501 to 11,000	14.33	28.67	750
11,001 to 11,500	**15.00**	**30.00**	**750**
11,501 to 12,000	15.67	31.33	750
12,001 to 12,500	**16.33**	**32.67**	**750**
12,501 to 13,000	17.00	34.00	750
13,001 to 13,500	**17.67**	**35.33**	**750**
13,501 to 14,000	18.33	36.67	750
14,001 to 14,500	**19.00**	**38.00**	**750**
14,501 to 15,000	19.67	39.33	750
15,001 to 30,000	**20.00**	**40.00**	**1,000**
30,001 to 30,500	20.17	40.33	1,250
30,501 to 31,000	**20.50**	**41.00**	**1,250**
31,001 to 31,500	20.83	41.67	1,250
31,501 to 32,000	**21.17**	**42.33**	**1,250**
32,001 to 32,500	21.50	43.00	1,250
32,501 to 33,000	**21.83**	**43.67**	**1,250**
33,001 to 33,500	22.17	44.33	1,250
33,501 to 34,000	**22.50**	**45.00**	**1,250**
34,001 to 34,500	22.83	45.67	1,250
34,501 to 35,000	**23.17**	**46.33**	**1,250**
35,001 to 35,500	23.50	47.00	1,250
35,501 to 36,000	**23.83**	**47.67**	**1,250**
36,001 to 36,500	24.17	48.33	1,250
36,501 to 37,000	**24.50**	**49.00**	**1,250**
37,001 to 37,500	24.83	49.67	1,250
37,501 to 38,000	**25.17**	**50.33**	**1,250**
38,001 to 38,500	25.50	51.00	1,250
38,501 to 39,000	**25.85**	**51.67**	**1,250**
39,001 to 39,500	26.17	52.33	1,250
39,501 to 40,000	**26.50**	**53.00**	**1,250**
40,001 to 40,500	26.83	53.67	1,500
40,501 to 41,000	**27.17**	**54.33**	**1,500**
41,001 to 41,500	27.50	55.00	1,500
41,501 to 42,000	**27.83**	**55.67**	**1,500**
42,001 to 42,500	28.17	56.33	1,500
42,501 to 43,000	**28.50**	**57.00**	**1,500**
43,001 to 43,500	28.83	57.67	1,500
43,501 to 44,000	**29.17**	**58.33**	**1,500**
44,001 to 44,500	29.50	59.00	1,500
44,501 to 45,000	**29.83**	**59.67**	**1,500**
45,001 to 45,500	30.17	60.33	1,500
45,501 to 46,000	**30.50**	**61.00**	**1,500**
46,001 to 46,500	30.83	61.67	1,500
46,501 to 47,000	**31.17**	**62.33**	**1,500**
47,001 to 47,500	31.50	63.00	1,500
47,501 to 48,000	**31.83**	**63.67**	**1,500**
48,001 to 48,500	32.17	64.33	1,500
48,501 to 49,000	**32.50**	**65.00**	**1,500**
49,001 to 49,500	32.83	65.67	1,500
49,501 to 50,000	**33.17**	**66.33**	**1,500**
50,001 and above	33.33	66.66	1,500

Appendix B

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC CARE

from the American Academy of Pediatrics

Committee on Practice and Ambulatory Care

These **Recommendations for Preventive Pediatric Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

A **prenatal visit** by the parents for anticipatory guidance and pertinent medical history is strongly recommended. Health supervision should begin with medical care of the newborn in the hospital.

	INFANCY						EARLY CHILDHOOD					LATE CHILDHOOD				
Age[1]	By 1 mo.	2 mos.	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos.	24 mos.	3 yrs	4 yrs.	5 yrs.	6 yrs.	8 yrs.	10 yrs	12 yrs
History																
Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Measurements																
Height and weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head circumference	•	•	•	•	•	•										
Blood pressure										•	•	•	•	•	•	•
Sensory Screening																
Vision	S	S	S	S	S	S	S	S	S	S	O	O	O	O	S	O
Hearing	S	S	S	S	S	S	S	S	S	S	O	O	S[2]	S[2]	S[2]	O
Devel/Behav.[3]																
Assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Physical Examination[4]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Procedures[5]																
Hered./metabolic screening[6]	•															
Immunization[7]		•	•	•			•	•	•			•				•
Tuberculin test[8]	—	—	—	—	—	•	—	—	•	—	—					
Hematocrit or hemaglobin[9]	—	—	—	—	•	—	—	—	•	—	—	—	—	•	—	—
Urinalysis[10]	—	—	—	•	—	—	—	—	•	—	—	—	—	•	—	—
Anticipatory Guidance[11]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Initial Dental Referral[12]										•						

Key: • = to be performed; S = subjective, by history; O = objective, by a standard testing method.

FOOTNOTES: These footnotes correspond with the numbers on the chart above.

1. If a child comes under care for the first time at any point on the schedule, of if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. At these points, history may suffice: if problem suggested, a standard testing method should be used.
3. By history and appropriate physical examination: if suspicious, by specific objective developmental testing.
4. At each visit, a complete physical examination is essential, with infant totally unclothed, older children undressed and suitably draped.
5. These may be modified, depending upon entry point into schedule and individual need.
6. Metabolic screening (e.g. thyroid, PKU, galactosemia) should be done according to state law
7. Recommended schedule for active immunization of normal infants and children:

Recommended age	Immunizations
2 months	DTP, OPV
4 months	DTP, OPV
6 months	DTP
15 months	MMR
18 months	DTP, OPV, PRP-D
4-6 years	DTP, OPV
12 years	MMR

DPT: Diptheria and tetanus toxoids with pertussis vaccine;
OPV: Oral poliovirus vaccine containing attenuated poliovirus types 1, 2, & 3;
MMR: live measles, mumps and rubella viruses in a combined vaccine;
PRP-D: haemophilus b diptheria toxoid conjugate vaccine.

8. For low risk groups, the Committee on Infectious Diseases recommends the following options: (1) no routine testing or (2) testing at three times -- infancy, preschool and adolescence For high risk groups, annual TB skin testing is recommended.
9. Present medical evidence suggests the need for reevaluation of the frequency and timing of hemaglobin or hematocrit tests. One determination is is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.
10. Present medical evidence suggests the need for reevaluation of the frequency and timing of urinalyses. One determination is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.
11. Appropriate discussion and counselling should be and integral part of each visit for care.
12. Subsequent examinations as prescribed by dentist.

N.B.: Special chemical, immunologic and endocrine testing are usually carried out upon specific indications. Testing other than newborn (e.g., inborn errors of metabolism, sickle disease, lead) are discretionary with the physician.

Appendix B

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC CARE
from the American Academy of Pediatrics
Committee on Practice and Ambulatory Care

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A **prenatal visit** by the parents for anticipatory guidance and pertinent medical history is strongly recommended. Health supervision should begin with medical care of the newborn in the hospital.

	INFANCY						EARLY CHILDHOOD					LATE CHILDHOOD				
Age[1]	By 1 mo.	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	24 mos	3 yrs	4 yrs	5 yrs	6 yrs	8 yrs	10 yrs	12 yrs
History																
Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Measurements																
Height and weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head circumference	•	•	•	•	•	•										
Blood pressure										•	•	•	•	•	•	•
Sensory Screening																
Vision	S	S	S	S	S	S	S	S	S	S	O	O	O	O	S	O
Hearing	S	S	S	S	S	S	S	S	S	S	O	O	S[9]	S[9]	S[9]	O
Devel/Behav.[3]																
Assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Physical Examination[4]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Procedures[5]																
Hered./metabolic screening[6]	•															
Immunization[7]		•	•	•			•	•	•			•				•
Tuberculin test[8]	—	—	—	—	—	—o—	—	—	—o—	—	—	—	—	—	—	—
Hematocrit or hemoglobin[9]	—	—	—	—	—o—	—	—	—	—o—	—	—	—	—	—o—	—	—
Urinalysis[10]	—	—	—	—o—	—	—	—	—	—o—	—	—	—	—	—o—	—	—
Anticipatory Guidance[11]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Initial Dental Referral[12]										•						

Key: • = to be performed; S = subjective, by history; O = objective, by a standard testing method.

FOOTNOTES: These footnotes correspond with the numbers on the chart above.

1. If a child comes under care for the first time at any point on the schedule, of if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. At these points, history may suffice: if problem suggested, a standard testing method should be used.
3. By history and appropriate physical examination: if suspicious, by specific objective developmental testing.
4. At each visit, a complete physical examination is essential, with infant totally undressed, older children undressed and suitably draped.
5. These may be modified, depending upon entry point into schedule and individual need.
6. Metabolic screening (e.g. thyroid, PKU, galactosemia) should be done according to state law.
7. Recommended schedule for active immunization of normal infants and children:

Recommended age	Immunizations
2 months	DTP, OPV
4 months	DTP, OPV
6 months	DTP
15 months	MMR
18 months	DTP, OPV, PRP-D
4-6 years	DTP, OPV
12 years	MMR

DPT: Diphtheria and tetanus toxoids with pertussis vaccine;
OPV: Oral poliovirus vaccine containing attenuated poliovirus types 1, 2, & 3;
MMR: live measles, mumps and rubella viruses in a combined vaccine;
PRP-D: haemophilus b diptheria toxoid conjugate vaccine

8. For low risk groups, the Committee on Infectious Diseases recommends the following options: (1) no routine testing or (2) testing at three times – infancy, preschool and adolescence. For high risk groups, annual TB skin testing is recommended.
9. Present medical evidence suggests the need for reevaluation of the frequency and timing of hemaglobin or hematocrit tests. One determination is is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.
10. Present medical evidence suggests the need for reevaluation of the frequency and timing of urinalyses. One determination is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.
11. Appropriate discussion and counseling should be and integral part of each visit for care.
12. Subsequent examinations as prescribed by dentist.

N.B. Special chemical, immunologic and endocrine testing are usually carried out upon specific indications. Testing other than newborn (e.g., inborn errors of metabolism, sickle disease, lead) are discretionary with the physician.

Appendix C

The following items will not be covered by the Plan:

Bath Paraffin (Unit)	Chair, Recliner
Child's Stroller	Contour Chair
Craftmatic Bed	Diapers (Adult or infant)
Enureris Unit	Escalator, Elevator or Stair lift
Exercise Bike, Exercycle	Food Liquidizer/Food Processor
Hearing Aid	Heating Pad
Hydraulic Van or Car Lift	Ice Bag
Language Master (Bell & Howell)	Lift Chair
Vibrator	Nutritional Supplements
Orthopedic Mattress	Room Heater (Portable)
Scale (Bathroom)	Thermometer
Treadmill, Jogger	Trapeze Bar
Walking Cane with Seat	Wig, Wig Styling

Bathroom Equipment: toilet seat, commode, bathtub seat, rail, grab bar, etc.

Environmental Control Equipment: air cleaner, air filter, air conditioner, dehumidifier, dust extractor, humdifier, air freshener, etc.

Portable Whirlpool Pump, Whirlpool Equipment

Professional Medical Equipment: blood pressure kit, stethoscope, etc.

Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1025
Charleston, WV 25305

PEIA Summary Plan Description

Public Employees Insurance Agency

Summary Plan Description

For Active Employees *of Non-State Agencies* and Their Dependents

To have coverage under the PEIA Health Benefit Plan after January 1, 1991, you must re-enroll by December 15, 1990.
Pay close attention to the ENROLLMENT Section for details.

This Summary Plan Description describes the Benefit Plan of the West Virginia Public Employees Insurance Agency ("PEIA"), which is effective on January 1, 1991.

The PEIA is a self-insured health insurance trust fund which offers hospital, surgical, major medical, prescription drug and other medical care benefit coverage, as well as basic and optional life insurance, to employees and retirees of all state agencies, organizations, universities and colleges, county boards of education and those county and municipal agencies and organizations which elect to participate. This represents 12% of West Virginia's population.

The increasing cost of health care is an economic fact of life for all employers and employees and retirees. The revised PEIA Benefit Plan seeks to maintain an equitable balance between the State's responsibility to adequately fund its insurance benefit, the responsibility of providers to offer cost-effective services and the insureds' responsibility to use the Plan in a cost-saving manner. Following are some important features which assist PEIA in attaining these balanced goals.

Read this document carefully so that you will have a clear understanding of your coverage under the Plan.

The Plan provides coverage for health services to members and their covered dependents as described in this Summary Plan Description and as set forth in greater detail in the Plan Document. Coverage for some health services is subject to prior approval of the Plan. No coverage is provided for health services rendered after coverage under the Plan terminates.

Only medically necessary health services are covered under the Plan. The fact that a physician has performed or prescribed a procedure or treatment does not mean that the procedure or treatment is covered under the Plan. The Plan has sole discretion in interpreting the benefits covered under the Plan and the other terms, conditions, limitations and exclusions set out in the Plan and the Summary Plan Description. The Summary Plan Description is subject to the Plan Document and, if there is a conflict between the documents, the Plan Document shall govern.

ASSIGNMENT OF BENEFITS

State law requires health care providers (except pharmacies and dental surgeons) to "accept assignment" of the PEIA member's right to receive payment for covered health services. Consequently, you have the right to request the physician or other provider to seek payment directly from Plan instead of from you. This provision means that physicians practicing in West Virginia can request, but cannot require PEIA members to pay for their care at the time of service. Unless the member wishes to pay at the time of service, physicians must first bill the Plan for covered services, be paid by the Plan directly, and then bill the member for the member's portion. The member's portion will be reflected on the Explanation of Benefits.

If the Plan pays the provider directly, you will still be responsible for making payment to the provider for any deductible amount, any Copayment and any amount for a non-covered service. You may decide to pay for the provider's care at the time of service and then to submit a claim to the Plan for reimbursement. If you wish to be reimbursed for covered health services, you must give the Plan all the information required to process the claim. If you do not provide the required information, you may not be reimbursed.

PROHIBITION AGAINST BALANCE BILLING

State law prohibits health care providers (other than pharmacies and dental surgeons) from billing PEIA members for any portion of their charges not paid by the Plan (other than for applicable deductibles, copayments and services not covered by the Plan).

The Plan pays health care providers according to maximum fee schedules established by PEIA. If the provider's charge is higher than the Plan maximum fee for a particular service, then the Plan will pay only the maximum fee. The provider cannot collect the unpaid portion from the member.

New fee schedules taking effect on January 1, 1991, will further reduce fees, increasing the likelihood that a provider's charges may be higher than the fee which the Plan will pay. You should monitor your provider's bills and your Explanation of Benefits statements carefully to insure that you have not been billed improperly. If you have been, you should first contact the provider and ask for a refund. If this does not resolve the situation, you should contact the PEIA.

The PEIA will be notifying providers located outside West Virginia that the agency expects them not to bill the member for the balance of any charges not paid by the Plan. However, it has not yet been determined by a court of law that State law can be enforced outside this State. You may wish to take this into consideration before deciding to seek care outside West Virginia. If you do obtain care out of State, and are balance billed by the provider, please contact the PEIA and we will request the Attorney General's Office to take whatever actions are possible.

ELIGIBILITY

Active Employees:

All elected and regular, full-time employees of the State of West Virginia, the State colleges and universities, County Boards of Education, Counties, Cities or Towns, and other individuals and

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ELIGIBILITY

All active employees

All active and regular, full-time employees of the State of West Virginia, the State colleges and universities, County Boards of Education, Counties, Cities or Towns, and other individuals and

Government Bodies so specified in the West Virginia State Code, Chapter 5, Article 16 are eligible for enrollment in the PEIA Benefit Plan.

The term "full-time" shall mean a permanent position that is considered full-time by the participating agency and that requires at least twenty hours per week, or 1,040 hours per year in that position, unless otherwise exempt from this requirement by the Code. PEIA reserves the right to make the final determination on these matters.

Temporary, substitute, and other part-time employees who do not meet the definitions as stated in this summary are excluded with the exception of those school service employees made eligible by Section 18A-4-15 of the Code.

Legislative Participation:

Members of the Legislature may participate in and be covered under any and all plans established by the PEIA. All Legislative members must enroll and pay the full cost for all group coverage on themselves, their spouses and dependents so that there will be no cost to the State of West Virginia. Enrollment period for Legislature is December next succeeding their election and the following January. (West Virginia Constitution, Article 4, Section 7)

Dependent:

A member's dependents shall only include:

a. Spouse (if legally married);

b. Natural child who has not reached its nineteenth birthday;

c. Legally adopted child (including a child living with the member during the period of probation) who has not reached its nineteenth birthday;

d. Stepchild who has not reached its nineteenth birthday and is living with the member;

e. Child who has not reached its nineteenth birthday, is fully dependent upon the member for support and maintenance, and is living with the member; and

f. Child of divorced parents when the divorce decree stipulates that the member is responsible for health insurance coverage.

PEIA reserves the right to request proof of marriage, copies of birth certificates and legal documents indicating responsibility for child support and/or showing legal custody.

Full-time Unmarried Student:

Children are considered to be dependents until they reach their twenty-fifth birthday if they are enrolled as full-time students, are unmarried and are fully dependent upon the member for support and maintenance.

Mentally Retarded/Physically Disabled Dependent Children:

A dependent child may be covered after reaching its nineteenth birthday while incapable of self-support because of mental retardation, mental illness, or a physical disability. The child must have been a dependent and covered by the plan at the onset of the mental retardation, mental illness or physical disability. The member shall contact the PEIA office within 31 days before coverage terminates for the appropriate form to request continuation of the child's coverage.

ENROLLMENT

To have coverage with PEIA after January 1, 1991, the member must complete an enrollment form which will be available through the payroll locations and return it to his/her payroll location no later than December 15, 1990.

Premiums and "Out-of-Pocket Maximums" are based on the member's annual salary. Two married eligible employees will always be considered as one family unit with one eligible employee being designated as the member, and the other being designated as the spouse dependent, and salary for the purpose of determining such member premium and/or out-of-pocket maximum will be the sum of the couple's separate annual salary amounts. The chart in **Appendix A** shows the premium rates and the out-of-pocket maximums for each individual or combined salary range.

The enrollment categories and premium levels are:

Eligible single employee ---------- No premium
Eligible employees married to each other (no dependent children) ---------- No Premium
Eligible employee with dependent child(ren) ---------- Children Only Premium
Eligible employees married to each other with child(ren)---------- Children Only Premium
Eligible employee with full family coverage ---------- Full Family Premium

TERMINATION OF COVERAGE

Active Employee:

The coverage for the employee terminates when the employee is no longer eligible or when group coverage terminates, whichever happens first.

a. Voluntary Termination: The basic medical coverage for the employee terminates at the end of the month in which the employee voluntarily ends his/her employment.

b. Involuntary Termination: The employee who is terminated from employment involuntarily or through a reduction of work force may continue coverage for 3 additional months after the end of the month in which the employee goes off of the payroll. Eligible dependent(s) who have been properly enrolled by the employee are included in the 3 months extension. This extension of basic coverage is provided at no additional cost to the employee.

Mentally Retarded/Physically Disabled Dependent Children:

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Misconduct Discharge: The employee who is discharged for misconduct is not entitled or eligible for the 3 months extension of coverage as mentioned above. However, basic coverage may be extended to the employee and/or eligible dependent(s) up to the maximum period of 3 months, while administrative remedies contesting the charge of misconduct are pursued by the employee. If the misconduct is upheld, the full premium cost of the extended basic coverage must be reimbursed by the employee through his/her respective payroll location.

Dependents:

The coverage for dependent(s) terminates at the end of the month in which one of the following occur:

1. Employee terminates or loses coverage;
2. Divorce from member (at the end of the month in which the divorce is final);
3. Child reaches nineteenth birthday;
4. Child marries;
5. Child is no longer a full-time student or reaches twenty-fifth birthday.

TIMELY SUBMISSION OF CLAIMS

All claims must be submitted to the Plan within 12 months of the date the health service is rendered. The only exception that will be made to this requirement is the submission of Medicare claims, which must be submitted to the Plan within 18 months of the date health services were rendered.

APPEALS PROCESS

The appeals process is as follows:

Step 1: Appeal in writing to the claims administrator or utilization management firm for determination of a processing error or reconsideration of a decision.

Step 2: Appeal to PEIA for review. Must be submitted in writing within sixty (60) days of final disposition of the claim by the claims administrator or utilization management firm .

Step 3: Review and determination by PEIA.

A claim may be settled at any point in the appeals process. Further information about the process will be provided to the member when an appeal is filed

PATIENT AUDIT PROGRAM

The Patient Audit Program rewards members for helping to control the rising cost of health care in West Virginia. It is becoming increasingly clear that errors may occur in the billing or payment of

health care services. These errors are unintentional, but costly. The Patient Audit program has been designed to help detect and correct these errors. All PEIA members who have Public Employees health insurance may submit Patient Audit reports.

Reported errors must be at least $50.00 to qualify for this program. Participants in HMO's are not eligible to participate, although it still makes sense to check hospital bills to see that they are correct.

Types of errors which qualify for this program are:

1. Charges for services you did not receive; and
2. Overcharges or overpayments resulting from clerical error or miscalculation.

The member must initiate the Patient Audit report for any overpayments prior to the receipt of any recovered amounts by the Claims Administrator. If the claims administrator detects and corrects an error before the member has made the Patient Audit Report, the report will be invalid.

When an error is detected, please contact the PEIA Patient Audit Coordinator for a report form and further instructions.

COORDINATION OF BENEFITS

The Plan, as secondary payor, will pay only its usual benefits less any amount already paid by the primary payor(s).

Following is an illustration of coordination of benefits:

Total Charges	$100.00
PEIA Plan's Usual Benefits	$ 80.00
Other Plan Pays	$ 60.00
PEIA Plan Pays	$ 20.00
Member's Payment	$ 20.00
Total Percentage of Claim Charges Paid	80%
Amount Paid in Excess of PEIA Benefits	$ 0.00

SUBROGATION

To the extent that benefits for covered services are provided or paid by the Plan, the Public Employees Insurance Agency shall be subrogated and succeed to all rights of a member to recover such paid expenses from any person or entity which may be liable for expenses incurred for covered services.

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To the extent that benefits for covered services are provided or paid by the Plan, the Public Employees Insurance Agency shall be subrogated and succeed to all rights of a member to recover such paid expenses from any person or entity which may be liable for expenses incurred for covered services.

This right of subrogation shall constitute a lien against any settlement or judgment obtained by or on behalf of a member for recovery of such expenses. A member shall, upon request, execute and deliver to the PEIA such documents and information which the PEIA may require to define, verify or protect its right of subrogation. Benefits may be withheld pending receipt of necessary documents from the member. In addition, the member shall be responsible for making prompt reimbursement to the PEIA from any settlement or judgment obtained.

Failure by the member to provide any requested documents or information, or to otherwise cooperate with the PEIA in protecting or securing its right, or to make prompt reimbursement from any settlement or judgment, shall not affect the PEIA's right of subrogation, but shall render the member liable to the PEIA for any expenses, including reasonable attorney's fees, incurred in obtaining any such requested information, or any reimbursement to which it is entitled.

RIGHT OF RECOVERY

The Public Employees Insurance Agency shall have the right to recover from any member or other person or entity to whom benefits have been paid for payments subsequently determined to be excessive, for noncovered services, or otherwise improperly or incorrectly made. The member shall cooperate fully with the PEIA to secure recovery of any such overpayments. The PEIA may, after making reasonable attempts to collect from the member or other person or entity to whom such overpayment has been made, deduct the amount of the overpayment from other benefits which are or may become payable to or on behalf of the member.

This provision shall not limit any other remedy provided by law.

UTILIZATION MANAGEMENT

Managing health care dollars is the responsibility of both PEIA and its insureds. Utilization Management is a process by which PEIA helps its insureds to receive the most appropriate types of medical care in the most cost-effective manner. Alternative care can shorten a hospital stay or eliminate a hospital stay altogether when appropriate, and utilization management can coordinate alternative care for insureds.

Utilization management also can help the member maximize health care benefits, since the staff is familiar with the PEIA benefit plan and can provide guidance in using benefits wisely. A helath service advice line with nurses answering questions is available.

To provide the best possible prenatal care for all PEIA insureds, PEIA requires that all pregnancies be reported to the utilization management firm during the first trimester, or as soon as the pregnancy is confirmed.

The member must contact the utilization management firm as soon as a hospital admission becomes necessary, or as soon as one of the specific outpatient procedures/services requiring precertification is prescribed. The utilization management firm will contact the doctor to discuss the

treatment plan, evaluate the need for a second opinion, and discuss the appropriate level of care. The member will be informed of the outcome of this discussion to assist him/her in making an informed decision.

The member must contact the utilization management firm:

- At least seven days prior to any scheduled inpatient admission.
- Within 48 hours following any emergency inpatient admission.
- At least seven days prior to any of the specified outpatient procedures or services.
- During the first trimester of pregnancy or as soon as it is confirmed.

The ultimate responsibility for precertification lies with the member or dependent or designee. Consult the PEIA medical identification card for the telephone number of the utilization management firm.

STATEMENT OF RIGHTS

The West Virginia Public Employees Insurance Agency, reserves the right to change, increase, decrease and/or alter the content of the policy provisions and procedures by giving written notice to policyholders and the Third Party Claims Administrator.

CONTRACT

The PEIA Director is authorized to pursue selective contracting with health care providers, including hospitals, physicians and pharmacies, and organizations comprised of such providers. The Director shall, through provider contracts, endeavor to reduce total costs to the PEIA by seeking price discounts in exchange for structuring benefit plan incentives to encourage PEIA insureds to use the contracting providers. The PEIA shall structure these incentives in such a way that members may incur reduced costs if they use contract providers. These contracts will be presented to the Finance Board and must be consistent with the financial plan adopted by it.

EMPLOYEE OR PROVIDER MISREPRESENTATION

"Any person who shall knowingly secure or attempt to secure benefits payable under this article to which the person is not entitled, or who shall knowingly secure or attempt to secure greater benefits than those to which the person is entitled, by willfully misrepresenting the presence or extent of benefits to which the person is entitled under a collateral insurance source, or by willfully misrepresenting any material fact relating to any other information requested by the Director of PEIA, or by willfully overcharging for services provided, or by willfully misrepresenting the diagnosis or nature of the service provided, may be found to be overpaid and shall be civilly liable for any overpayment.

In addition to the civil remedy provided herein, PEIA shall withhold payment of benefits due to

treatment plan, evaluate the need for a second opinion, and discuss the appropriate level of care. The member will be informed of the outcome of this discussion to assist him/her in making an informed decision.

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In addition to the civil remedy provided herein, PEIA shall withhold payment of benefits due to

that person until any overpayment has been recovered or may directly set off, after holding internal administrative proceedings to assure due process, any such overcharges or improperly derived payment against benefits due such person hereunder. Nothing in this section shall be construed to limit any other remedy or civil or criminal penalty provided by law." W.Va. Code 5-16-11a.

DEFINITIONS

"Alternate Facility" - a non-hospital health care facility, or an attached facility designated as such by a hospital, which provides one or more of the following services on an outpatient basis pursuant to the law of jurisdiction in which treatment is received: prescheduled surgical services, emergency health services, or prescheduled rehabilitative, laboratory or diagnostic services, mental health or chemical dependency services.

"Annual Out-of-Pocket Maximum" - the ceiling on the amount of copayments that a member pays in a plan year before the Plan payment/member copayment ratio goes from 80/20 to 100/0, i.e., the plan thereafter for the remainder of the plan year pays at 100% for those payments and copayments not excluded from this annual out-of-pocket copayment maximum provision.

"Chemical Dependency Services" - services and supplies for the diagnosis and treatment of alcoholism and chemical dependency, whether having a physiological or psychological origin.

"Confined" or "Confinement" - an uninterrupted stay following formal admission to a hospital, a skilled nursing facility or other inpatient facility..

"Copayment" - the percentage of eligible expenses (after deductibles) which the member is required to pay for health services covered under the Plan. The member is responsible for paying the copayment (and deductible amounts) directly to the provider of the health services.

"Coverage" or "Covered" - the entitlement by a member to have the Plan pay for health services, subject to all the terms, conditions, limitations and exclusions of the Plan.

"Deductible" - any initial portion of a covered health service eligible expense which a member is responsible for paying and which is, therefore, subtracted — i.e. deducted — from that eligible expense before the plan payment (typically at 80%) and member copayment (typically at 20%) are calculated. There are two types of deductibles:

"Per-service Deductible" - the initial amount of eligible expense that the member must pay for each covered health service for which prior approval or precertification was required by the Plan, but not obtained by the member.

"Annual Deductible" - the initial amount, after any applicable per-service deductible, of each insured's cumulative plan year eligible expenses which the member must pay.

"Detoxification" - those health services which are required for the physical withdrawal and stabilization from alcohol and/or addictive drugs.

"Durable Medical Equipment" - medical equipment which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of a sickness or injury.

"Eligible Expenses" - for each PEIA covered health service is the lesser of the actual charge amount and the PEIA maximum allowable charge amount for that service. (PEIA maximum allowable charges are set by the Director of the PEIA in consultation with the Finance Board and its consulting actuarial firm in consideration of both State of West Virginia providers' usual and customary charges and the actuarially projected financial status of the Plan.)

"Emergency" - a serious medical condition resulting from injury, sickness, pregnancy or mental illness which arises suddenly and requires immediate care and treatment to avoid jeopardy to the life or health of an insured.

"Emergency Health Services" - those health services necessary for the treatment of an emergency.

"Enrolled Dependent" - a dependent who is properly enrolled for coverage under the Plan.

"Experimental, Investigational or Unproven Procedures" - medical, surgical, psychiatric or drug procedures, treatments and devices (including investigational drugs and drug therapies) not generally accepted by the medical community or approved by federal authorizing agencies.

"Health Services" - any health care services and supplies.

"Home Health Care Services" - those services including nursing, IV therapy, etc., provided by a properly licensed home health care program.

"Hospice Care" - medical, palliative, supportive procedures necessary for pain control and acute and chronic symptom management provided to a terminally ill insured through a Medicare certified hospice agency, counseling services for the insured and bereavement counseling for any of the insured's immediate family members.

"Annual Deductible" - the initial amount, after any applicable per-service deductible, of each insured's cumulative plan year eligible expenses which the member must pay.

"Detoxification" - those health services which are required for the physical withdrawal and stabilization from alcohol and/or addictive drugs.

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"Emergency Services" - those health services necessary for the treatment of an emergency.

"Eligible Dependent" - a dependent who is properly enrolled for coverage under the Plan.

"Experimental, Investigational or Unproven Procedures" - medical, surgical, psychiatric or drug therapies, devices (including investigational drugs and drug therapies) not generally recognized by the medical community or approved by federal authorizing agencies.

"Health Care Services" - health care services and supplies.

"Home Health Care" - those services including nursing, IV therapy, etc., provided by a Medicare certified home care program.

"Hospice Care" - palliative, supportive procedures necessary for pain control and acute and chronic management provided to a terminally ill insured through a Medicare certified hospice program. Services for the insured and bereavement counseling for any of the insured's family members.

"Hospital" - a properly licensed institution which is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities, by, or under the supervision of, a staff of physicians, and has 24 hour nursing services.

"Insured" - an eligible person, as determined by Plan, who is properly enrolled for coverage under the Plan.

"Lifetime Maximum Benefit" - the maximum amount which will be paid by Plan for certain health services provided to each member during the member's lifetime.

"Medically Necessary Health Services" - health care services and supplies provided with respect to the insured's condition, which are determined by Plan to be (1) consistent with the diagnosis of, and prescribed course of treatment for the condition; (2) necessary to treat the Insured's condition; (3) required for reasons other than the convenience of either the insured or his or her physician, or not to be required solely for custodial, comfort or maintenance reasons; (4) rendered in the most cost-efficient setting appropriate for the condition; (5) rendered at a frequency which is medically appropriate; and (6) likely to be effective in treating the condition.

"Member" - an eligible person, as determined by the Plan, who is properly enrolled for coverage under the Plan. The Member is the person (who is not a dependent) on whose behalf coverage under the Plan is provided.

"Mental Health Services" - those health care services and supplies for the diagnosis and treatment of mental illnesses, whether having a physiological or psychological origin.

"Health Care Professional" - any doctor of medicine, "M.D.," or doctor of osteopathy, "D.O.," or other health care professional who is licensed and qualified under the law of the jurisdiction in which treatment is received and who is providing treatment within the scope or limitation of his or her professional license.

"Plan" - the benefit plan of the West Virginia Public Employees Insurance Agency.

"Plan Year" - a calendar year period beginning January 1 and ending December 31.

"Pregnancy" - includes prenatal and postnatal care, childbirth, early termination of pregnancy and any associated complications.

"Rehabilitation Hospital" - a facility primarily engaged in providing medical rehabilitation care services to those disabled by disease or injury to be able to achieve the highest practicable level of functional ability. Such services are provided by, or under the supervision of, an organized staff of physicians with continuous nursing services provided under the supervision of a registered graduate nurse (R.N.).

"Reconstructive Surgery" - surgery which is incidental to an injury, sickness, or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, which defect is determined by a physician to have been present at the time of birth.) For the purpose of coverage under the Plan, this definition shall also include breast reconstruction following mastectomy.

"Salary" - for all salary-related plan provisions, a single salary amount will apply to coverage within a portion of each plan year, and that amount will be the employee's annualized salary as of the later of January 1 or the first date of employment within that plan year.

"Skilled Nursing Facility" - a properly licensed hospital, or other nursing facility, which is Medicare approved as a skilled nursing facility.

BENEFITS

"Lifetime Maximum Benefit" is $1,000,000.00.

"Annual Deductible" (without pharmacy) is $100.00 in a calendar year, and will not exceed per family.

"Annual Out-of-Pocket Maximum" is based on the member's ability to pay. The schedule of pocket maximums is printed in Appendix A. Any amount a member pays for annual deductible, service deductibles, specifically excluded copayments or non-covered services will not be toward meeting the "Annual Out-of-Pocket Maximum."

for the treatment of a **Pre-existing Medical Condition** which has been diagnosed or existed within the 3 months immediately preceding the effective date of coverage is will be provided only after a period of 12 consecutive months following the effective age.

vices covered under the Plan are described below, along with the level of coverage the Plan. Members are required to pay, directly to the provider, any deductibles, and full charges for any services not covered.

...tion Hospital" - a facility primarily engaged in providing medical rehabilitation care ...disabled by disease or injury to be able to achieve the highest practicable level of ...which services are provided by, or under the supervision of, an organized staff of ...continuous nursing services provided under the supervision of a registered graduate

...surgery which is incidental to an injury, sickness, or congenital anomaly ...is to restore normal physiological functioning of the involved part of the ...is a defective development or formation of a part of the body, which ...physician to have been present at the time of birth.) For the purpose of ...definition shall also include breast reconstruction following mastec-

...plan provisions, a single salary amount will apply to coverage within ...that amount will be the employee's annualized salary as of the later ...employment within that plan year.

...properly licensed hospital, or other nursing facility, which is Medicare

BENEFITS

...$1,000,000.00.

...pharmacy) is $100.00 in a calendar year, and will not exceed

...is based on the member's ability to pay. The schedule of ...Appendix A. Any amount a member pays for annual deduct- ...ly excluded copayments or non-covered services will not be ...t-of-Pocket Maximum."

...**isting Medical Condition** which has been diagnosed or ...immediately preceding the effective date of coverage is ...period of 12 consecutive months following the effective

...are described below, along with the level of coverage ...ired to pay, directly to the provider, any deductibles, and ...not covered.

Beginning January 1, 1991, and continuing through the remainder of Fiscal Year 1991, PEIA will pay amounts significantly lower than the providers' charges. Providers of service practicing within the State of West Virginia will be prohibited from collecting amounts exceeding the PEIA maximum (at this lower rate) from PEIA insureds. Hospitals located outside, and other providers practicing outside the State of West Virginia may collect these additional amounts from PEIA members.

Stars (★) mark those services for which prior approval must be obtained. If the prior approval is not obtained, a separate 30% per-service deductible will be required (prior to and in addition to consideration of any applicable annual deductible).

Unless otherwise noted, all PEIA covered health services are reimbursed at 80%, i.e., with 20% member copayment, of net eligible expenses remaining after first deducting any applicable per-service and annual deductible amounts. Moreover, unless otherwise noted, these same net eligible expenses are reimbursed at 100% after the member's 20% copayment total for the calendar year reaches the applicable out-of-pocket copayment maximum.

HEALTH SERVICE DESCRIPTIONS

Medical services and supplies in a physician's or other provider's office for treatment of a sickness or injury. Covered health services also include well-child care and immunizations for children (as determined by Plan — see Appendix B), pap smears and mammogram screening, and allergy services, testing, injections, extract, serum, and venoms.

Other Medical Services or Physician-related Surgical Services, not including office visits, but including inpatient hospital visits.

★Inpatient Hospital and Related services. Confinement in a hospital including semi-private room, special care units, confinement for detoxification, related services and other supplies, provided during confinement in a hospital.

Emergency Outpatient Services and Supplies. Stabilization or initiation of treatment of emergency conditions provided on an outpatient basis at either a hospital or an alternate facility.

★Outpatient Surgery. Services and supplies for prescheduled outpatient surgery provided at a hospital, an alternate facility or a physician's office. Prior approval must be obtained for certain procedures listed below.

★Outpatient diagnostic and therapeutic services for pre-scheduled laboratory and diagnostic tests and therapeutic treatments, when ordered by a physician. Prior approval must be obtained for certain outpatient diagnostic and therapeutic services listed below.

The following outpatient procedures require precertification:

arthroscopy of the knee,
hammertoe,
cataract extraction,
laparoscopy,
osteotomy of the foot,
tonsillectomy.
bunionectomy,
hallux valgus,
colonoscopy,
MRI,
septoplasty,

Maternity Services. Maternity-related medical, hospital and other covered health services, as as birthing centers and midwife services. Prior approval must be obtained during the first ster of pregnancy or as soon as the pregnancy is confirmed. Maternity-related services are ed only for the member or the member's enrolled dependent spouse.

patient Mental Health and Chemical Dependency Services. Coverage to a maximum of its per calendar year of short-term individual and/or group outpatient mental health and dependency evaluations and referral services, diagnostic, crisis intervention and therapeu- ces. First 5 visits paid at 80%; visits 6-26 paid at 50%. No coverage after 26 visits. The Plan's out-of-pocket maximum provision does not apply to either the 20% or 50% copayment

patient and/or Partial Hospitalization Mental Health and Chemical Dependency Coverage is limited to a maximum cost to Plan of $10,000 per calendar year.

Health Services. Intermittent health services of a Home Health Agency and private duty en prescribed by a physician and provided by or under the supervision of a registered member's home, required for care and treatment which otherwise would require confine- spital or skilled nursing facility.

Nursing Facility Services. Confinement in a skilled nursing facility including semi- related services and other supplies. Confinement must be prescribed by a physician in lization, and is limited to 180 days per calendar year.

Services. Emergency ground ambulance transportation by a licensed ambulance earest hospital where emergency health services can be rendered. Air ambulance, necessary, is covered when moving the patient to the nearest facility providing ment.

Necessary Dental Surgery

The following outpatient procedures require precertification:

arthroscopy of the knee,
hammertoe,
cataract extraction,
laparoscopy,
osteotomy of the foot,
tonsillectomy,
bunionectomy,
hallux valgus,
colonoscopy,
MRI,
septoplasty.

★**Maternity Services.** Maternity-related medical, hospital and other covered health services, as well as birthing centers and midwife services. Prior approval must be obtained during the first trimester of pregnancy or as soon as the pregnancy is confirmed. Maternity-related services are covered only for the member or the member's enrolled dependent spouse.

Outpatient Mental Health and Chemical Dependency Services. Coverage to a maximum of 26 visits per calendar year of short-term individual and/or group outpatient mental health and chemical dependency evaluations and referral services, diagnostic, crisis intervention and therapeutic services. First 5 visits paid at 80%; visits 6-26 paid at 50%. No coverage after 26 visits. The Plan's annual out-of-pocket maximum provision does not apply to either the 20% or 50% copayment amounts.

★**Inpatient and/or Partial Hospitalization Mental Health and Chemical Dependency Services.** Coverage is limited to a maximum cost to Plan of $10,000 per calendar year.

Home Health Services. Intermittent health services of a Home Health Agency and private duty nursing when prescribed by a physician and provided by or under the supervision of a registered nurse in member's home, required for care and treatment which otherwise would require confinement in a hospital or skilled nursing facility.

Skilled Nursing Facility Services. Confinement in a skilled nursing facility including semi-private accommodations, services and other supplies. Confinement must be prescribed by a physician in lieu of hospitalization and is limited to 180 days per calendar year.

Emergency ground ambulance transportation by a licensed ambulance to the nearest hospital where emergency health services can be rendered. Air ambulance, is covered when moving the patient to the nearest facility providing

Dental Surgery

★**Accident-Related Dental Services** to repair sound natural teeth.

★**Prosthetics and Durable Medical Equipment.** Coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices and for the rental or purchase (at Plan's discretion) of standard Durable Medical Equipment when prescribed by a physician. Certain specific items are excluded from coverage, refer to Appendix C.

★**Inpatient Rehabilitation Services** when ordered by a physician limited to 150 days per plan year.

★**Outpatient Speech Therapy** when ordered by a physician. Limited to $750.00 each year for each therapy unless further therapy is prior approved and case managed.

★**Outpatient Occupational Therapy** when ordered by a physician. Limited to $750.00 each year for each therapy unless further therapy is prior approved and case managed.

★**Outpatient Physical Therapy.** Physical therapy is limited to $750.00 each year unless further therapy is prior approved and case managed. After the first 5 physical therapy visits, physical therapy must be prescribed by a physician.

Chiropractic Services. Health services provided by a chiropractor in the chiropractor's office for the treatment of neuro-muscular-skeletal conditions, limited to a maximum cost to Plan of $750.00 per calendar year. The Plan's annual out-of-pocket maximum provision does not apply to the 20% copayment amount.

★**Hospice Care.** Hospice Care when ordered by a physician. Hospice Care is limited to a total insured lifetime cost to Plan of $3,000.

Outpatient Prescription Medication Benefit. There will be a change to the prescription medication benefit as of January 1, 1991, however the specific coverage for outpatient prescription medications has not yet been determined. Coverage under the revised benefit will not cost members (in the aggregate) any more than does the current drug benefit.

GENERAL EXCLUSIONS

The following are not covered:

(a) Chemical dependency treatments when patient leaves against medical advice.

(b) Cosmetic or reconstructive surgery unless such charges are incurred as the result of accidental bodily injury or disease, or unless the surgery is performed to correct birth defects.

(c) Custodial care, intermediate care, domiciliary care, respite care or rest cures.

(d) Devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, diversion or general motivation.

(e) Diagnosis and/or treatment by any method of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint, with the exception of Class III and Class IV oral and maxillofacial surgery after medical record review by the American Board of Dental Examiners.

(f) Duplicate testing or handling fee for laboratory test.

(g) Health services and associated expenses for infertility services, including in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, donor semen, and non-medically necessary ultrasound screening and non-medically necessary amniocentesis.

(h) Health services and associated expenses for procedures intended primarily for the treatment of morbid obesity, including gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, and health services of a similar nature.

(i) Health services and associated expenses for sex transformation operations and for reversal of voluntary sterilizations.

(j) Health services otherwise covered under the Plan, but rendered after the date individual coverage under the Plan terminates, including health services for medical conditions arising prior to the date individual coverage under the Plan terminates.

(k) Hospital days associated with weekend admissions or other unauthorized admissions prior to scheduled surgery..

(l) Hypnosis.

(m) Incidental surgery performed through the course of a medically necessary surgery.

GENERAL EXCLUSIONS

The following are not covered:

(a) Chemical dependency treatments when patient leaves against medical advice.

(b) Cosmetic or reconstructive surgery unless such charges are incurred as the result of accidental bodily injury or disease, or unless the surgery is performed to correct birth defects.

(c) Custodial care, intermediate care, domiciliary care, respite care or rest cures.

(d) Devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, diversion or general motivation.

(e) Diagnosis and/or treatment by any method of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint, with the exception of Class III and Class IV oral and maxillofacial surgery after medical record review by the American Board of Dental Examiners.

(f) Duplicate testing or handling fee for laboratory test.

(g) Health services and associated charges for infertility services, including in vitro fertilization and gamete intrafallopian [illegible] (GIFT), embryo transport, surrogate parenting, donor semen, and non-medically [illegible] ultrasound screening and non-medically necessary amniocentesis.

(h) Health services [illegible] procedures intended primarily for the treatment of morbid obesity [illegible] gastric balloons, stomach stapling, jejunal bypasses, wiring [illegible] services of a similar nature.

(i) Health services [illegible] sex transformation operations and for reversal of voluntary sterilization.

(j) Health services [illegible] Plan, but rendered after the date individual coverage under [illegible] health services for medical conditions arising prior to the date [illegible] Plan terminates.

(k) Hospital [illegible] missions or other unauthorized admissions prior to scheduled [illegible]

(l) Hypn[illegible]

(m) Incid[illegible] course of a medically necessary surgery.

(n) Injury or sickness connected with employment with any employer.

(o) Marital counseling..

(p) Medical rehabilitation which is educational/cognitive only.

(q) Mental health services for the treatment of mental illnesses which will not substantially improve beyond the current level of functioning.

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

(s) Physical, psychiatric, or psychological examinations or testing, or vaccinations, immunizations, or treatments not otherwise covered under the Plan, when such services are for purposes of obtaining, maintaining or otherwise relating to employment, insurance, marriage or adoption, or relating to judicial or administrative proceedings or orders, or which are conducted for purposes of medical research, or to obtain or maintain a license or official document of any type.

(t) Pregnancy related conditions for dependent children.

(u) Prosthetic devices, durable medical equipment and appliances, and personal comfort items, including air conditioners, even though prescribed by a physician, except as otherwise provided in this Summary Plan Description.

(v) Radial keratotomy.

(w) Routine dental and optical work, dental x-rays, routine eye examinations, routine office visits, routine physical examinations (except pap smears and mammograms).

(x) Services rendered outside the scope of a provider's license or rendered by a provider with the same legal residence as an insured or rendered by a person who is a member of an insured's family including spouse, brother, sister, parent or child.

(y) Therapy for a patient showing no progression.

(z) Transportation other than local ambulance service as provided elswhere in this Summary Plan Description, and air ambulance not deemed medically necessary.

(aa) Treatment (including cutting or removal by any method) of toe nails or of superficial lesions of the feet including corns, callouses, pedicures and hyperkeratoses, other than the removal of nail matrix or root. Treatment of weak, strained, or flat feet or instability or imbalance of the feet, or any tarsalgia, metatarsalgia or bunion, other than surgery involving the exposure of bones, tendons or ligaments.

(bb)Treatment in a federal hospital for service related injuries/disabilities or on account of war or for treatment in any state-supported institution.

YOUR RIGHTS UNDER COBRA

Legal Requirements:

Federal law entitles the employee and covered dependents under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue medical coverage only in certain cases when coverage would otherwise terminate, provided the employee and/or dependent(s) pay the full group premiums.

Enrollment Guidelines:

Active Employees:

A covered active employee who would lose eligibility for coverage because of voluntary or involuntary termination (except for gross misconduct) or reduction in work hours to part-time status may elect to continue medical coverage for himself and his dependents at his own expense for up to 18 months from the date coverage would have terminated. It will be the responsibility of the employing agency to notify the Program of termination or reductions in hours within 60 days of date coverage would ordinarily have terminated under the Plan. The Program will then notify the employee within 14 days of his right to continue coverage. Coverage may be continued for up to 18 months, but will end earlier if he becomes covered under another group health plan, fails to pay the required premium, or becomes covered by Medicare.

Surviving Spouse and Dependents:

Upon the death of a covered employee or retiree, the surviving legal spouse and dependents may elect to continue medical coverage at their own expense. For the surviving spouse, coverage may be continued for [illegible] unless they become covered under another group health plan. For surviving dependents, coverage may continue for up to 36 months beyond the termination date for children [illegible] the Plan Document, but will end earlier if the child becomes covered in another [illegible] Either the agency or surviving spouse must notify the Program within 60 days of [illegible] employee or retiree; the Program will then notify the spouse within 14 days of his or [illegible] coverage.

Divorced Spouse:

[illegible] covered active or retired employee, the divorced spouse may elect to continue [illegible] at her own expense for up to 36 months from the date coverage would [illegible] will end earlier if the spouse remarries and becomes covered under another [illegible] covered by Medicare. It will be the responsibility of the divorced spouse [illegible] divorce within 60 days from the date coverage would terminate, and [illegible] of his or her option to continue coverage within 14 days. (Legal

(bb)Treatment in a federal hospital for service related injuries/disabilities or on account of war or for treatment in any state-supported institution.

YOUR RIGHTS UNDER COBRA

Legal Requirements:

Federal law entitles the employee and covered dependents under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue medical coverage only in certain cases when coverage would otherwise terminate, provided the employee and/or dependent(s) pay the full group premiums.

Enrollment Guidelines:

Active Employees:

A covered active employee who would lose eligibility for coverage because of voluntary or involuntary termination (except for gross misconduct) or reduction in work hours to part-time status may elect to continue medical coverage for himself and his dependents at his own expense for up to 18 months from the date coverage would have terminated. It will be the responsibility of the employing agency to notify the Program of termination or reductions in hours within 60 days of date coverage would ordinarily have terminated under the Plan. The Program will then notify the employee within 14 days of his right to continue coverage. Coverage may be continued for up to 18 months, but will end earlier if he becomes covered under another group health plan, fails to pay the required premium, or becomes covered by Medicare.

Surviving Spouse and Dependents:

Upon the death of a covered employee or retiree, the surviving legal spouse and dependents may elect to continue medical coverage at their own expense. For the surviving spouse, coverage may be continued for up to 36 months, unless they become covered under another group health plan. For surviving dependent children, coverage may continue for up to 36 months beyond the termination date for children as set forth in the Plan Document, but will end earlier if the child becomes covered in another group health plan. Either the agency or surviving spouse must notify the Program within 60 days of the death of the employee or retiree; the Program will then notify the spouse within 14 days of his or her right to continue coverage.

Divorced Spouse:

In the event of divorce from a covered active or retired employee, the divorced spouse may elect to continue medical coverage at his or her own expense for up to 36 months from the date coverage would have terminated. Coverage will end earlier if the spouse remarries and becomes covered under another group plan or becomes covered by Medicare. It will be the responsibility of the divorced spouse to notify the Program of the divorce within 60 days from the date coverage would terminate, and the Program will notify the spouse of his or her option to continue coverage within 14 days. (Legal separation is treated the same as a divorce).

Dependent Children:

A covered employee or retiree may elect to continue coverage on a dependent child, if the child no longer meets the definition of a covered dependent as defined in the Plan Document. Loss of eligibility may result from marriage, attainment of age 19 (or 25, if a full-time student), failure to maintain student status, etc. Coverage may be continued for up to 36 months following the date coverage would have terminated, but will end earlier if the dependent child becomes covered under another group health plan or becomes covered by Medicare. It will be the responsibility of the covered employee or retiree to notify the Program within 60 days of loss of the dependent's eligibility; the Program will then notify the employee within 14 days of his right to elect continued coverage on that dependent.

Further details of this program are available from your payroll location or the PEIA.

Conversions after COBRA:

Conversion Privileges

When a person's eligibility for continued group coverage ends because he/she has continued coverage for 18 or 36 months, that person has the right to apply for the individual conversion coverage available under the PEIA plan.

HMO Conversion Options after COBRA

If the member is enrolled in a Health Maintenance Organization (HMO), the member will be given the opportunity to convert to either the PEIA or the HMO conversion plan.

For further information on conversion privileges, contact the PEIA office at least thirty days prior to the end of continuation coverage.

HEALTH MAINTENANCE ORGANIZATIONS

The Federal Health Maintenance Organization (HMO) Act of 1973 provides a system for delivering a broad scope of specified comprehensive health care services to its members for a fixed, pre-negotiated fee, 24 hours each day, 7 days each week. The HMO removes the barrier which usually causes individuals to wait until an illness becomes severe before seeking medical care and emphasizes outpatient and preventive care to reduce the need for hospitalization.

All HMO's must be certified by the Department of Health and Human Services and licensed by the West Virginia Insurance Commission.

Solicitation by an HMO:

Any agency in a HMO service area and currently enrolled in the Public Employees Insurance Program may be solicited by an HMO. Employees are given the option of remaining with the PEIA or joining the HMO plan for a contract period of one year. Since the HMO's do not have life insurance coverage as provided by the PEIA, if an individual wishes to enroll for health coverage with an HMO, the life insurance coverage as well as the optional life insurance coverage would be continued with the PEIA

Open enrollment or solicitation by the HMO is done only once a year (in May and June), to be effective July 1.

Eligibility:

Eligibility for enrollment in an HMO is based on the same eligibility guidelines used for enrollment in the PEIA insurance program. Members must meet minimum eligibility and participation requirements.

Contact your payroll location for further information about HMO enrollment and coverage.

Solicitation by an HMO:

Any agency in a HMO service area and currently enrolled in the Public Employees Insurance Program may be solicited by an HMO. Employees are given the option of remaining with the PEIA or joining the HMO plan for a contract period of one year. Since the HMO's do not have life insurance coverage as provided by the PEIA, if an individual wishes to enroll for health coverage with an HMO, the life insurance coverage as well as the optional life insurance coverage would be continued with the PEIA

Open enrollment or solicitation by the HMO is done only once a year (in May and June), to be effective July 1.

Eligibility:

Eligibility for enrollment in an HMO is based on the same eligibility guidelines used for enrollment in the PEIA insurance program. Members must meet minimum eligibility and participation requirements.

Contact your payroll location for further information about HMO enrollment and coverage.

Appendix A

Non-State Employee Premium and Annual Out-of-Pocket Maximum

Employees of the State, county boards of education, and colleges and universities have variable monthly premiums and annual out-of-pocket maximums set by the Plan based on the concept of ability to pay. This Appendix A in their Summary Plan Description describes those variable amounts by annual salary ranges.

Premium:

Non-State employees have their premium participation amounts set by their employing agencies.

Annual Out-Of-Pocket Maximum:

All non-State employees have an annual out-of-pocket maximum amount, set by the Plan, of $1,000.

A married couple in which one spouse is a non-State agency employee and the other an employee of the State, county board of education, or college or university will have to choose to be in this plan, i.e., the plan for non-State employees, or the plan for the State, county board of education, and college and university employees. If the plan of the employee of the State, county board of education, or college or university, is chosen, then the two salaries of the spouses are added together to determine the salary range that determines the applicable premium amount, if any, and applicable annual out-of-pocket maximum for that plan.

Married couples so affected should compare their respective Summary Plan Descriptions in deciding which of the two plan options to take.

Appendix B

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC CARE

from the American Academy of Pediatrics

Committee on Practice and Ambulatory Care

These **Recommendations for Preventive Pediatric Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

A **prenatal visit** by the parents for anticipatory guidance and pertinent medical history is strongly recommended. Health supervision should begin with medical care of the newborn in the hospital.

	INFANCY						EARLY CHILDHOOD					LATE CHILDHOOD				
Age[1]	By 1 mo.	2 mos.	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos.	24 mos.	3 yrs	4 yrs.	5 yrs.	6 yrs.	8 yrs.	10 yrs	12 yrs
History																
Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Measurements																
Height and weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head circumference	•	•	•	•	•	•										
Blood pressure										•	•	•	•	•	•	•
Sensory Screening																
Vision	S	S	S	S	S	S	S	S	S	S	O	O	O	O	S	O
Hearing	S	S	S	S	S	S	S	S	S	S	O	O	S[2]	S[2]	S[2]	O
Devel./Behav.[3] **Assessment**	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Physical Examination[4]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Procedures[5]																
Hered./metabolic screening[6]	•															
Immunization[7]		•	•	•			•	•	•			•				•
Tuberculin test[8]	—	—	—	—	—	•—	—	—	•—	—		—	—	•—	—	—
Hematocrit or hemaglobin[9]	—	—	—	—	•—	—	—	—	•—	—		—	—	•—	—	—
Urinalysis[10]	—	—	—	—	•—	—	—	—	•—	—		—	—	—	—	—
Anticipatory Guidance[11]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Initial Dental Referral[12]										•						

Key: • = to be performed; S = subjective, by history; O = objective, by a standard testing method.

FOOTNOTES: These footnotes correspond with the numbers on the chart above.

1. If a child comes under care for the first time at any point on the schedule, of if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. At these points, history may suffice: if problem suggested, a standard testing method should be used.
3. By history and appropriate physical examination: if suspicious, by specific objective developmental testing.
4. At each visit, a complete physical examination is essential, with infant totally unclothed, older children undressed and suitably draped.
5. These may be modified, depending upon entry point into schedule and individual need.
6. Metabolic screening (e.g. thyroid, PKU, galactosemia) should be done according to state law.
7. Recommended schedule for active immunization of normal infants and children:

Recommended age	Immunizations
2 months	DTP, OPV
4 months	DTP, OPV
6 months	DTP
15 months	MMR
18 months	DTP, OPV, PRP-D
4-6 years	DTP, OPV
12 years	MMR

DPT: Diptheria and tetanus toxoids with pertussis vaccine;
OPV: Oral poliovirus vaccine containing attenuated poliovirus types 1, 2, & 3;
MMR: live measles, mumps and rubella viruses in a combined vaccine;
PRP-D: haemophilus b diptheria toxoid conjugate vaccine.

8. For low risk groups, the Committee on Infectious Diseases recommends the following options: (1) no routine testing or (2) testing at three times -- infancy, preschool and adolescence. For high risk groups, annual TB skin testing is recommended.
9. Present medical evidence suggests the need for reevaluation of the frequency and timing of hemaglobin or hematocrit tests. One determination is is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.
10. Present medical evidence suggests the need for reevaluation of the frequency and timing of urinalyses. One determination is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.
11. Appropriate discussion and counselling should be and integral part of each visit for care.
12. Subsequent examinations as prescribed by dentist.

N.B.: Special chemical, immunologic and endocrine testing are usually carried out upon specific indications. Testing other than newborn (e.g., inborn errors of metabolism, sickle disease, lead) are discretionary with the physician.

Appendix B

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC CARE
from the American Academy of Pediatrics
Committee on Practice and Ambulatory Care

These **Recommendations for Preventive Pediatric Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

A **prenatal visit** by the parents for anticipatory guidance and pertinent medical history is strongly recommended. Health supervision should begin with medical care of the newborn in the hospital.

	INFANCY						EARLY CHILDHOOD					LATE CHILDHOOD				
Age[1]	By 1 mo.	2 mos.	4 mos.	6 mos.	9 mos.	12 mos.	15 mos.	18 mos.	24 mos.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	8 yrs.	10 yrs.	12 yrs.
History																
Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Measurements																
Height and weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head circumference	•	•	•	•	•	•										
Blood pressure										•	•	•	•	•	•	•
Sensory Screening																
Vision	S	S	S	S	S	S	S	S	S	S	O	O	O	O	S	O
Hearing	S	S	S	S	S	S	S	S	S	S	O	O	S[2]	S[2]	S[2]	O
Devel/Behav.[3] Assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Physical Examination[4]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Procedures[5]																
Hered./metabolic screening[6]	•															
Immunization[7]		•	•	•			•	•	•			•				•
Tuberculin test[8]	—	—	—	—	—	—	—	—	—	•	—	—	—	—	—	—
Hematocrit or hemoglobin[9]	—	—	—	—	•	—	—	—	•	—	—	—	—	•	—	—
Urinalysis[10]	—	—	—	•	—	—	—	—	•	—	—	—	—	•	—	—
Anticipatory Guidance[11]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Initial Dental Referral[12]										•						

Key: • = to be performed; S = subjective, by history; O = objective, by a standard testing method.

FOOTNOTES. These footnotes correspond with the numbers on the chart above.

1. If a child comes under care for the first time at any point on the schedule, of if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. At these points, history may suffice: if problem suggested, a standard testing method should be used.
3. By history and appropriate physical examination: if suspicious, by specific objective developmental testing.
4. At each visit, a complete physical examination is essential, with infant totally unclothed, older children undressed and suitably draped.
5. These may be modified, depending upon entry point into schedule and individual need.
6. Metabolic screening (e.g. thyroid, PKU, galactosemia) should be done according to state law
7. Recommended schedule for active immunization of normal infants and children:

Recommended age	Immunizations
2 months	DTP, OPV
4 months	DTP, OPV
6 months	DTP
15 months	MMR
18 months	DTP, OPV, PRP-D
4-6 years	DTP, OPV
12 years	MMR

DPT: Diphtheria and tetanus toxoids with pertussis vaccine;
OPV: Oral poliovirus vaccine containing attenuated poliovirus types 1, 2, & 3;
MMR: live measles, mumps and rubella viruses in a combined vaccine;
PRP-D: haemophilus b diphtheria toxoid conjugate vaccine.

8. For low risk groups, the Committee on Infectious Diseases recommends the following options: (1) no routine testing or (2) testing at three times -- infancy, preschool and adolescence. For high risk groups, annual TB skin testing is recommended.
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11. Appropriate discussion and counselling should be and integral part of each visit for care.
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N.B.: Special chemical, immunologic and endocrine testing are usually carried out upon specific indications. Testing other than newborn (e.g., inborn errors of metabolism, sickle disease, lead) are discretionary with the physician.

Appendix C

The following items will not be covered by the Plan:

Bath Paraffin (Unit)	Chair, Recliner
Child's Stroller	Contour Chair
Craftmatic Bed	Diapers (Adult or infant)
Enureris Unit	Escalator, Elevator or Stair lift
Exercise Bike, Exercycle	Food Liquidizer/Food Processor
Hearing Aid	Heating Pad
Hydraulic Van or Car Lift	Ice Bag
Language Master (Bell & Howell)	Lift Chair
Vibrator	Nutritional Supplements
Orthopedic Mattress	Room Heater (Portable)
Scale (Bathroom)	Thermometer
Treadmill, Jogger	Trapeze Bar
Walking Cane with Seat	Wig, Wig Styling

Bathroom Equipment: toilet seat, commode, bathtub seat, rail, grab bar, etc.

Environmental Control Equipment: air cleaner, air filter, air conditioner, dehumidifier, dust extractor, humdifier, air freshener, etc.

Portable Whirlpool Pump, Whirlpool Equipment

Professional Medical Equipment: blood pressure kit, stethoscope, etc.

Public Employees Insurance Agency
State Capitol Complex
Building 5, Tenth Floor
Charleston, WV 25305

Non-State Agency Employees' Summary Plan Description

Public Employees Insurance Agency

Summary Plan Description

For Retired Employees and Their Dependents, and Surviving Dependents

To elect a lower cost alternative coverage described in this Summary Plan Description, you must submit the form at the back of this document to the PEIA. You'll find further information on pages 2 - 4.

This Summary Plan Description describes the Benefit Plan of the West Virginia Public Employees Insurance Agency ("PEIA"), which is effective on January 1, 1991.

The PEIA is a self-insured health insurance trust fund which offers comprehensive medical benefits, as well as basic and optional life insurance, to employees and retired employees.

The increasing cost of health care is an economic fact of life for all employers, employees and retired employees. The revised PEIA Benefit Plan seeks to maintain an equitable balance between the State's responsibility to adequately fund its insurance benefit, the responsibility of providers to offer cost-effective services and the insureds' responsibility to use the Plan in a cost-saving manner.

Read this document carefully so that you will have a clear understanding of your coverage under the Plan.

The Plan provides coverage for health services to members and their covered dependents as described in this Summary Plan Description and as set forth in greater detail in the Plan Document. Coverage for some health services is subject to prior approval of the Plan. No coverage is provided for health services rendered after coverage under the Plan terminates.

Only medically necessary health services are covered under the Plan. The fact that a physician has performed or prescribed a procedure or treatment does not mean that the procedure or treatment is covered under the Plan. The Plan has sole discretion in interpreting the benefits covered under the Plan and the other terms, conditions, limitations and exclusions set out in the Plan and the Summary Plan Description. The Summary Plan Description is subject to the Plan Document and, if there is a conflict between the documents, the Plan Document shall govern.

STATEMENT OF RIGHTS

The West Virginia Public Employees Insurance Agency, reserves the right to change, increase, decrease and/or alter the content of the policy provisions and procedures by giving written notice to members and the claims administrator.

NON-MEDICARE RETIRED EMPLOYEE MEDICAL COVERAGE

All employees who participate in the PEIA medical plan and retire before becoming eligible for Medicare, may elect to continue medical coverage. There are two plan options available to these retired employees (1) the Basic Medical Plan which is identical to the active employee plan, and (2) the Catastrophic Medical Plan, which has lower monthly premiums but higher deductibles and out-of-pocket maxiumums. The options offer the same eligible benefit provisions, with the differences being only the amount of annual deductibles and the amount of annual out-of-pocket maximums.

The following table outlines the key features of the medical plan options available:

Medical Option	Annual Deductible	Your Copayment	Annual Out-of Pocket Maximum
Basic Plan	$100/person $200/family	20%	$1,000/person $1,000/family
Catastrophic Plan	$500/person $1,000/family	20%	$2,000/person $4,000/family

Because there are differences in the deductibles and out-of-pocket maximums for retired employee coverage, the cost of these options varies. Review the rate schedule in Appendix A to evaluate the differences in cost for the two plan options available. Your known medical expenses and your ability to handle unexpected medical costs should also be evaluated as you make your plan choice. Retired employees currently enrolled in the Basic Plan will remain so unless the Optional Election Form at the back of this document is completed and returned to PEIA.

Once you become eligible for Medicare, your benefit options will be based on the Medicare eligible retired employee coverages described in the next section of this Summary Plan Document.

MEDICARE ELIGIBLE RETIRED EMPLOYEE MEDICAL COVERAGE

Retired employees who are 65 and over, or otherwise eligible for Medicare have two plan options available:

Medical Option	Annual Deductible	Your Copayment	Annual Out-of-Pocket Maximum	Coordination of Benefits (COB)
Basic Plan I	$100/person $200/family	20%	$1,000/person $1,000/family	Traditional
Basic Plan II	$100/person $200/family	20%	$1,000/person $1,000/family	Carveout

The only difference between the two Medicare eligible plan options is the way that benefit payments are coordinated with benefits payable under Medicare. The following examples illustrate how the coordination of benefits options differ. The medical charges in the examples are assumed to be Medicare eligible. Medicare eligible charges are charges for services covered under the Medicare program.

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When you become eligible for Medicare, your benefit options will be based on the Medicare eligible retired employee coverages described in the next section of this Summary Plan Document.

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The difference between the two Medicare eligible plan options is the way that benefit payments are coordinated with benefits payable under Medicare. The following examples illustrate how the benefits options differ. The medical charges in the examples are assumed to be Medicare eligible charges are charges for services covered under the Medicare

In both examples, we assume total charges of $2,800 with Medicare reimbursing $1,748. The difference between the two coordination approaches is the amount of reimbursement you will receive from the PEIA plans. Based on the following examples, your cost under the Basic Plan options are as follows:

Basic Plan I (Traditional COB)	$0
Basic Plan II (Carveout COB)	$640

The first example deals with Basic Plan I (Traditional COB)

Basic Plan I (Traditional COB)

In order to determine the maximum eligible payment under the PEIA Basic Plan I, the PEIA Plan benefit amount is determined first under the Traditional COB option. This is illustrated in Step I.

Step 1	Eligible Medical Charges	$ 2,800
	Basic Plan I Deductible	-100
	Balance	2,700
	80% PEIA benefit	x 80%
	Basic Plan I eligible reimbursement	$ 2,160

The next step involves determining the Medicare reimbursement.

Step 2	Eligible Medical Charges	$ 2,800
	Medicare reimbursement	-1,748
	Balance	1,052

Medicare is the primary plan for retired employee coverage, which means that Medicare will pay a claim before any other secondary coverage (like the PEIA Plan). In the Traditional COB example, Medicare will pay $1,748, leaving a balance of $1,052. This balance is less than the Basic Plan I eligible reimbursement amount determined in Step 1, so the PEIA Basic Plan I will cover the expenses in excess of the Medicare allowable reimbursement, not to exceed the total eligible charges. This is illustrated in Step 3.

Step 3	Eligible Medical Charges	$ 2,800
	Medicare reimbursement	-1,748
	Basic Plan I reimbursement	$ 1,052
	Your Cost	$ 0

If the balance remaining after Medicare has been applied is greater than the Basic Plan I eligible reimbursement, the Basic Plan I will pay no more than the eligible reimbursement. You will be responsible for the balance.

The next example illustrates how the Basic Plan II (Carveout COB) option works

Basic Plan II (Carveout COB)

Under the Carveout COB options, the Basic Plan II deductible and PEIA benefit percentage are applied to eligible medical charges in order to determine the maximum allowable reimbursement from all sources. This is illustrated in Step 1.

Step 1	Eligible Medical Charges	$ 2,800
	Basic Plan I Deductible	-100
	Balance	2,700
	80% PEIA benefit	x 80%
	Basic Plan I eligible reimbursement	$ 2,160

In the next step, the Medicare reimbursement is subtracted from the Basic Plan II eligible reimbursement amount. The balance remaining is the amount that would be reimbursed by the Basic Plan II as the secondary payor. You would be responsible for $640, which includes the deductible.

Basic Plan II eligible reimbursement	$ 2,160
Medicare reimbursement	-1,748
Basic Plan II reimbursement	$ 412
Your Cost	$ 640

Because of the difference in benefits coordination, the cost of the Medicare eligible options varies. Please see the rate schedule in Appendix A for details. Retired employees currently enrolled in Basic Plan 1 will remain so unless the Optional Election Form at the back of this document is completed and returned to PEIA.

Medicare Ineligible Charges

The PEIA Basic Plans cover some medical expenses not covered by Medicare. Medical expenses which are not eligible under Medicare (e.g. skilled nursing care), which are eligible under the Basic Plans, will be reimbursed at 80% after the deductible.

Medicare Participating Providers

In some instances a provider will accept Medicare reimbursement as payment in full. These providers are recognized by Medicare as participating providers. In these instances, reimbursements will be made by Medicare only. Any balance remaining will be absorbed by the participating provider.

ASSIGNMENT OF BENEFITS

In the case where PEIA is the primary insurer, State law requires health care providers (except pharmacies and dental surgeons) to "accept assignment" of the PEIA member's right to receive payment for covered health services. Consequently, you have the right to request the physician or other provider to seek payment directly from Plan instead of from you. This provision means that physicians practicing in West Virginia can request, but cannot require PEIA members to pay for their care at the time of service. Unless the member wishes to pay at the time of service, physicians must first bill the Plan for covered services, be paid by the Plan directly, and then bill the member for the member's portion. The member's portion will be reflected on the Explanation of Benefits.

If the Plan pays the provider directly, you will still be responsible for making payment to the provider for any deductible amount, any Copayment and any amount for a non-covered service. You may decide to pay for the provider's care at the time of service and then to submit a claim to the Plan for reimbursement. If you wish to be reimbursed for covered health services, you must give the Plan all the information required to process the claim. If you do not provide the required information, you may not be reimbursed.

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	Balance	2,700
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PROHIBITION AGAINST BALANCE BILLING

State law prohibits health care providers (other than pharmacies and dental surgeons) from billing PEIA members for any portion of their charges not paid by the Plan (other than for applicable deductibles, copayments and services not covered by the Plan).

The Plan pays health care providers according to maximum fee schedules established by PEIA. If the provider's charge is higher than the Plan maximum fee for a particular service, then the Plan will pay only the maximum fee. The provider cannot collect the unpaid portion from the member.

New fee schedules taking effect on January 1, 1991, will further reduce fees, increasing the likelihood that a provider's charges may be higher than the fee which the Plan will pay. You should monitor your provider's bills and your Explanation of Benefits statements carefully to insure that you have not been billed improperly. If you have been, you should first contact the provider and ask for a refund. If this does not resolve the situation, you should contact the PEIA.

The PEIA will be notifying providers located outside West Virginia that the agency expects them not to bill the member for the balance of any charges not paid by the Plan. However, it has not yet been determined by a court of law that State law can be enforced outside this State. You may wish to take this into consideration before deciding to seek care outside West Virginia. If you do obtain care out of State, and are balance billed by the provider, please contact the PEIA and we will request the Attorney General's Office to take whatever actions are possible.

ELIGIBILITY

Retired Employees:

All eligible retired employees may elect coverage upon retirement for themselves and their dependents. Participation in the PEIA Benefit Plan is not automatically continued at the time of retirement, and premiums for the coverage selected must be paid by the retired employee. The retired employee must complete new enrollment cards at his/her respective retirement system or former payroll location and receive a new medical identification card.

Earned Extension of Insurance Coverage

Your eligibility for the use of accrued sick and annual leave for insurance coverage upon retirement will not change. However, once you have exhausted any accrued sick and/or annual leave accumulation, the health and life plan option you have chosen will require you to pay premiums.

Dependent

A member's dependents shall only include:

a. Spouse (if legally married);
b. Natural child who has not reached its nineteenth birthday;
c. Legally adopted child (including a child living with the member during the period of probation) who has not reached its nineteenth birthday;
d. Stepchild who has not reached its nineteenth birthday and is living with the member;
e. Child who has not reached its nineteenth birthday, is fully dependent upon the member for support and maintenance, and is living with the member; and

f. Child of divorced parents who has not reached its nineteenth birthday, when the divorce decree stipulates that the member is responsible for health insurance coverage.

PEIA reserves the right to request proof of marriage, copies of birth certificates and legal documents indicating responsibility for child support and/or showing legal custody.

Full-time Unmarried Student:

Children are considered to be dependents until they reach their twenty-fifth birthday if they are enrolled as full-time students, are unmarried and are fully dependent upon the member for support and maintenance.

Mentally Retarded/Physically Disabled Dependent Children:

A dependent child may be covered after reaching its nineteenth birthday while incapable of self-support because of mental retardation, mental illness, or a physical disability. The child must have been a dependent and covered by the plan at the onset of the mental retardation, mental illness or physical disability. The member shall contact the PEIA office within 31 days before coverage terminates for the appropriate form to request continuation of the child's coverage.

Surviving Dependents:

Surviving spouse and dependents of deceased active and retired employees are eligible for coverage under the following conditions:

1. Only those dependents who were enrolled and covered under the deceased employees' insurance coverage at the time of death are considered eligible to enroll as surviving dependents. A surviving spouse who is pregnant at the time of death of the member will be permitted to enroll the newborn child(ren).
2. Surviving dependents must forward the monthly premium to either the deceased employees' last payroll location, or retirement board each month.
3. Surviving spouse and dependents are not eligible for life insurance.
4. When surviving spouse/dependents become eligible for Medicare, the appropriate plan choices must be made. See the ENROLLMENT Section for details.

ENROLLMENT

Retired Employees

A retiree will have continuous coverage only if enrolled during the month he/she retires or the following month. The effective date of coverage for all retirees who enroll after the stated enrollment period will be the first day of the month following completion of the proper enrollment materials, and pre-existing condition limitations will apply. A statement of health will be required for life insurance. Retired employees must complete enrollment forms at their retirement systems. The enrollment authorizes the deduction of premium cost for elected coverage from the retired employee's pension annuity.

Participation in the PEIA health insurance plan is voluntary.

f. Child of divorced parents who has not reached its nineteenth birthday, when the divorce decree stipulates that the member is responsible for health insurance coverage.

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Participation in the PEIA health insurance plan is voluntary.

Surviving Dependent

A surviving spouse or dependent will have continuous health coverage if enrolled during the month death occurs or the following month.

The effective date of coverage for all surviving dependents who enroll after the month death occurs or the following month will be the first day of the month following the date of enrollment, and pre-existing condition limitations will apply.

TERMINATION OF COVERAGE

Retired employees:

Coverage terminates at the end of the month in which the retired employee elects to terminate his/her coverage, or when the group coverage terminates, or for failure to pay premium, whichever happens first.

Dependents:

The coverage for dependent(s) terminates at the end of the month in which one of the following occur:

1. Member terminates or loses coverage;
2. Divorce from member (at the end of the month in which the divorce is final);
3. Child reaches nineteenth birthday;
4. Child marries;
5. Child is no longer a full-time student or reaches twenty-fifth birthday.
6. Child is no longer handicapped.

Surviving Dependent

Coverage 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.

TIMELY SUBMISSION OF CLAIMS

All claims must be submitted to the Plan within 12 months of the date the health service is rendered. The only exception that will be made to this requirement is the submission of Medicare claims, which must be submitted to the Plan within 18 months of the date health services were rendered.

APPEALS PROCESS

The appeals process is as follows:

Step 1: Appeal in writing to the claims administrator or utilization management firm for

determination of a processing error or reconsideration of a decision.

Step 2: Appeal to PEIA for review. Must be submitted in writing within sixty (60) days of final disposition of the claim by the claims administrator or utilization management firm .

Step 3: Review and determination by PEIA.

A claim may be settled at any point in the appeals process. Further information about the process will be provided to the member when an appeal is filed

PATIENT AUDIT PROGRAM

The Patient Audit Program rewards members for helping to control the rising cost of health care in West Virginia. The Patient Audit program helps detect and correct these errors that occur in the billing or payment of health care services. All members who have PEIA health insurance may submit Patient Audit reports.

Charges for services you did not receive, and overcharges or overpayments resulting from miscalculation qualify for this program. Reported errors must be at least $50.00 to qualify for this program. Participants in HMOs are not eligible to participate, although it still makes sense to check hospital bills to see that they are correct.

The member must initiate the Patient Audit report for any overpayments prior to the receipt of any recovered amounts by the claims administrator. If the claims administrator detects and corrects an error before the member has made the Report, it will be invalid.

When an error is detected, please contact the PEIA Patient Audit Coordinator for a report form and further instructions.

COORDINATION OF BENEFITS

The Plan, as secondary payor, will pay only its usual benefits less any amount already paid by the primary payor(s). Following is an illustration of coordination of benefits:

Total Charges	$100.00
PEIA Plan's Usual Benefits	$ 80.00
Other Plan Pays	$ 60.00
PEIA Plan Pays	$ 20.00
Member's Payment	$ 20.00
Total Percentage of Claim Charges Paid	80%
Amount Paid in Excess of PEIA Benefits	$ 0.00

SUBROGATION

To the extent that benefits for covered services are provided or paid by the Plan, the Public Employees Insurance Agency shall be subrogated and succeed to all rights of a member to recover such paid expenses from any person or entity which may be liable for expenses incurred for covered services.

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PATIENT AUDIT PROGRAM

The Patient Audit Program rewards members for helping to control the rising cost of health care in West Virginia. The Patient Audit program helps detect and correct these errors that occur in the billing or payment of health care services. All members who have PEIA health insurance may submit Patient Audit reports.

Charges for services you did not receive, and overcharges or overpayments resulting from miscalculation qualify for this program. Reported errors must be at least $50.00 to qualify for this program. Participants in HMOs are not eligible to participate, although it still makes sense to check hospital bills to see that they are correct.

The member must initiate the Patient Audit report for any overpayments prior to the receipt of any recovered amounts by the claims administrator. If the claims administrator detects and corrects an error before the member has made the Report, it will be invalid.

When an error is detected, please contact the PEIA Patient Audit Coordinator for a report form and further instructions.

COORDINATION OF BENEFITS

The Plan, as secondary payor, will pay only its usual benefits less any amount already paid by the primary payor(s). Following is an illustration of coordination of benefits:

Total Charges	$100.00
PEIA Plan's Usual Benefits	$ 80.00
Other Plan Pays	$ 60.00
PEIA Plan Pays	$ 20.00
Member's Payment	$ 20.00
Total Percentage of Claim Charges Paid	80%
Amount Paid in Excess of PEIA Benefits	$ 0.00

SUBROGATION

To the extent that benefits for covered services are provided or paid by the Plan, the Public Employees Insurance Agency shall be subrogated and succeed to all rights of a member to recover such paid expenses from any person or entity which may be liable for expenses incurred for covered services.

This right of subrogation shall constitute a lien against any settlement or judgment obtained by or on behalf of a member for recovery of such expenses. A member shall, upon request, execute and deliver to the PEIA such documents and information which the PEIA may require to define, verify or protect its right of subrogation. Benefits may be withheld pending receipt of necessary documents from the member. In addition, the member shall be responsible for making prompt reimbursement to the PEIA from any settlement or judgment obtained.

Failure by the member to provide any requested documents or information, or to otherwise cooperate with the PEIA in protecting or securing its right, or to make prompt reimbursement from any settlement or judgment, shall not affect the PEIA's right of subrogation, but shall render the member liable to the PEIA for any expenses, including reasonable attorney's fees, incurred in obtaining any such requested information, or any reimbursement to which it is entitled.

RIGHT OF RECOVERY

The Public Employees Insurance Agency shall have the right to recover from any member or other person or entity to whom benefits have been paid for payments subsequently determined to be excessive, for noncovered services, or otherwise improperly or incorrectly made. The member shall cooperate fully with the PEIA to secure recovery of any such overpayments. The PEIA may, after making reasonable attempts to collect from the member or other person or entity to whom such overpayment has been made, deduct the amount of the overpayment from other benefits which are or may become payable to or on behalf of the member.

This provision shall not limit any other remedy provided by law.

UTILIZATION MANAGEMENT

Managing health care dollars is the responsibility of both PEIA and its insureds. Utilization Management (UM) is a process by which PEIA helps its insureds to receive the most appropriate types of medical care in the most cost-effective manner. UM can coordinate alternative care for insureds which can shorten or eliminate a hospital stay when appropriate.

UM also can help the member maximize health care benefits, since the staff is familiar with the PEIA benefit plan and can provide guidance in using benefits wisely. A helath service advice line with nurses answering questions is available.

To provide the best possible prenatal care for all PEIA insureds, PEIA requires that all pregnancies be reported to the UM firm during the first trimester, or as soon as the pregnancy is confirmed.

The member must contact the UM firm as soon as a hospital admission becomes necessary, or as soon as one of the specific outpatient procedures/services requiring precertification is prescribed. The UM firm will contact the doctor to discuss the treatment plan, evaluate the need for a second opinion, and discuss the appropriate level of care. The member will be informed of the outcome of this discussion to assist him/her in making an informed decision.

The member must contact the UM firm:

- At least seven days prior to any scheduled inpatient admission.
- Within 48 hours following any emergency inpatient admission.

- At least seven days prior to any of the specified outpatient procedures or services.
- During the first trimester of pregnancy or as soon as it is confirmed.

Retired employees who are covered under Medicare are required to obtain precertification only in the case of a service which is not covered by Medicare or when the retired employee has reached his or her Medicare maximum.

The ultimate responsibility for precertification lies with the member or dependent or designee. Consult the PEIA medical identification card for the telephone number of the UM firm.

CONTRACT

The PEIA Director is authorized to pursue selective contracting with health care providers, including hospitals, physicians and pharmacies, and organizations comprised of such providers. The Director shall, through provider contracts, endeavor to reduce total costs to the PEIA by seeking price discounts in exchange for structuring benefit plan incentives to encourage PEIA insureds to use the contracting providers. The PEIA shall structure these incentives in such a way that members may incur reduced costs if they use contract providers. These contracts will be presented to the Finance Board and must be consistent with the financial plan adopted by it.

MEMBER OR PROVIDER MISREPRESENTATION

"Any person who shall knowingly secure or attempt to secure benefits payable under this article to which the person is not entitled, or who shall knowingly secure or attempt to secure greater benefits than those to which the person is entitled, by willfully misrepresenting the presence or extent of benefits to which the person is entitled under a collateral insurance source, or by willfully misrepresenting any material fact relating to any other information requested by the Director of PEIA, or by willfully overcharging for services provided, or by willfully misrepresenting the diagnosis or nature of the service provided, may be found to be overpaid and shall be civilly liable for any overpayment.

In addition to the civil remedy provided herein, PEIA shall withhold payment of benefits due to that person until any overpayment has been recovered or may directly set off, after holding internal administrative proceedings to assure due process, any such overcharges or improperly derived payment against benefits due such person hereunder. Nothing in this section shall be construed to limit any other remedy or civil or criminal penalty provided by law." W.Va. Code 5-16-11a.

DEFINITIONS

"Alternate Facility" - a non-hospital health care facility, or an attached facility designated as such by a hospital, which provides one or more of the following services on an outpatient basis pursuant to the law of jurisdiction in which treatment is received: prescheduled surgical services, emergency health services, or prescheduled rehabilitative, laboratory or diagnostic services, mental health or chemical dependency services.

"Annual Out-of-Pocket Maximum" - the ceiling on the amount of copayments that a member pays in a plan year before the Plan payment/member copayment ratio goes from 80/20 to 100/0, i.e., the

- At least seven days prior to any of the specified outpatient procedures or services.
- During the first trimester of pregnancy or as soon as it is confirmed.

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"Annual Out-of-Pocket Maximum" - the ceiling on the amount of copayments that a member pays in a plan year before the Plan payment/member copayment ratio goes from 80/20 to 100/0, i.e., the

plan thereafter for the remainder of the plan year pays at 100% for those payments and copayments not excluded from this annual out-of-pocket copayment maximum provision.

"Chemical Dependency Services" - services and supplies for the diagnosis and treatment of alcoholism and chemical dependency, whether having a physiological or psychological origin.

"Confined" or "Confinement" - an uninterrupted stay following formal admission to a hospital, a skilled nursing facility or other inpatient facility..

"Copayment" - the percentage of eligible expenses (after deductibles) which the member is required to pay for health services covered under the Plan. The member is responsible for paying the copayment (and deductible amounts) directly to the provider of the health services.

"Coverage" or "Covered" - the entitlement by a member to have the Plan pay for health services, subject to all the terms, conditions, limitations and exclusions of the Plan.

"Deductible" - any initial portion of a covered health service eligible expense which a member is responsible for paying and which is, therefore, subtracted -- i.e. deducted -- from that eligible expense before the plan payment (typically at 80%) and member copayment (typically at 20%) are calculated. There are two types of deductibles:

"Annual Deductible" - the initial amount, after any applicable per-service deductible, of each insured's cumulative plan year eligible expenses which the member must pay.

"Per-service Deductible" - the initial amount of eligible expense that the member must pay for each covered health service for which prior approval or precertification was required by the Plan, but not obtained by the member.

"Detoxification" - those health services which are required for the physical withdrawal and stabilization from alcohol and/or addictive drugs.

"Durable Medical Equipment" - medical equipment which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of a sickness or injury.

"Eligible Expenses" - for each PEIA covered health service is the lesser of the actual charge amount and the PEIA maximum allowable charge amount for that service. (PEIA maximum allowable charges are set by the Director of the PEIA in consultation with the Finance Board and its consulting actuarial firm in consideration of both State of West Virginia providers' usual and customary charges and the actuarially projected financial status of the Plan.)

"Emergency Health Services" - those health services necessary for the treatment of an emergency.

"Emergency" - a serious medical condition resulting from injury, sickness, pregnancy or mental illness which arises suddenly and requires immediate care and treatment to avoid jeopardy to the life or health of an insured.

"Enrolled Dependent" - a dependent who is properly enrolled for coverage under the Plan.

"Experimental, Investigational or Unproven Procedures" - medical, surgical, psychiatric or drug procedures, treatments and devices (including investigational drugs and drug therapies) not

generally accepted by the medical community or not approved by federal authorizing agencies.

"Health Care Professional" - any health care professional who is licensed and qualified under the law of the jurisdiction in which treatment is received and who is providing treatment within the scope or limitation of his or her professional license.

"Health Services" - any health care services and supplies.

"Home Health Care Services" - those services including nursing, IV therapy, etc., provided by a properly licensed home health care program.

"Hospice Care" - medical, palliative, supportive procedures necessary for pain control and acute and chronic symptom management provided to a terminally ill insured through a Medicare certified hospice agency, counseling services for the insured and bereavement counseling for any of the insured's immediate family members.

"Hospital" - a properly licensed institution which is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities, by, or under the supervision of, a staff of physicians, and has 24 hour nursing services.

"Insured" - a member or dependent who is properly enrolled for coverage under the Plan.

"Lifetime Maximum Benefit" - the maximum amount which will be paid by Plan during the member's lifetime for certain health services provided to the member and the member's dependents.

"Medically Necessary Health Services" - health care services and supplies provided with respect to the insured's condition, which are determined by Plan to be (1) consistent with the diagnosis of, and prescribed course of treatment for the condition; (2) necessary to treat the insured's condition; (3) required for reasons other than the convenience of either the insured or his or her physician, or not to be required solely for custodial, comfort or maintenance reasons; (4) rendered in the most cost-efficient setting appropriate for the condition; (5) rendered at a frequency which is medically appropriate; and (6) likely to be effective in treating the condition.

"Member" - an eligible and enrolled active employee, member of the Legislature or person similarly entitled by law on whose behalf coverage under the Plan is provided (for benefit of the member and the member's eligible and enrolled dependents).

"Mental Health Services" - those health care services and supplies for the diagnosis and treatment of mental illnesses, whether having a physiological or psychological origin.

"Plan Year" - a calendar year period beginning January 1 and ending December 31.

"Plan" - the benefit plan of the West Virginia Public Employees Insurance Agency.

"Pregnancy" - includes prenatal and postnatal care, childbirth, early termination of pregnancy and any associated complications.

"Reconstructive Surgery" - surgery which is incidental to an injury, sickness, or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, which defect is determined by a physician to have been present at the time of birth.) For the purpose

generally accepted by the medical community or not approved by federal authorizing agencies.

"Health Care Professional" - any health care professional who is licensed and qualified under the law of the jurisdiction in which treatment is received and who is providing treatment within the scope or limitation of his or her professional license.

"Health Services" - any health care services and supplies.

"Home Health Care Services" - those services including nursing, IV therapy, etc., provided by a properly licensed home health care program.

"Hospice Care" - medical, palliative, supportive procedures necessary for pain control and acute and chronic symptom management provided to a terminally ill insured through a Medicare certified hospice agency, counseling services for the insured and bereavement counseling for any of the insured's immediate family members.

"Hospital" - a properly licensed institution which is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities, by, or under the supervision of, a staff of physicians, and has 24 hour nursing services.

"Insured" - a member or dependent who is properly enrolled for coverage under the Plan.

"Lifetime Maximum Benefit" - the maximum amount which will be paid by Plan during the member's lifetime for certain health services provided to the member and the member's dependents.

"Medically Necessary Health Services" - health care services and supplies provided with respect to the insured's condition, which are determined by Plan to be (1) consistent with the diagnosis of, and prescribed course of treatment for the condition; (2) necessary to treat the insured's condition; (3) required for reasons other than the convenience of either the insured or his or her physician, or not to be required solely for custodial, comfort or maintenance reasons; (4) rendered in the most cost-efficient setting appropriate for the condition; (5) rendered at a frequency which is medically appropriate; and (6) likely to be effective in treating the condition.

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of coverage under the Plan, this definition shall also include breast reconstruction following mastectomy.

"Rehabilitation Hospital" - an inpatient facility primarily engaged in providing medical rehabilitation care services to those disabled by disease or injury to be able to achieve the highest practicable level of functional ability. Such services are provided by, or under the supervision of, an organized staff of physicians with continuous nursing services provided under the supervision of a graduate registered nurse (R.N.).

"Skilled Nursing Facility" - a properly licensed hospital, or other nursing facility, which is Medicare approved as a skilled nursing facility.

BENEFITS

The **"Lifetime Maximum Benefit"** is $1,000,000.00.

The **"Annual Deductible"** varies depending on the type of coverage you have elected. Please refer to the information specific to your choice at the front of this Summary Plan Description for your specific annual deductible.

The **"Annual Out-of-Pocket Maximum"** is based on the member's type of coverage. Please refer to the information specific to your choice at the front of this Summary Plan Description for your specific annual out-of-pocket maximum. Any amount a member pays for annual deductibles, per-service deductibles, specifically excluded copayments or non-covered services will not be counted toward meeting the "Annual Out-of-Pocket Maximum."

Coverage for the treatment of a **Pre-existing Medical Condition** which has been diagnosed or treated or that existed within the 3 months immediately preceding the effective date of coverage is excluded and will be provided only after a period of 12 consecutive months following the effective date of coverage.

Health services covered under the Plan are described below, along with the level of coverage provided by the Plan. Members are required to pay, directly to the provider, any deductibles, and copayments or full charges for any services not covered.

Beginning January 1, 1991, and continuing through the remainder of Fiscal Year 1991, PEIA will pay based on maximum allowable charges typically significantly lower than the providers' charges. Providers of service practicing within the State of West Virginia will be prohibited from collecting amounts exceeding the PEIA maximum (at this lower rate) from PEIA members. Hospitals and other providers of services outside the State of West Virginia may collect these additional amounts from PEIA members.

Stars (★) mark those services for which prior approval must be obtained. If the prior approval is not obtained, a separate 30% per-service deductible will be required (prior to and in addition to consideration of any applicable annual deductible).

Unless otherwise noted, all PEIA covered health services are reimbursed at 80%, i.e., with 20% member copayment, of net eligible expenses remaining after first deducting any applicable per-service and annual deductible amounts. Moreover, unless otherwise noted, these same net eligible expenses are reimbursed at 100% after the member's 20% copayment total for the calendar year reaches the applicable out-of-pocket copayment maximum.

HEALTH SERVICE DESCRIPTIONS

Medical Services and Supplies in a physician's or other provider's office for treatment of a sickness or injury. Covered health services also include well-child care and immunizations for children (as determined by Plan -- see Appendix B), pap smears and mammogram screening, and allergy services, testing, injections, extract, serum, and venoms.

Other Medical Services or Physician-related Surgical Services, not including office visits, but including inpatient hospital visits.

★**Inpatient Hospital and Related services.** Confinement in a hospital including semi-private room, special care units, confinement for detoxification, related services and other supplies, provided during confinement in a hospital.

Emergency Outpatient Services and Supplies. Stabilization or initiation of treatment of emergency conditions provided on an outpatient basis at either a hospital or an alternate facility.

★**Outpatient Surgery.** Services and supplies for prescheduled outpatient surgery provided at a hospital, an alternate facility or a physician's office. Prior approval must be obtained for certain procedures listed below.

★**Outpatient diagnostic and therapeutic services** for pre-scheduled laboratory and diagnostic tests and therapeutic treatments, when ordered by a physician. Prior approval must be obtained for certain outpatient diagnostic and therapeutic services listed below.

The following outpatient procedures require precertification: arthroscopy of the knee, bunionectomy, hammertoe, hallux valgus, cataract extraction, colonoscopy, laparoscopy, MRI, osteotomy of the foot, septoplasty, tonsillectomy

★**Maternity Services.** Maternity-related medical, hospital and other covered health services, as well as birthing centers and midwife services. Prior approval must be obtained during the first trimester of pregnancy or as soon as the pregnancy is confirmed. Maternity-related services are covered only for the member or the member's enrolled dependent spouse.

Outpatient Mental Health and Chemical Dependency Services. Coverage to a maximum of 26 visits per calendar year of short-term individual and/or group outpatient mental health and chemical dependency evaluations and referral services, diagnostic, crisis intervention and therapeutic services. First 5 visits paid at 80%; visits 6-26 paid at 50%. No coverage after 26 visits. The Plan's annual out-of-pocket maximum provision does not apply to either the 20% or 50% copayment amounts.

and/or Partial Hospitalization Mental Health and Chemical Dependency Services. Co[illegible] limited to a maximum cost to Plan of $10,000 per calendar year.

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Medical Services and Supplies in a physician's or other provider's office for treatment of a sickness or injury. Covered health services also include well-child care and immunizations for children (as determined by Plan -- see Appendix B), pap smears and mammogram screening, and allergy services, testing, injections, extract, serum, and venoms.

Other Medical Services or Physician-related Surgical Services, not including office visits, but including inpatient hospital visits.

★Inpatient Hospital and Related services. Confinement in a hospital including semi-private room, special care units, confinement for detoxification, related services and other supplies, provided during confinement in a hospital.

Emergency Outpatient Services and Supplies. Stabilization or initiation of treatment of emergency conditions provided on an outpatient basis at either a hospital or an alternate facility.

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The following outpatient procedures require precertification: arthroscopy of the knee, bunionectomy, hammertoe, hallux valgus, cataract extraction, colonoscopy, laparoscopy, MRI, osteotomy of the foot, septoplasty, tonsillectomy

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Inpatient and/or Partial Hospitalization Mental Health and Chemical Dependency Services. Coverage is limited to a maximum cost to Plan of $10,000 per calendar year.

★Home Health Services. Intermittent health services of a Home Health Agency and private duty nursing when prescribed by a physician and provided by or under the supervision of a registered nurse, in a member's home, required for care and treatment which otherwise would require confinement in a hospital or skilled nursing facility.

★Skilled Nursing Facility Services. Confinement in a skilled nursing facility including semi-private room, related services and other supplies. Confinement must be prescribed by a physician in lieu of hospitalization, and is limited to 180 days per calendar year.

Ambulance Services. Emergency ground ambulance transportation by a licensed ambulance service to the nearest hospital where emergency health services can be rendered. Air ambulance, when medically necessary, is covered when moving the patient to the nearest facility providing necessary treatment.

★Medically Necessary Dental Surgery

★Accident-Related Dental Services to repair sound natural teeth.

★Prosthetics and Durable Medical Equipment. Coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices and for the rental or purchase (at Plan's discretion) of standard Durable Medical Equipment when prescribed by a physician. Certain specific items are excluded from coverage, refer to Appendix C.

★Inpatient Rehabilitation Services when ordered by a physician limited to 150 days per plan year.

★Outpatient Speech Therapy when ordered by a physician. Limited to $750.00 each year for each therapy unless further therapy is prior approved and case managed.

★Outpatient Occupational Therapy when ordered by a physician. Limited to $750.00 each year for each therapy unless further therapy is prior approved and case managed.

★Outpatient Physical Therapy. Physical therapy is limited to $750.00 each year unless further therapy is prior approved and case managed. After the first 5 physical therapy visits, physical therapy must be prescribed by a physician.

Chiropractic Services. Health services provided by a chiropractor in the chiropractor's office for the treatment of neuro-muscular-skeletal conditions, limited to a maximum cost to Plan of $750.00 per calendar year. The Plan's annual out-of-pocket maximum provision does not apply to the 20% copayment amount.

★Hospice Care. Hospice Care when ordered by a physician. Hospice Care is limited to a total insured lifetime cost to Plan of $3,000.

Outpatient Prescription Medication Benefit. There will be a change to the prescription medication benefit as of January 1, 1991, however the specific coverage for outpatient prescription medications has not yet been determined. Coverage under the revised benefit will not cost members (in the aggregate) any more than does the current drug benefit.

GENERAL EXCLUSIONS

The following are not covered:

(a) Chemical dependency treatments when patient leaves against medical advice.

(b) Cosmetic or reconstructive surgery unless such charges are incurred as the result of accidental bodily injury or disease, or unless the surgery is performed to correct birth defects.

(c) Custodial care, intermediate care, domiciliary care, respite care or rest cures.

(d) Devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, diversion or general motivation.

(e) Diagnosis and/or treatment by any method of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint, with the exception of Class III and Class IV oral and maxillofacial surgery after medical record review by the American Board of Dental Examiners.

(f) Duplicate testing or handling fee for laboratory test.

(g) Health services and associated expenses for infertility services, including in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, donor semen, and non-medically necessary ultrasound screening and non-medically necessary amniocentesis.

(h) Health services and associated expenses for procedures intended primarily for the treatment of morbid obesity, including gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, and health services of a similar nature.

(i) Health services and associated expenses for sex transformation operations and for reversal of voluntary sterilizations.

(j) Health services otherwise covered under the Plan, but rendered after the date individual coverage under the Plan terminates, including health services for medical conditions arising prior to the date individual coverage under the Plan terminates.

(k) Hospital days associated with weekend admissions or other unauthorized admissions prior to scheduled surgery..

(l) Hypnosis.

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(i) Health services and associated expenses for sex transformation operations and for reversal of voluntary sterilizations.

(j) Health services otherwise covered under the Plan, but rendered after the date individual coverage under the Plan terminates, including health services for medical conditions arising prior to the date individual coverage under the Plan terminates.

(k) Hospital days associated with weekend admissions or other unauthorized admissions prior to scheduled surgery..

(l) Hypnosis.

(m) Incidental surgery performed through the course of a medically necessary surgery.

(n) Injury or sickness connected with employment with any employer.

(o) Marital counseling.

(p) Medical rehabilitation which is educational/cognitive only.

(q) Mental health services for the treatment of mental illnesses which will not substantially improve beyond the current level of functioning.

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

(s) Physical, psychiatric, or psychological examinations or testing, or vaccinations, immunizations, or treatments not otherwise covered under the Plan, when such services are for purposes of obtaining, maintaining or otherwise relating to employment, insurance, marriage or adoption, or relating to judicial or administrative proceedings or orders, or which are conducted for purposes of medical research, or to obtain or maintain a license or official document of any type.

(t) Pregnancy related conditions for dependent children.

(u) Prosthetic devices, durable medical equipment and appliances, and personal comfort items, including air conditioners, even though prescribed by a physician, except as otherwise provided in this Summary Plan Description.

(v) Radial keratotomy.

(w) Routine dental and optical work, dental x-rays, routine eye examinations, routine office visits, routine physical examinations (except pap smears and mammograms).

(x) Services rendered outside the scope of a provider's license or rendered by a provider with the same legal residence as an insured or rendered by a person who is a member of an insured's family including spouse, brother, sister, parent or child.

(y) Therapy for a patient showing no progression.

(z) Transportation other than local ambulance service as provided elswhere in this Summary Plan Description, and air ambulance not deemed medically necessary.

(aa) Treatment (including cutting or removal by any method) of toe nails or of superficial lesions of the feet including corns, callouses, pedicures and hyperkeratoses, other than the removal of nail matrix or root. Treatment of weak, strained, or flat feet or instability or imbalance of the feet, or any tarsalgia, metatarsalgia or bunion, other than surgery involving the exposure of bones, tendons or ligaments.

(bb) Treatment in a federal hospital for service related injuries/disabilities or on account of war or for treatment in any state-supported institution.

YOUR RIGHTS UNDER COBRA

Legal Requirements:

Federal law entitles the employee and covered dependents under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue medical coverage only in certain cases when coverage would otherwise terminate, provided the employee and/or dependent(s) pay the full group premiums.

Enrollment Guidelines: Active Employees:

A covered active employee who would lose eligibility for coverage because of voluntary or involuntary termination (except for gross misconduct) or reduction in work hours to part-time status may elect to continue medical coverage for himself and his dependents at his own expense for up to 18 months from the date coverage would have terminated. It will be the responsibility of the employing agency to notify the Program of termination or reductions in hours within 60 days of date coverage would ordinarily have terminated under the Plan. The Program will then notify the employee within 14 days of his right to continue coverage. Coverage may be continued for up to 18 months, but will end earlier if he becomes covered under another group health plan, fails to pay the required premium, or becomes covered by Medicare.

Surviving Spouse and Dependents:

Upon the death of a covered employee or retired employee, the surviving legal spouse and dependents may elect to continue medical coverage at their own expense. For the surviving spouse, coverage may be continued for up to 36 months, unless they become covered under another group health plan. For surviving dependent children, coverage may continue for up to 36 months beyond the termination date for children as set forth in the Plan Document, but will end earlier if the child becomes covered in another group health plan. Either the agency or surviving spouse must notify the Program within 60 days of the death of the employee or retired employee; the Program will then notify the spouse within 14 days of his or her right to continue coverage.

Divorced Spouse:

In the event of divorce from a covered active or retired employee, the divorced spouse may elect to continue medical coverage at his or her own expense for up to 36 months from the date coverage would have terminated. Coverage will end earlier if the spouse remarries and becomes covered under another group plan or becomes covered by Medicare. It will be the responsibility of the divorced spouse to notify the Program of the divorce within 60 days from the date coverage would terminate, and the Program will notify the spouse of his or her option to continue coverage within 14 days. (Legal separation is treated the same as a divorce).

Dependent Children:

A covered employee or retired employee may elect to continue coverage on a dependent child, if the child no longer meets the definition of a covered dependent as defined in the Plan Document. Loss of eligibility may result from marriage, attainment of age 19 (or 25, if a full-time student), failure to maintain student status, etc. Coverage may be continued for up to 36 months following the date coverage would have terminated, but will end earlier if the dependent child becomes covered under another group health plan or becomes covered by Medicare. It will be the responsibility of the covered

YOUR RIGHTS UNDER COBRA

Legal Requirements:

Federal law entitles the employee and covered dependents under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue medical coverage only in certain cases when coverage would otherwise terminate, provided the employee and/or dependent(s) pay the full group premiums.

Enrollment Guidelines: Active Employees:

A covered active employee who would lose eligibility for coverage because of voluntary or involuntary termination (except for gross misconduct) or reduction in work hours to part-time status may elect to continue medical coverage for himself and his dependents at his own expense for up to 18 months from the date coverage would have terminated. It will be the responsibility of the employing agency to notify the Program of termination or reductions in hours within 60 days of date coverage would ordinarily have terminated under the Plan. The Program will then notify the employee within 14 days of his right to continue coverage. Coverage may be continued for up to 18 months, but will end earlier if he becomes covered under another group health plan, fails to pay the required premium, or becomes covered by Medicare.

Surviving Spouse and Dependents:

Upon the death of a covered employee or retired employee, the surviving legal spouse and dependents may elect to continue medical coverage at their own expense. For the surviving spouse, coverage may be continued for up to 36 months, unless they become covered under another group health plan. For surviving dependent children, coverage may continue for up to 36 months beyond the termination date for children as set forth in the Plan Document, but will end earlier if the child becomes covered in another group health plan. Either the agency or surviving spouse must notify the Program within 60 days of the death of the employee or retired employee; the Program will then notify the spouse within 14 days of his or her right to continue coverage.

Divorced Spouse:

Upon divorce from a covered active or retired employee, the divorced spouse may elect to continue coverage at his or her own expense for up to 36 months from the date coverage terminated. Coverage will end earlier if the spouse remarries and becomes covered under another plan or becomes covered by Medicare. It will be the responsibility of the divorced spouse to notify the Program of the divorce within 60 days from the date coverage would terminate, and to notify the spouse of his or her option to continue coverage within 14 days. (Legal separation is the same as a divorce).

Dependent Children:

A covered active or retired employee may elect to continue coverage on a dependent child, who ceases the definition of a covered dependent as defined in the Plan Document. Cessation may result from marriage, attainment of age 19 (or 25, if a full-time student), failure to meet the definition of a dependent, etc. Coverage may be continued for up to 36 months following the date coverage would terminated, but will end earlier if the dependent child becomes covered under another plan or becomes covered by Medicare. It will be the responsibility of the covered

employee or retired employee to notify the Program within 60 days of loss of the dependent's eligibility; the Program will then notify the employee within 14 days of his right to elect continued coverage on that dependent.

Further details of this program are available from your payroll location or the PEIA.

Conversions after COBRA:

When a person's eligibility for continued group coverage ends because he/she has continued coverage for 18 or 36 months, that person has the right to apply for the individual conversion coverage available under the PEIA plan.

HMO Conversion Options after COBRA

If the member is enrolled in a Health Maintenance Organization (HMO), the member will be given the opportunity to convert to either the PEIA or the HMO conversion plan.

For further information on conversion privileges, contact the PEIA office at least thirty days prior to the end of continuation coverage.

HEALTH MAINTENANCE ORGANIZATIONS

The Federal Health Maintenance Organization (HMO) Act of 1973 provides a system for delivering a broad scope of specified comprehensive health care services to its members for a fixed, pre-negotiated fee, 24 hours each day, 7 days each week. The HMO removes the barrier which usually causes individuals to wait until an illness becomes severe before seeking medical care and emphasizes outpatient and preventive care to reduce the need for hospitalization.

All HMO's must be certified by the Department of Health and Human Services and licensed by the West Virginia Insurance Commission.

Solicitation by an HMO:

Any agency in a HMO service area and currently enrolled in the Public Employees Insurance Program may be solicited by an HMO. Employees are given the option of remaining with the PEIA or joining the HMO plan for a contract period of one year. Since the HMO's do not have life insurance coverage as provided by the PEIA, if an individual wishes to enroll for health coverage with an HMO, the life insurance coverage as well as the optional life insurance coverage would be continued with the PEIA

NOTE: Open enrollment or solicitation by the HMO is done only once a year (in May and June), to be effective July 1.

Eligibility:

Eligibility for enrollment in an HMO is based on the same eligibility guidelines used for enrollment in the PEIA insurance program. Members must meet minimum eligibility and participation requirements.

Contact your payroll location for further information about HMO enrollment and coverage.

Appendix A

Non-Medicare Retired Employee/Survivor Rate Schedule

Basic Plan:	Monthly Health Insurance Premium Only
Single not on Medicare	$ 117.00
Family not on Medicare	236.00
Family (dependents on Medicare)	149.00

Catastrophic Plan:

Single not on Medicare	$ 89.00
Family not on Medicare	174.00
Family (dependents on Medicare)	109.00

Medicare Retired Employee/Survivor Rate Schedule

Basic Plan I	Monthly Health Insurance Premium Only
Single on Medicare	$ 40.00
Family (dependents on Medicare)	67.00
Family (dependents not on Medicare)	162.00

Basic Plan II

Single on Medicare	$ 28.00
Family (dependents on Medicare)	47.00
Family (dependents not on Medicare)	147.00

Life Insurance

Premiums for life insurance are NOT included in this rate schedule. Please add the appropriate amount below to the health insurance premium to get your total premium:

Under age 67	$2.00
Age 67 and over	$1.00

Life insurance premiums not applicable to surviving dependents.

Appendix A

Non-Medicare Retired Employee/Survivor Rate Schedule

Basic Plan:	Monthly Health Insurance Premium Only
Single not on Medicare	$ 117.00
Family not on Medicare	236.00
Family (dependents on Medicare)	149.00

Catastrophic Plan:	
Single not on Medicare	$ 89.00
Family not on Medicare	174.00
Family (dependents on Medicare)	109.00

Medicare Retired Employee/Survivor Rate Schedule

Basic Plan I	Monthly Health Insurance Premium Only
Single on Medicare	$ 40.00
Family (dependents on Medicare)	67.00
Family (dependents not on Medicare)	162.00

Basic Plan II	
Single on Medicare	$ 28.00
Family (dependents on Medicare)	47.00
Family (dependents not on Medicare)	147.00

Premiums for [illegible] included in this rate schedule. Please add the appropriate amount [illegible] premium to get your total premium:

Under Age [illegible]	$2.00
Age [illegible]	$1.00

Life insurance [illegible] surviving dependents.

Appendix B

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC CARE

from the American Academy of Pediatrics Committee on Practice and Ambulatory Care

These **Recommendations for Preventive Pediatric Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

A **prenatal visit** by the parents for anticipatory guidance and pertinent medical history is strongly recommended. Health supervision should begin with medical care of the newborn in the hospital.

	INFANCY					EARLY CHILDHOOD					LATE CHILDHOOD				
Age[1]	By 1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	24 mos	3 yrs	4 yrs	5 yrs	6 yrs	8 yrs	10 yrs	12 yrs
History																
Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Measurements																
Height and weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head circumference	•	•	•	•	•	•										
Blood pressure										•	•	•	•	•	•	•
Sensory Screening																
Vision	S	S	S	S	S	S	S	S	S	S	O	O	O	O	S	O
Hearing	S	S	S	S	S	S	S	S	S	S	O	O	S[2]	S[2]	S[2]	O
Devel./Behav.[3] **Assessment**	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Physical Examination[4]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Procedures[5]																
Hered./metabolic screening[6]	•															
Immunization[7]		•	•	•			•	•	•			•				•
Tuberculin test[8]	—	—	—	—	—	•	—	—	•	—	—					
Hematocrit or hemaglobin[9]	—	—	—	—	•	—	—	—	•	—	—				•	
Urinalysis[10]	—	—	—	•	—	—	—	—	•	—	—				•	
Anticipatory Guidance[11]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Initial Dental Referral[12]										•						

Key: • = to be performed; S = subjective, by history; O = objective, by a standard testing method.

FOOTNOTES: These footnotes correspond with the numbers on the chart above.

1. If a child comes under care for the first time at any point on the schedule, of if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. At these points, history may suffice: if problem suggested, a standard testing method should be used.
3. By history and appropriate physical examination; if suspicious, by specific objective developmental testing.
4. At each visit, a complete physical examination is essential, with infant totally unclothed, older children undressed and suitably draped.
5. These may be modified, depending upon entry point into schedule and individual need.
6. Metabolic screening (e.g. thyroid, PKU, galactosemia) should be done according to state law.
7. Recommended schedule for active immunization of normal infants and children:

Recommended age	Immunizations
2 months	DTP, OPV
4 months	DTP, OPV
6 months	DTP
15 months	MMR
18 months	DTP, OPV, PRP-D
4-6 years	DTP, OPV
12 years	MMR

DPT: Diptheria and tetanus toxoids with pertussis vaccine;
OPV: Oral poliovirus vaccine containing attenuated poliovirus types 1, 2, & 3;
MMR: live measles, mumps and rubella viruses in a combined vaccine;
PRP-D: haemophilus b diptheria toxoid conjugate vaccine.

8. For low risk groups, the Committee on Infectious Diseases recommends the following options: (1) no routine testing or (2) testing at three times -- infancy, preschool and adolescence. For high risk groups, annual TB skin testing is recommended.
9. Present medical evidence suggests the need for reevaluation of the frequency and timing of hemaglobin or hematocrit tests. One determination is is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.
10. Present medical evidence suggests the need for reevaluation of the frequency and timing of urinalyses. One determination is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.
11. Appropriate discussion and counselling should be and integral part of each visit for care.
12. Subsequent examinations as prescribed by dentist.

N.B.: Special chemical, immunologic and endocrine testing are usually carried out upon specific indications. Testing other than newborn (e.g., inborn errors of metabolism, sickle disease, lead) are discretionary with the physician.

Appendix C

The following items will not be covered by the Plan:

Bath Paraffin (Unit)

Child's Stroller

Craftmatic Bed

Enureris Unit

Exercise Bike, Exercycle

Hearing Aid

Hydraulic Van or Car Lift

Language Master (Bell & Howell)

Vibrator

Orthopedic Mattress

Scale (Bathroom)

Treadmill, Jogger

Walking Cane with Seat

Chair, Recliner

Contour Chair

Diapers (Adult or infant)

Escalator, Elevator or Stair lift

Food Liquidizer/Food Processor

Heating Pad

Ice Bag

Lift Chair

Nutritional Supplements

Room Heater (Portable)

Thermometer

Trapeze Bar

Wig, Wig Styling

Bathroom Equipment: toilet seat, commode, bathtub seat, rail, grab bar, etc.

Environmental Control Equipment: air cleaner, air filter, air conditioner, dehumidifier, dust extractor, humidifier, air freshener, etc.

Portable Whirlpool Pump, Whirlpool Equipment

Professional Medical Equipment: blood pressure kit, stethoscope, etc.

Appendix C

The following items will not be covered by the Plan:

Bath Paraffin (Unit)	Chair, Recliner
Child's Stroller	Contour Chair
Craftmatic Bed	Diapers (Adult or infant)
Enureris Unit	Escalator, Elevator or Stair lift
Exercise Bike, Exercycle	Food Liquidizer/Food Processor
Hearing Aid	Heating Pad
Hydraulic Van or Car Lift	Ice Bag
Language Master (Bell & Howell)	Lift Chair
Vibrator	Nutritional Supplements
Orthopedic Mattress	Room Heater (Portable)
Scale (Bathroom)	Thermometer
Treadmill, Jogger	Trapeze Bar
Walking Cane with Seat	Wig, Wig Styling

Bathroom Equipment: toilet seat, commode, bathtub seat, rail, grab bar, etc.

Environmental Control Equipment: air cleaner, air filter, air conditioner, dehumidifier, dust extractor, humdifier, air freshener, etc.

Portable Whirlpool Pump, Whirlpool Equipment

Professional Medical Equipment: blood pressure kit, stethoscope, etc.

Retired Employee/Surviving Dependent Plan Selection Form

You are currently enrolled in the basic plan, Medicare or non-Medicare, retired employees and surviving dependents, as indicated by your current PEIA enrollment data. If you wish to select an alternative plan, complete the following information and return this form to PEIA.

Any changes will be effective the first of the month following the receipt of updated information. Note: premiums will be based on the rate structure shown in Appendix A.

Name _____

Social Security Number _____

Address _____

City _____ State _____ ZIP _____

Signed _____ Date _____

Options for health insurance (all coverages described in detail on pages 2-4 of this document). **Please choose only one option**:

____ Basic Plan I Medicare -- This coverage coordinates to 100% of eligible expenses; it has a $100 per person per year (maximum $200 per family) deductible and a 20% copayment up to a maximum of $1,000 per plan year.

____ Basic Plan II Medicare -- This coverage coordinates to 80% of eligible expenses; it has a $100 per person deductible per year (maximum $200 per family) with a 20% copayment up to a maximum of $1,000 per plan year.

____ Basic Plan non-Medicare -- This coverage has a $100 per person per plan year (maximum $200 per family) deductible and a 20% copayment up to a maximum of $1,000 per plan year.

____ Catastrophic Non-Medicare -- This coverage has a $500 per person deductible per plan year (maximum $1,000 per family) with a 20% copayment up to a maximum of $2000 per person (maximum of $4,000 per family)per plan year.

Return this form to: PEIA
State Capitol Complex
Building 5, Tenth Floor,
Charleston, WV 25305
ATTN: Plan Selection Dept.

Public Employees Insurance Agency
State Capitol Complex
Building 5, Tenth Floor
Charleston, WV 25305

Retired Employee
Summary Plan Description

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850
FAX: 304-348-2516

Gaston Caperton
Governor

Sally K. Richardson
Director

February 28, 1991

Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Rate Schedule notebook copies of the following documents:

1. Memorandum to All Benefit Coordinators/Payroll Clerks of State Agencies, Colleges and Universities, and County Boards of Education, from Sally K. Richardson, dated December 14, 1990, entitled: "Clarifications of PEIA Summary Plan Description and New Procedures." This memo includes a new PEIA premium rate schedule effective January 1, 1991.

2. Memorandum to Non-State Agency Payroll Clerks/Benefit Coordinators, from Sally K. Richardson, dated January 9, 1991, entitled: "PEIA Health Benefit Plan for Non-State Agencies." This memorandum includes new PEIA rate schedules for non-State agencies effective January 1, 1991.

3. Memorandum to All Payroll Locations (S), from Sally K. Richardson, dated January 18, 1991, entitled: "Monthly Health Insurance Premiums for Surviving Dependents." This memo contains a correction in the State agency premium rates for surviving dependents under age 65 and not on Medicare.

4. Memorandum to All Payroll Locations (N-S), from Sally K. Richardson, dated January 18, 1991, entitled: "Monthly Health Insurance Premiums for Surviving Dependents." This memorandum contains a correction in the non-State agency premium rates for surviving dependents under age 65 and not on Medicare.

As always, your cooperation and assistance are greatly appreciated.

Sincerely,

Sally K Richardson

Sally K. Richardson
Director

SKR:DPL:trs

Public Employees Insurance Agency

Capitol Complex
Building 5
Room 506
Charleston
WV 25305
304-348-7550
FAX 304-348-2516

Gaston Caperton
Governor

Sally K. Richardson
Director

MEMORANDUM

TO: ALL PAYROLL LOCATIONS (N-S)

FROM: SALLY K. RICHARDSON SKR
DIRECTOR

SUBJECT: MONTHLY HEALTH INSURANCE PREMIUMS FOR SURVIVING DEPENDENTS

DATE: JANUARY 18, 1991

This is to inform you that your January billing contains an error in the rates for Surviving Dependents, under the age of 65 and not on Medicare.

The insurance premiums for coverage codes WS, WF, YS and YF that appear on your January billing and on the premium rate schedules are different from those included in the employee notification provided in the Summary Plan Description.

Since the insurance premium rates were given to all Surviving Dependents in the Summary Plan Description, the WV Public Employees Insurance Agency will use those premiums until there is an overall premium increase. At that time we will adjust the rates for Surviving Dependents to match the actuarial experience of that group.

Enclosed is a revised premium rate schedule for your convenience.

e:\mhip

N-S

BASIC PLAN SURVIVING DEPENDENT RATE SCHEDULE

COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
WS	SURVIVING SPOUSE UNDER AGE 65	$117.00
WOM1	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$162.00
WWM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$40.00
WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$236.00
WXM1	SURVIVING SPOUSE OVER AGE 65	$40.00
WMM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$162.00
YS	SURVIVING CHILD/NO PARENT	$117.00
YF	SURVIVING CHILDREN/NO PARENT	$236.00

CATASTROPHIC PLAN SURVIVING DEPENDENT RATE SCHEDULE

COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTROPHIC PLAN
WS	SURVIVING SPOUSE UNDER AGE 65	$117.00
WOM2	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$147.00
WWM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$28.00
WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$236.00
WXM2	SURVIVING SPOUSE OVER AGE 65	$28.00
WMM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$147.00
YS	SURVIVING CHILD/NO PARENT	$117.00
YF	SURVIVING CHILDREN/NO PARENT	$236.00

COBRA RATE SCHEDULE

COVERAGE CODE	EXPLANATION OF COVERAGE CODE	COBRA PREMIUM
NES	COBRA EMPLOYEE - SINGLE COVERAGE	$167.00
NEF	COBRA EMPLOYEE - FAMILY COVERAGE	$356.00
NDS	COBRA DEPENDENT - SINGLE COVERAGE	$167.00
NDF	COBRA DEPENDENT - FAMILY COVERAGE	$356.00
NSD	COBRA EMPLOYEE - SINGLE DISABLED	$246.00
NFD	COBRA EMPLOYEE - FAMILY DISABLED	$523.00
NMO	COBRA - HEALTH MAINTENANCE ORGANIZATION	$0.00

EFFECTIVE DATE OF RATE SCHEDULE: ***JANUARY 1, 1991***

Public Employees Insurance Agency

Gaston Caperton

Sally K. Richardson

MEMORANDUM

TO: ALL PAYROLL LOCATIONS (S)

FROM: SALLY K. RICHARDSON SKR
DIRECTOR

SUBJECT: MONTHLY HEALTH INSURANCE PREMIUMS FOR SURVIVING DEPENDENTS

DATE: JANUARY 18, 1991

This is to inform you that your January billing contains an error in the rates for Surviving Dependents, under the age of 65 and not on Medicare.

The insurance premiums for coverage codes WS, WF, YS and YF that appear on your January billing and on the premium rate schedules are different from those included in the employee notification provided in the Summary Plan Description.

Since the insurance premium rates were given to all Surviving Dependents in the Summary Plan Description, the WV Public Employees Insurance Agency will use those premiums until there is an overall premium increase. At that time we will adjust the rates for Surviving Dependents to match the actuarial experience of that group.

Enclosed is a revised premium rate schedule for your convenience.

e:\mhip

S

BASIC PLAN SURVIVING DEPENDENT RATE SCHEDULE

WS	SURVIVING SPOUSE UNDER AGE 65	$117.00
WOM1	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$162.00
WWM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$40.00
WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$236.00
WXM1	SURVIVING SPOUSE OVER AGE 65	$40.00
WMM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$162.00
YS	SURVIVING CHILD/NO PARENT	$117.00
YF	SURVIVING CHILDREN/NO PARENT	$236.00

CATASTROPHIC SURVIVING DEPENDENT RATE SCHEDULE

WS	SURVIVING SPOUSE UNDER AGE 65	$117.00
WOM2	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$147.00
WWM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$28.00
WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$236.00
WXM2	SURVIVING SPOUSE OVER AGE 65	$28.00
WMM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$147.00
YS	SURVIVING CHILD/NO PARENT	$117.00
YF	SURVIVING CHILDREN/NO PARENT	$236.00

COBRA RATE SCHEDULE

CES	COBRA EMPLOYEE - SINGLE COVERAGE	$181.00
CESC	COBRA EMPLOYEE - WITH CHILD(REN) ONLY	$315.00
CEF	COBRA EMPLOYEE - FAMILY COVERAGE	$449.00
CDS	COBRA DEPENDENT - SINGLE COVERAGE	$181.00
CDSC	COBRA DEPENDENT - WITH CHILD(REN) ONLY	$315.00
CDF	COBRA DEPENDENT - FAMILY COVERAGE	$449.00
CSD	COBRA EMPLOYEE - SINGLE DISABLED	$181.00
CSDC	COBRA EMPLOYEE - DISABLED - WITH CHILD(REN) ONLY	$315.00
CFD	COBRA EMPLOYEE - FAMILY DISABLED	$449.00

Public Employees Insurance Agency

Gaston Caperton

Sally K. Richardson

Monthly Premiums

Index Code	Annual Salary	Type of Family: Child(ren) Only	Type of Family: Full Family	Annual Out-of Pocket Maximum	Benefit Code
01	$ 0 to $ 8,000	$10.66	$21.32	$ 750	A1
02	8,001 to 8,500	11.00	22.00	750	A1
03	8,501 to 9,000	11.68	23.34	750	A1
04	9,001 to 9,500	12.34	24.68	750	A1
05	9,501 to 10,000	13.00	26.00	750	A1
06	10,001 to 10,500	13.68	27.34	750	A1
07	10,501 to 11,000	14.34	28.68	750	A1
08	11,001 to 11,500	15.00	30.00	750	A1
09	11,501 to 12,000	15.68	31.34	750	A1
10	12,001 to 12,500	16.34	32.68	750	A1
11	12,501 to 13,000	17.00	34.00	750	A1
12	13,001 to 13,500	17.68	35.34	750	A1
13	13,501 to 14,000	18.34	36.68	750	A1
14	14,001 to 14,500	19.00	38.00	750	A1
15	14,501 to 15,000	19.68	39.34	750	A1
16	15,001 to 30,000	20.00	40.00	1,000	A2
17	30,001 to 30,500	20.18	40.34	1,250	A3
18	30,501 to 31,000	20.50	41.00	1,250	A3

19	31,001 to	31,500	20.84	41.68	1,250	A3
20	**31,501 to**	**32,000**	**21.18**	**42.34**	**1,250**	**A3**
21	32,001 to	32,500	21.50	43.00	1,250	A3
22	**32,501 to**	**33,000**	**21.84**	**43.68**	**1,250**	**A3**
23	33,001 to	33,500	22.18	44.34	1,250	A3
24	**33,501 to**	**34,000**	**22.50**	**45.00**	**1,250**	**A3**
25	34,001 to	34,500	22.84	45.68	1,250	A3
26	**34,501 to**	**35,000**	**23.18**	**46.34**	**1,250**	**A3**
27	35,001 to	35,500	23.50	47.00	1,250	A3
28	**35,501 to**	**36,000**	**23.84**	**47.68**	**1,250**	**A3**
29	36,001 to	36,500	24.18	48.34	1,250	A3
30	**36,501 to**	**37,000**	**24.50**	**49.00**	**1,250**	**A3**
31	37,001 to	37,500	24.84	49.68	1,250	A3
32	**37,501 to**	**38,000**	**25.18**	**50.34**	**1,250**	**A3**
33	38,001 to	38,500	25.50	51.00	1,250	A3
34	**38,501 to**	**39,000**	**25.86**	**51.68**	**1,250**	**A3**
35	39,001 to	39,500	26.18	52.34	1,250	A3
36	**39,501 to**	**40,000**	**26.50**	**53.00**	**1,250**	**A3**
37	40,001 to	40,500	26.84	53.68	1,500	A4
38	**40,501 to**	**41,000**	**27.18**	**54.34**	**1,500**	**A4**
39	41,001 to	41,500	27.50	55.00	1,500	A4
40	**41,501 to**	**42,000**	**27.84**	**55.68**	**1,500**	**A4**
41	42,001 to	42,500	28.18	56.34	1,500	A4

42	42,501 to	43,000	28.50	57.00	1,500	A4
43	43,001 to	43,500	28.84	57.68	1,500	A4
44	43,501 to	44,000	29.18	58.34	1,500	A4
45	44,001 to	44,500	29.50	59.00	1,500	A4
46	44,501 to	45,000	29.84	59.68	1,500	A4
47	45,001 to	45,500	30.18	60.34	1,500	A4
48	45,501 to	46,000	30.50	61.00	1,500	A4
49	46,001 to	46,500	30.84	61.68	1,500	A4
50	46,501 to	47,000	31.18	62.34	1,500	A4
51	47,001 to	47,500	31.50	63.00	1,500	A4
52	47,501 to	48,000	31.84	63.68	1,500	A4
53	48,001 to	48,500	32.18	64.34	1,500	A4
54	48,501 to	49,000	32.50	65.00	1,500	A4
55	49,001 to	49,500	32.84	65.68	1,500	A4
56	49,501 to	50,000	33.18	66.34	1,500	A4
57	50,001 and above		33.34	66.66	1,500	A4

KM/de
E:\MONPREM

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850
FAX 304-348-2516

Gaston Caperton
Governor

Sally K. Richardson
Director

MEMORANDUM

TO: Non-State Agency
Payroll Clerks/Benefit Coordinators

FROM: Sally K. Richardson
Director

DATE: January 9, 1991

SUBJECT: PEIA Health Benefit Plan for
Non-State Agencies

The purpose of this memorandum is to provide you with information you need as your agency's PEIA representative, and to provide additional clarification of data provided in the PEIA Summary Plan Description which is effective January 1, 1991.

First, let me apologize for the instructions on Page 1 of the Summary Plan Description which stated that your employees needed to re-enroll by December 15, 1990, if they were to have coverage under the PEIA Health Benefit Plan after January 1, 1991. The incorrect re-enrollment date was inadvertently printed on Non-State Agency booklets. The Non-State Agency employee re-enrollment forms must be returned by **February 15, 1991.**

Enclosed you will find:

1. A Re-enrollment form for each employee which is to be completed and returned to the PEIA **no later than February 15, 1991.**

2. An Enrollment form which is to be completed and forwarded to PEIA along with the current enrollment and/or change-in-status cards for all new insureds whose coverage is effective January 1, 1991 or after.

3. Revised guidelines for Earned Extension of Insurance Coverage (sick and annual leave) effective January 1, 1991. These guidelines will apply to two eligible retirees married to each other. (**NOTE:** These are only guidelines -- each non-State agency will continue to administer this benefit according to its own policy.)

Plan Changes: Two married employees who change their coverage to two single Plans will be required to meet two annual out-of-pocket maximums. The same applies to married employees who change to one paying monthly premium of "child(ren) only" and the other changing to the "single" Plan.

Earned Extension of Insurance Coverage (Sick and Annual Leave) Effective January 1, 1991, two eligible retired employees who are married to each other may elect to combine their accrued annual and/or sick leave credits toward one family plan, with the other retired employee electing to continue "life insurance only" coverage. The "life insurance only" coverage will require a monthly payment of the $1.00 or $2.00 premium. Accrued leave will apply only toward health insurance.

Each Non-State Agency will continue to administer the accrued sick and/or annual leave policy according to its own policy.

Thank you for your attention to these matters. This insurance program is changing quickly, and your continued support and cooperation are greatly appreciated! If you need further clarification of any of these issues, please contact the PEIA office at 348-7850.

Enclosures

PEIA Non-State Agency Enrollment Form

This form is to be used in conjunction with the existing PEIA enrollment and change-in-status cards for enrollments and changes in insurance coverage.

Employee's Name _____ Date _____

Home Address _____

City _____ State _____ ZIP _____

Social Security Number _____ Account Number _____

Agency Name _____

Please indicate below the type of coverage you have with PEIA. Please mark one of the following:

1. Single Coverage ____
2. Family Coverage ____
3. Life Insurance only with PEIA health coverage under spouse's plan ____
4. Life Insurance only with no PEIA health coverage ____

If option 2 or 3 was chosen, complete the following:

Spouse's agency/employer name _____

Spouse's Payroll location number _____

Spouse's Social Security Number _____-_____-_____

Annual Salary: yours: $_____ your spouse's: $_____

Please enter the following information for each dependent,if you have family coverage:

Dependent Name (last, first, middle)	Birth Date	Rel Code*	Social Sec. Number	Other Insurance Company

*Rel Code: Relationship code. Please enter "S" for spouse and/or "C" for child.

Signed: _____ Date: _____
Employee

Signed: _____ Date: _____
Benefits Coordinator

Routing: Copy 1 to PEIA; Copy 2 to Payroll Location; Copy 3 to Employee

PEIANSENR 1/91

REVISED GUIDELINES

EFFECTIVE JANUARY 1, 1991

Earned Extension of Insurance Coverage (Sick and Annual Leave)

Effective January 1, 1991, two eligible retired employees who are married to each other may elect to combine their accrued annual and/or sick leave credits toward one family plan with the other retiree electing to continue "life insurance only" coverage by paying the monthly life insurance premium. Accrued leave will apply toward health insurance only.

Should the retiree who has the family plan die, only the credits or remaining credits earned by the survivor will be available for use in continuing a single or family plan. In other words, no individual may use more credits than he or she earned. Combined credits may only be used if both retired employees are living.

State and Board of Education Retired Employees:

An active employee who elects to participate in the PEIA Benefit Plan prior to July 1, 1988, who voluntarily retires, or is compelled or required by law to retire before age 65, is eligible to receive credit towards his/her health and/or life insurance benefits. Only that portion of sick and annual leave for which the employee has not been reimbursed at the time of retirement is eligible to be applied to the extension of insurance coverage. Credit will be calculated as follows:

2 days of accrued leave = 1 month of Single Plan Coverage
3 days of accrued leave = 1 month of Family Plan Coverage

Partial months are not acceptable.

When a new employee who elects to participate in the PEIA benefit plan on or **after July 1, 1988,** voluntarily retires, or is compelled or required by law to retire before reaching age 65, he/she is eligible to receive credit toward group health and/or life insurance benefits. Only that portion of sick and annual leave for which the employee has not been reimbursed at the time of retirement, is eligible to be applied to the extension of insurance coverage. Fifty-percent of the premium for each month's coverage must be paid by the member. An employee who has been a participant under spouse or dependent coverage, and who reenters the plan within twelve months after termination of his or her prior coverage, shall be considered to have elected to participate in the plan as of the date of commencement of the prior coverage.
Credit will be calculated as follows:

2 days of accrued leave = 50% of the premium for 1 month Single Plan Coverage
3 days of accrued leave = 50% of the premium for 1 month Family Plan Coverage

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC INSURANCE RATE SCHEDULE FOR
ACTIVE EMPLOYEES
OF COUNTY COMMISSIONS, MUNICIPALITIES AND OTHER
POLITICAL SUBDIVISIONS

ACTIVE EMPLOYEE RATE SCHEDULE

	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	TOTAL PREMIUM
EMPLOYEES UNDER AGE OF 65: AMOUNT OF LIFE INSURANCE $10,000.00	ASN	SINGLE COVERAGE	$168.00
	AFN	FAMILY COVERAGE	$353.00
	LA	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$4.34
	LAD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$4.34
	MS	LIFE INSURANCE ONLY - HMO SINGLE	$4.34
	MF	LIFE INSURANCE ONLY - HMO FAMILY	$4.34
EMPLOYEES AGES 65 THRU 69 AMOUNT OF LIFE INSURANCE $6,500.00	BSN	SINGLE COVERAGE	$167.00
	BFN	FAMILY COVERAGE	$352.00
	LB	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$2.82
	LBD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$2.82
	MA	LIFE INSURANCE ONLY - HMO SINGLE	$2.82
	MB	LIFE INSURANCE ONLY - HMO FAMILY	$2.82
EMPLOYEES AGES 70 AND OLDER AMOUNT OF LIFE INSURANCE $5,000.00	CSN	SINGLE COVERAGE	$166.00
	CFN	FAMILY COVERAGE	$351.00
	LD	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$2.17
	LDD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$2.17
	MC	LIFE INSURANCE ONLY - HMO SINGLE	$2.17
	MD	LIFE INSURANCE ONLY - HMO FAMILY	$2.17

EFFECTIVE DATE OF RATE SCHEDULE: ***JANUARY 1, 1991***

	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
RETIREE AGE 67 OR OVER – AMOUNT OF LIFE INSURANCE $2,500	ISM1	SINGLE COVERAGE	$41.00
	ISBM1	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$40.00
	IFM1	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER , OR ON MEDICARE	$68.00
	IFBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER , OR ON MEDICARE	$67.00
	IWPN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$163.00
	IWBPN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	LI	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$1.00
	LIB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	—
	LID	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$1.00
	LIE	LIFE INSURANCE COVERAGE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	—

	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
RETIREE ANY AGE HEALTH INSURANCE ONLY	ZSPN	SINGLE COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$117.00
	ZSAM1	SINGLE COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$40.00
	ZFPN	FAMILY COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$236.00
	ZFAM1	FAMILY COVERAGE - RETIREE MEDICARE AND DEPENDENT NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$162.00
	ZWPN	FAMILY COVERAGE - RETIREE NON-MEDICARE AND DEPENDENT MEDICARE - NO LIFE INSURANCE BENEFITS	$149.00
	ZWAM1	FAMILY COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$67.00

CATASTROPHIC PLAN RATE SCHEDULE

	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTROPHIC PLAN
RETIREE UNDER AGE 65 AMOUNT OF LIFE INSURANCE $5,000	GSCN	SINGLE COVERAGE	$91.00
	GSAM2	SINGLE COVERAGE WITH MEDICARE	$30.00
	GSBCN*	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$89.00
	GSCM2*	SINGLE COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM	$28.00
***AMOUNT OF LIFE INSURANCE $10,000**	GFCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$176.00
	GFAM2	FAMILY COVERAGE WITH MEDICARE AND DEPENDENT(S) UNDER AGE 65	$149.00
	GFBCN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$174.00
	GFCM2*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	GWCN	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$111.00
	GWAM2	FAMILY COVERAGE WITH MEDICARE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$49.00
	GWBCN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$109.00
	GWCM2*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$47.00
	LG	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT	

BASIC PLAN SURVIVING DEPENDENT RATE SCHEDULE

COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
WS	SURVIVING SPOUSE UNDER AGE 65	$178.00
WOM1	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$162.00
WWM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$40.00
WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$289.00
WXM1	SURVIVING SPOUSE OVER AGE 65	$40.00
WMM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$162.00
YS	SURVIVING CHILD/NO PARENT	$178.00
YF	SURVIVING CHILDREN/NO PARENT	$289.00

CATASTROPHIC PLAN SURVIVING DEPENDENT RATE SCHEDULE

COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTROPHIC PLAN
WS	SURVIVING SPOUSE UNDER AGE 65	$178.00
WOM2	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$147.00
WWM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$28.00
WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$289.00
WXM2	SURVIVING SPOUSE OVER AGE 65	$28.00
WMM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$147.00
YS	SURVIVING CHILD/NO PARENT	$178.00
YF	SURVIVING CHILDREN/NO PARENT	$289.00

COBRA RATE SCHEDULE

COVERAGE CODE	EXPLANATION OF COVERAGE CODE	COBRA PREMIUM
NES	COBRA EMPLOYEE - SINGLE COVERAGE	$167.00
NEF	COBRA EMPLOYEE - FAMILY COVERAGE	$356.00
NDS	COBRA DEPENDENT - SINGLE COVERAGE	$167.00
NDF	COBRA DEPENDENT - FAMILY COVERAGE	$356.00
NSD	COBRA EMPLOYEE - SINGLE DISABLED	$246.00
NFD	COBRA EMPLOYEE - FAMILY DISABLED	$523.00
NMO	COBRA - HEALTH MAINTENANCE ORGANIZATION	$0.00

EFFECTIVE DATE OF RATE SCHEDULE: ***JANUARY 1, 1991***

Public Employees Insurance Agency

Capitol Complex
Building 5
Room 506
Charleston
WV 25305
304-348-7390
FAX 304-558-3541

Gaston Caperton
Governor

Sally K. Richardson
Director

MEMORANDUM

TO: All Benefit Coordinators/Payroll Clerks
of State Agencies, Colleges and Universities,
and County Boards of Education

FROM: Sally K. Richardson SKR
Director

SUBJECT: Clarifications of PEIA Summary Plan Description
and new procedures

DATE: December 14, 1990

The purpose of this memorandum is two-fold. First, you will find as enclosures:

1. Agency premium rate schedule effective January 1, 1991.

2. Employee premium rate schedule which is also to be used to code the annual salary and annual out-of-pocket maximum.

3. Guide for revising existing enrollment and change-in-status cards, and a form which is to be completed and forwarded with the appropriate card to the PEIA for all insureds with an effective date of coverage of January 1, 1991 or after.

4. Revised guidelines for Earned Extension of Insurance Coverage (sick and annual leave), effective January 1, 1991. These guidelines will apply to two eligible retirees married to each other.

Second, you will find either additional explanations or clarification of data provided in the PEIA Summary Plan Description which is effective on January 1, 1991.

Employee Premium Rate: A change has been made in the base for calculating employee monthly premium rates and out-of-pocket maximums. For two eligible employees married to each other, the rate will be based on the higher of their two salaries.

Agency Premium Rate: This rate has been revised to compensate for the number of insureds who will change from family to individual coverage. It is essential to the balance of the PEIA financial plan that all the projected state revenue be captured

in premiums even with employee status changes. Most agencies' overall premium amounts should be close to the original amount budgeted. Adjustments will be made if actuarial projections of required rates do not materialize.

Salary To Be Used For Monthly Premium and Annual Out-of-pocket Maximum: The salary to be used as a base should be an annualized salary based on the latest monthly figure available, and is **not** to include incidentals such as yearly increment, overtime, additional functions (i.e., coaches, extra curricular activities) etc.

Pre-existing Condition Limitations: Those employees who are re-enrolling because of the change in the benefit plan will not be subject to pre-existing condition limitations because this re-enrollment has not caused any lapse in coverage. This re-enrollment process does not change the insured's effective date of coverage if he or she has had continuous coverage with the PEIA.

The pre-existing condition limitations clause stated in the Summary Plan Description will apply, however, to employees and/or family members who are NEW enrollees in the Plan or have had a lapse of coverage and are coming back into the Plan.

COBRA Insureds: Income differentials for premium and out-of-pocket maximum will not apply to COBRA insureds. Insureds who continue their health insurance coverage with PEIA will be required to pay an additional $20.00 for child(ren) only, or $40.00 for a full family plan and a $1,000.00 annual out-of-pocket maximum will be applied.

Dependent Status For a Retiree: An active employee who carries an eligible retiree on his/her plan as a dependent will have an annual out-of-pocket maximum based only on the salary of the active employee.

Dependent Status For a Non-State Employee: An active employee of a State Agency, college or university, or County Board of Education who enrolls an employee of a county commission, city or town, or other non-state agency as an eligible dependent will be required to pay the annual out-of-pocket maximum based on the higher of the two salaries.

Plan Status: Two enrollees, one with the Family Plan and the other with Life Insurance only, will be allowed to exchange coverages on January 1 of each year only, unless there are extenuating circumstances such as loss of employment, death or divorce, etc.

Employees Covered by Health Maintenance Organizations (HMO): The agency will be required to pay the difference between the HMO rate and the November 1 premium rate to the PEIA. HMO-covered employees are NOT required to pay any additional premium themselves.

HMO-covered employees do not have to re-enroll at this time, but will be asked to do so at a later date.

Re-enrollment/Verification of Data: Data provided by insureds during this period for implementation of the new Health Benefit Plan on January 1, 1991, is being accepted subject to verification at a later date.

Plan Changes: Two eligible employees married to each other who choose single plans will be required to meet two annual out-of-pocket maximums.

Section 125 Plan: For State employees, the PEIA and the Auditor's Office implemented the State of West Virginia Employees Section 125 Plan on October 1, 1990. This plan allows employees to pay PEIA health and life premiums before taxes are calculated on their salaries, if they did not opt out before October 1, 1990. Employees who will begin paying premiums for the first time on January 1, 1991, must be identified on the master payroll change sheets which are sent to the Auditor's office. Those employees who are no longer required to pay a premium must also be identified.

The PEIA is in the process of selecting an Administrator to put in place an expanded Section 125 Plan beginning March 1, 1991. This Plan will allow employees to pay for dental, vision, dependent care, and deductibles and co-payments with pre-tax dollars. More information will be provided as it becomes available.

Earned Extension of Insurance Coverage (Sick and Annual Leave): Effective January 1, 1991, two eligible retired employees who are married to each other may elect to combine their accrued annual and/or sick leave credits toward one family plan with the other retiree electing to continue "life insurance only" coverage. The "life only" coverage will require a monthly payment of the $1.00 or $2.00 premium. Accrued leave will only apply toward health insurance.

Should the retiree who has the family plan die, only the credits or remaining credits earned by the survivor will be available for use in continuing a single or family plan. In other words, no individual may use more credits than he or she earned. Combined credits may only be used if both retired employees are living.

Thank you for your attention to these matters. This insurance program is changing quickly, and your continued support and cooperation are greatly appreciated! If you need further clarification of any of these issues, please contact the PEIA office at 348-7850.

SKR:DE:JEL

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC INSURANCE RATE SCHEDULE FOR ACTIVE EMPLOYEES FOR
STATE AGENCIES, COLLEGES AND UNIVERSITIES, AND
COUNTY BOARDS OF EDUCATION

	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	AGENCY PREMIUM
EMPLOYEES UNDER AGE OF 65: AMOUNT OF LIFE INSURANCE $10,000.00	AS	EMPLOYEE ONLY	$182.00
	ASC	EMPLOYEE WITH CHILD(REN) ONLY	$293.00
	AF	EMPLOYEE WITH SPOUSE, AND CHILD(REN)	$404.00
	AFX	EMPLOYEE WITH EMPLOYEE SPOUSE, NO CHILD(REN)	$359.00
	AFP	EMPLOYEE WITH EMPLOYEE SPOUSE, WITH CHILD(REN)	$404.00
	LA	LIFE INSURANCE ONLY - EMPLOYEE COVERED AS DEPENDENT UNDER SPOUSE'S AFX/AFP COVERAGE FOR MEDICAL BENEFITS	$4.34
	LAD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$4.34
	MS	LIFE INSURANCE ONLY - HMO SINGLE	$4.34
	MF	LIFE INSURANCE ONLY - HMO FAMILY	$4.34
EMPLOYEES AGES 65 THRU 69 AMOUNT OF LIFE INSURANCE $6,500.00	BS	EMPLOYEE ONLY	$181.00
	BSC	EMPLOYEE WITH CHILD(REN) ONLY	$292.00
	BF	EMPLOYEE WITH SPOUSE, AND CHILD(REN)	$403.00
	BFX	EMPLOYEE WITH EMPLOYEE SPOUSE, NO CHILD(REN)	$358.00
	BFP	EMPLOYEE WITH EMPLOYEE SPOUSE, WITH CHILD(REN)	$403.00
	LB	LIFE INSURANCE ONLY - EMPLOYEE COVERED AS DEPENDENT UNDER SPOUSE'S BFX/BFP COVERAGE FOR MEDICAL BENEFITS	$2.82
	LBD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$2.82
	MA	LIFE INSURANCE ONLY - HMO SINGLE	$2.82
	MB	LIFE INSURANCE ONLY - HMO FAMILY	$2.82
EMPLOYEES AGES 70 AND OLDER AMOUNT OF LIFE INSURANCE $5,000.00	CS	EMPLOYEE ONLY	$180.00
	CSC	EMPLOYEE WITH CHILD(REN) ONLY	$291.00
	CF	EMPLOYEE WITH SPOUSE, AND CHILD(REN)	$402.00
	CFX	EMPLOYEE WITH EMPLOYEE SPOUSE, NO CHILD(REN)	$357.00
	CFP	EMPLOYEE WITH EMPLOYEE SPOUSE, WITH CHILD(REN)	$402.00
	LD	LIFE INSURANCE ONLY - EMPLOYEE COVERED AS DEPENDENT UNDER SPOUSE'S CFX/CFP COVERAGE FOR MEDICAL BENEFITS	$2.17
	LDD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$2.17
	MC	LIFE INSURANCE ONLY - HMO SINGLE	$2.17
	MD	LIFE INSURANCE ONLY - HMO FAMILY	$2.17

EFFECTIVE DATE OF RATE SCHEDULE: JANUARY 1, 1991

BASIC PLAN RATE SCHEDULE FOR RETIREES

	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
RETIREE UNDER AGE 65	GSPN	SINGLE COVERAGE	$119.00
AMOUNT OF LIFE INSURANCE	GSAM1	SINGLE COVERAGE WITH MEDICARE	$42.00
$5,000.00	GSBPN*	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$117.00
	GSCM1*	SINGLE COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM	$40.00
*AMOUNT OF LIFE	GFPN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$238.00
INSURANCE $10,000.00	GFAM1	FAMILY COVERAGE WITH MEDICARE AND DEPENDENT(S) UNDER AGE 65	$164.00
	GFBPN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$236.00
	GFCM1*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	GWPN	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$151.00
	GWAM1	FAMILY COVERAGE WITH MEDICARE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$69.00
	GWBPN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$149.00
	GWCM1*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$67.00
	LG	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$2.00
	LGB*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	---
	LGD	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$2.00
	LGE*	LIFE INSURANCE COVERAGE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	---
RETIREE AGE 65-66	HSM1	SINGLE COVERAGE	$42.00
AMOUNT OF LIFE	HSBM1	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$40.00
INSURANCE $5,000.00	HFM1	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER , OR ON MEDICARE	$69.00
	HFBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER , OR ON MEDICARE	$67.00
	HWPN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$164.00
	HWBPN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	LH	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$2.00
	LHB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	---
	LHD	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$2.00
	LHE	LIFE INSURANCE COVERAGE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	---
RETIREE AGE 67 OR OVER	ISM1	SINGLE COVERAGE	$41.00
AMOUNT OF LIFE INSURANCE	ISBM1	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$40.00
$2,500.00	IFM1	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER , OR ON MEDICARE	$68.00
	IFBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER , OR ON MEDICARE	$67.00
	IWPN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$163.00
	IWBPN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	LI	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$1.00
	LIB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	---
	LID	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$1.00
	LIE	LIFE INSURANCE COVERAGE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	---
RETIREE ANY AGE	ZSPN	SINGLE COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$117.00
HEALTH INSURANCE ONLY	ZSAM1	SINGLE COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$40.00
	ZFPN	FAMILY COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$236.00
	ZFAM1	FAMILY COVERAGE - RETIREE MEDICARE AND DEPENDENT NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$162.00
	ZWPN	FAMILY COVERAGE - RETIREE NON-MEDICARE AND DEPENDENT MEDICARE - NO LIFE INSURANCE BENEFITS	$149.00
	ZWAM1	FAMILY COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$67.00

ATASTROPHIC PLAN RATE SCHEDULE FOR RETIREES

	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTROPHIC PLAN
ETIREE UNDER AGE 65	GSCN	SINGLE COVERAGE	$91.00
MOUNT OF LIFE INSURANCE	GSAM2	SINGLE COVERAGE WITH MEDICARE	$30.00
5,000.00	GSBCN*	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$89.00
	GSCM2*	SINGLE COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM	$28.00
AMOUNT OF LIFE	GFCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$176.00
NSURANCE $10,000.00	GFAM2	FAMILY COVERAGE WITH MEDICARE AND DEPENDENT(S) UNDER AGE 65	$149.00
	GFBCN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$174.00
	GFCM2*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	GWCN	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$111.00
	GWAM2	FAMILY COVERAGE WITH MEDICARE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$49.00
	GWBCN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$109.00
	GWCM2*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$47.00
	LG	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$2.00
	LGB*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	---
	LGD	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$2.00
	LGE*	LIFE INSURANCE COVERAGE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	---
ETIREE AGE 65-66	HSM2	SINGLE COVERAGE	$30.00
MOUNT OF LIFE	HSBM2	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$28.00
NSURANCE $5,000.00	HFM2	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER , OR ON MEDICARE	$49.00
	HFBM2	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER , OR ON MEDICARE	$47.00
	HWCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$149.00
	HWBCN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	LH	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$2.00
	LHB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	---
	LHD	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$2.00
	LHE	LIFE INSURANCE COVERAGE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	---
ETIREE AGE 67 OR OVER	ISM2	SINGLE COVERAGE	$29.00
MOUNT OF LIFE INSURANCE	ISBM2	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$28.00
2,500.00	IFM2	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER , OR ON MEDICARE	$48.00
	IFBM2	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER , OR ON MEDICARE	$47.00
	IWCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$148.00
	IWBCN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	LI	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$1.00
	LIB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	---
	LID	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$1.00
	LIE	LIFE INSURANCE COVERAGE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	---
ETIREE ANY AGE	ZSCN	SINGLE COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$89.00
EALTH INSURANCE ONLY	ZSAM2	SINGLE COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$28.00
	ZFCN	FAMILY COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$174.00
	ZFAM2	FAMILY COVERAGE - RETIREE MEDICARE AND DEPENDENT NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$147.00
	ZWCN	FAMILY COVERAGE - RETIREE NON-MEDICARE AND DEPENDENT MEDICARE - NO LIFE INSURANCE BENEFITS	$109.00
	ZWAM2	FAMILY COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$47.00

BASIC PLAN SURVIVING DEPENDENT RATE SCHEDULE

WS	SURVIVING SPOUSE UNDER AGE 65	$178.00
WOM1	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$162.00
WMM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$40.00
WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$289.00
WXM1	SURVIVING SPOUSE OVER AGE 65	$40.00
WMM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$162.00
YS	SURVIVING CHILD/NO PARENT	$178.00
YF	SURVIVING CHILDREN/NO PARENT	$289.00

CATASTROPHIC SURVIVING DEPENDENT RATE SCHEDULE

WS	SURVIVING SPOUSE UNDER AGE 65	$178.00
WOM2	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$147.00
WMM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$28.00
WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$289.00
WXM2	SURVIVING SPOUSE OVER AGE 65	$28.00
WMM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$147.00
YS	SURVIVING CHILD/NO PARENT	$178.00
YF	SURVIVING CHILDREN/NO PARENT	$289.00

OBRA RATE SCHEDULE

CES	COBRA EMPLOYEE - SINGLE COVERAGE	$181.00
CESC	COBRA EMPLOYEE - WITH CHILD(REN) ONLY	$315.00
CEF	COBRA EMPLOYEE - FAMILY COVERAGE	$449.00
CDS	COBRA DEPENDENT - SINGLE COVERAGE	$181.00
CDSC	COBRA DEPENDENT - WITH CHILD(REN) ONLY	$315.00
CDF	COBRA DEPENDENT - FAMILY COVERAGE	$449.00
CSD	COBRA EMPLOYEE - SINGLE DISABLED	$181.00
CSDC	COBRA EMPLOYEE - DISABLED - WITH CHILD(REN) ONLY	$315.00
CFD	COBRA EMPLOYEE - FAMILY DISABLED	$449.00

Monthly Premiums

Index Code	Annual Salary	Type of Family: Child(ren) Only	Type of Family: Full Family	Annual Out-of Pocket Maximum	Benefit Code
01	$ 0 to $ 8,000	$10.66	$21.32	$ 750	A1
02	8,001 to 8,500	11.00	22.00	750	A1
03	8,501 to 9,000	11.67	23.33	750	A1
04	9,001 to 9,500	12.33	24.67	750	A1
05	9,501 to 10,000	13.00	26.00	750	A1
06	10,001 to 10,500	13.67	27.33	750	A1
07	10,501 to 11,000	14.33	28.67	750	A1
08	11,001 to 11,500	15.00	30.00	750	A1
09	11,501 to 12,000	15.67	31.33	750	A1
10	12,001 to 12,500	16.33	32.67	750	A1
11	12,501 to 13,000	17.00	34.00	750	A1
12	13,001 to 13,500	17.67	35.33	750	A1
13	13,501 to 14,000	18.33	36.67	750	A1
14	14,001 to 14,500	19.00	38.00	750	A1
15	14,501 to 15,000	19.67	39.33	750	A1
16	15,001 to 30,000	20.00	40.00	1,000	A2
17	30,001 to 30,500	20.17	40.33	1,250	A3
18	30,501 to 31,000	20.50	41.00	1,250	A3

Monthly Premiums
Page Two

19	31,001 to	31,500	20.83	41.67	1,250	A3
20	**31,501 to**	**32,000**	**21.17**	**42.33**	**1,250**	**A3**
21	32,001 to	32,500	21.50	43.00	1,250	A3
22	**32,501 to**	**33,000**	**21.83**	**43.67**	**1,250**	**A3**
23	33,001 to	33,500	22.17	44.33	1,250	A3
24	**33,501 to**	**34,000**	**22.50**	**45.00**	**1,250**	**A3**
25	34,001 to	34,500	22.83	45.67	1,250	A3
26	**34,501 to**	**35,000**	**23.17**	**46.33**	**1,250**	**A3**
27	35,001 to	35,500	23.50	47.00	1,250	A3
28	**35,501 to**	**36,000**	**23.83**	**47.67**	**1,250**	**A3**
29	36,001 to	36,500	24.17	48.33	1,250	A3
30	**36,501 to**	**37,000**	**24.50**	**49.00**	**1,250**	**A3**
31	37,001 to	37,500	24.83	49.67	1,250	A3
32	**37,501 to**	**38,000**	**25.17**	**50.33**	**1,250**	**A3**
33	38,001 to	38,500	25.50	51.00	1,250	A3
34	**38,501 to**	**39,000**	**25.85**	**51.67**	**1,250**	**A3**
35	39,001 to	39,500	26.17	52.33	1,250	A3
36	**39,501 to**	**40,000**	**26.50**	**53.00**	**1,250**	**A3**
37	40,001 to	40,500	26.83	53.67	1,500	A4
38	**40,501 to**	**41,000**	**27.17**	**54.33**	**1,500**	**A4**
39	41,001 to	41,500	27.50	55.00	1,500	A4
40	**41,501 to**	**42,000**	**27.83**	**55.67**	**1,500**	**A4**
41	42,001 to	42,500	28.17	56.33	1,500	A4

42	42,501 to	43,000	28.50	57.00	1,500	A4
43	43,001 to	43,500	28.83	57.67	1,500	A4
44	43,501 to	44,000	29.17	58.33	1,500	A4
45	44,001 to	44,500	29.50	59.00	1,500	A4
46	44,501 to	45,000	29.83	59.67	1,500	A4
47	45,001 to	45,500	30.17	60.33	1,500	A4
48	45,501 to	46,000	30.50	61.00	1,500	A4
49	46,001 to	46,500	30.83	61.67	1,500	A4
50	46,501 to	47,000	31.17	62.33	1,500	A4
51	47,001 to	47,500	31.50	63.00	1,500	A4
52	47,501 to	48,000	31.83	63.67	1,500	A4
53	48,001 to	48,500	32.17	64.33	1,500	A4
54	48,501 to	49,000	32.50	65.00	1,500	A4
55	49,001 to	49,500	32.83	65.67	1,500	A4
56	49,501 to	50,000	33.17	66.33	1,500	A4
57	50,001 and above		33.33	66.66	1,500	A4

KM/de
E:\MONPREM

INSTRUCTIONS FOR COMPLETING THE REVISED ENROLLMENT CARD

The current stock of the existing enrollment and change-in-status cards are to be revised to add:

1) Benefit Code

2) Index Code (See attached examples)

Coding is to be completed by the Benefits Coordinator/Payroll Clerk, and the codes:

1) **Coverage code** is the code to be taken from the basic insurance rate schedule based on the option selected by the employee (i.e., ASC Employee with children, no spouse).

2) **Benefit code** is the code to be taken from the monthly premium enclosure and is based on the annual salary of the insured (i.e., annual salary is $30,001 - $30,500 and the benefit code is A3).

3) **Index code** is also taken from the monthly premium enclosure and based on the annual salary of the insured (i.e., annual salary is $30,001 - $30,500 and the type of family is "full family" the index code is 17).

In addition, the employee is to complete and sign the enrollment form which is also enclosed.

DE/th
WP:\INSTRUCT.D14

STATE OF WEST VIRGINIA
PUBLIC EMPLOYEES INSURANCE AGENCY

(1) _____ AGENCY NAME

(2) _____ ACCOUNT NUMBER

(3) EMPLOYEE'S NAME _____ LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL

(4) SS NO _____

(5) SEX: __ MALE __ FEMALE

(6) HOME ADDRESS: _____

(7) CITY OR TOWN _____

(8) ZIP CODE: _____

(9) HOME PHONE: _____

(10) BUS PHONE: _____

(11) JOB TITLE: _____

(12) NO. HOURS WEEK WORKED: _____

(13) EMPLOYEE BIRTH DATE: _____

(14) SPOUSE BIRTH DATE: _____

(15) DATE OF EMPLOYMENT: _____

(16) EMPLOYEE EFFECTIVE DATE: _____

(17) DEPENDENT EFFECTIVE DATE: _____

(18) COVERAGE CODE: _____

Benefit Code____

Index Code ____

(19) DO YOU WISH TO ENROLL YOUR ELIGIBLE DEPENDENTS? NO _____ YES _____ (IF YES, LIST DEPENDENTS ON SIDE B)

(20) WERE YOU PREVIOUSLY INSURED AS AN EMPLOYEE UNDER THIS INSURANCE PLAN? NO ____ YES ____ AGENCY _____ TERM DATE _____

(21) SPOUSE S.S. NO. _____

(22) IS SPOUSE CURRENTLY INSURED AS AN EMPLOYEE UNDER THIS INSURANCE PLAN? NO ____ YES ____ ACCT. NO. _____

(23) ☐ THE BENEFITS HAVE BEEN EXPLAINED TO ME, AND I REFUSE TO PARTICIPATE

(24) ☐ THE BENEFITS HAVE BEEN EXPLAINED TO ME, AND I HEREBY ACCEPT THE FORMS OF GROUP COVERAGE, AND AUTHORIZE PAYROLL DEDUCTION FOR MY CONTRIBUTION UNTIL REVOKED BY ME IN WRITING.

(25) _____ DATE SIGNED

(26) _____ SIGNATURE OF EMPLOYEE

SIDE A

CHANGE-IN-STATUS CARD
CHANGE-IN-STATUS FOR THE PUBLIC EMPLOYEES INSURANCE PROGRAM

EMPLOYEE'S NAME _____ S.S. _____
LAST NAME FIRST NAME MIDDLE INITIAL

ADDRESS _____ ZIP CODE _____

☐ ADD The following Dependents to my coverage
** ☐ **REMOVE ** SEE REVERSE SIDE OF CARD IF REMOVING DEPENDENTS**
☐ Change my name to: _____

Reasons for Removal:
☐ DIVORCE/LEGAL SEPARATION — DATE _____
☐ DECEASED — DATE _____
☐ OTHER _____

FULL NAME OF DEPENDENT TO BE ADDED/REMOVED	SOCIAL SECURITY #	DATE OF BIRTH MO	DAY	YEAR	RELATIONSHIP	DATE OF MARRIAGE MO	DAY	YEAR
						DATE OF CHILD IN YOUR HOME MO	DAY	YEAR

As a part of this request, I certify that all statements are true and correct If statements are untrue, I understand the addition of dependents to my present coverage will be invalid

_____
SIGNATURE DATE

THIS SECTION TO BE COMPLETED BY THE INSURANCE COORDINATOR OR PAYROLL CLERK

Account Number	Effective Date of Change	New Coverage Code	New Premium Employer's Share	First Month New Premium Will be Deducted
		Benefit Code ___ Index Code ___		

WVBEIB 1-87

PEIA Enrollment Form

This form is to be used in conjunction with the existing PEIA enrollment and change-in-status cards for enrollments and changes in the insurance plan.

Employee's Name _____ Date _____

Social Security Number _____ Account Number _____

Payroll Location _____

PEIA offers several benefit options for active employees. This form provides you the opportunity to select the benefit option which is best for you. Please complete all requested information and return this form to your payroll location.

Please mark one of the following:

1. Eligible single employee ____
2. Eligible employees married to each other ____
3. Eligible employee with dependent child(ren) ____
4. Eligible employees married to each other with dependent child(ren) ____
5. Eligible employee with full family coverage ____

If option 2 or 4 was chosen, complete the following:

Spouse's agency/employer name _____

Payroll location number _____

Spouse's Social Security Number _____-_____-_____

Please enter the following information for each dependent, regardless of the option chosen above:

Dependent Name (last, first, middle)	Birth Date	Rel Code*	Social Sec. Number	Other Insurance Company

*Rel Code: Relationship code. Please enter "S" for spouse and/or "C" for child.

Signed: _____ Date: _____

Routing: Copy 1 to PEIA; Copy 2 to Payroll Location; Copy 3 to Employee

PEIAENR 1/91

REVISED GUIDELINES

EFFECTIVE JANUARY 1, 1991

Earned Extension of Insurance Coverage (Sick and Annual Leave)

Effective January 1, 1991, two eligible retired employees who are married to each other may elect to combine their accrued annual and/or sick leave credits toward one family plan with the other retiree electing to continue "life insurance only" coverage by paying the monthly life insurance premium. Accrued leave will apply toward health insurance only.

Should the retiree who has the family plan die, only the credits or remaining credits earned by the survivor will be available for use in continuing a single or family plan. In other words, no individual may use more credits than he or she earned. Combined credits may only be used if both retired employees are living.

State and Board of Education Retired Employees:

An active employee who elects to participate in the PEIA Benefit Plan prior to July 1, 1988, who voluntarily retires, or is compelled or required by law to retire before age 65, is eligible to receive credit towards his/her health and/or life insurance benefits. Only that portion of sick and annual leave for which the employee has not been reimbursed at the time of retirement is eligible to be applied to the extension of insurance coverage. Credit will be calculated as follows:

2 days of accrued leave = 1 month of Single Plan Coverage
3 days of accrued leave = 1 month of Family Plan Coverage

Partial months are not acceptable.

When a new employee who elects to participate in the PEIA benefit plan on or after July 1, 1988, voluntarily retires, or is compelled or required by law to retire before reaching age 65, he/she is eligible to receive credit toward group health and/or life insurance benefits. Only that portion of sick and annual leave for which the employee has not been reimbursed at the time of retirement, is eligible to be applied to the extension of insurance coverage. Fifty-percent of the premium for each month's coverage must be paid by the member. An employee who has been a participant under spouse or dependent coverage, and who reenters the plan within twelve months after termination of his or her prior coverage, shall be considered to have elected to participate in the plan as of the date of commencement of the prior coverage.
Credit will be calculated as follows:

2 days of accrued leave = 50% of the premium for 1 month Single Plan Coverage
3 days of accrued leave = 50% of the premium for 1 month Family Plan Coverage

Higher Education Retired Employees:

When an active employee, who is a higher education full-time faculty member, employed on an annual contract basis other than for twelve (12) months, voluntarily retires and/or is compelled or required by law to retiree before age 65, he/she is eligible to receive credit toward health and/or life insurance benefits based on years of teaching service.
Credit will be calculated as follows:

3 1/3 years of teaching service = 1 year Single Plan Coverage
5 years of teaching service = 1 year Family Plan Coverage

Elected public officials are not entitled to any sick, annual and personal leave accumulation as it pertains to extended insurance coverage.

Deferred Retirement:

A participating employee with a minimum of five years vested service, who leaves state employment after November 1, 1988, but does not immediately become a member of a state retirement system, is not entitled to apply unpaid accrued sick and annual leave toward extension of coverage.

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

October 30, 1990

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Rate Schedule notebook a copy of a memorandum to All Benefit Coordinators/Payroll Clerks, dated October 26, 1990, entitled "Revised Premium Rate Schedule."

Enclosed with the memorandum are revised premium rate schedules effective November 1, 1990. The revisions reflect a reduction in rates originally planned for implementation on November 1, due to a reduction in the PEIA's actuary's estimate of projected claims costs for the current fiscal year.

Thank you for your attention to this request.

Sincerely,

Sally K. Richardson /by DPC

Sally K. Richardson
Director

SKR:trs

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston
WV 25305
304-348-7850
FAX 304-347-0511

Gaston Caperton
Governor

Sally K. Richardson
Director

M E M O R A N D U M

TO: All Benefit Coordinators/Payroll Clerks

FROM: Sally K. Richardson SKR
Director

SUBJECT: Revised Premium Rate Schedule

DATE: October 26, 1990

Please find attached a revised premium rate schedule for retirees, surviving dependents and COBRA insureds to become effective November 1, 1990.

Please destroy previous retiree, surviving dependent and COBRA insured premium rate schedule to become effective November 1, 1990.

Thank you for your assistance. If you have any questions, please let me know.

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Attachment

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for All Retirees,
Surviving Dependents and COBRA

Basic Rate Schedule for Retirees

	Code	Explanation of Coverage Code	Total Premium
RETIREE UNDER AGE 65	GS	Single Coverage	$123.00
AMOUNT OF LIFE INSURANCE	GSA	Single Coverage with Medicare	46.00
$5,000.00	GSB*	Single Coverage with Waiver of Premium	121.00
	GSC*	Single Coverage with Medicare and Waiver of Premium	44.00
*AMOUNT OF LIFE	GF	Family Coverage with dependent(s) under age 65	246.00
INSURANCE $10,000.00	GFA	Family Coverage with Medicare and dependent(s) under age 65	169.00
	GFB*	Family Coverage with Waiver of Premium and dependent(s) under age 65	244.00
	GFC*	Family Coverage with Medicare and Waiver of Premium and dependent(s) under age 65	167.00
	GW	Family Coverage with dependent(s) age 65 or over, or on Medicare	169.00
	GWA	Family Coverage with Medicare with dependent(s) age 65 or over, or on Medicare	76.00
	GWB*	Family Coverage with Waiver of Premium and dependent(s) age 65 or over, or on Medicare	167.00
	GWC*	Family Coverage with Medicare and Waiver of Premium and dependent(s) age 65 or over, or on Medicare	74.00
	LC	Life Insurance Only - Must be covered as dependent under spouse's PEIA coverage for medical benefits	2.00
	LCB*	Life Insurance only - Waiver of Premium - must be covered under spouse's PEIA coverage for medical benefits	0.00
	LCD	Life Insurance Only - No Medical Benefits	2.00
	LCE*	Life Insurance Only - Waiver of Premium - No Medical Benefits	0.00

EFFECTIVE DATE OF REVISED RATE SCHEDULE: NOVEMBER 1, 1990

A:\RATESACT/th
REVISED: October 26, 1990

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for All Retirees,
Surviving Dependents, and COBRA

Basic Rate Schedule for Retirees

	Code	Explanation of Coverage Code	Total Premium
RETIREE AGE 65-66	HS	Single Coverage	$ 46.00
AMOUNT OF LIFE	HSB	Single Coverage with Waiver of Premium	44.00
INSURANCE $5,000.00	HF	Family Coverage with dependent(s) age 65 or over, or on Medicare	76.00
	HFB	Family Coverage with Waiver of Premium and dependent(s) age 65 or over, or on Medicare	74.00
	HW	Family Coverage with dependent(s) under age 65	169.00
	HWB	Family Coverage with Waiver of Premium and dependent(s) under age 65	167.00
	LH	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits	2.00
	LHD	Life Insurance Only - no medical benefits	2.00
	LHB	Life Insurance Only - Waiver of Premium and must be covered as dependent under spouse's PEIA coverage for medical benefits	0.00
	LHE	Life Insurance Only - Waiver of Premium and No Medical Benefits	0.00
RETIREE AGE 67 OR OVER	IS	Single Coverage	45.00
AMOUNT OF LIFE INSURANCE	ISB	Single Coverage with Waiver of premium	43.00
$2,500.00	IF	Family Coverage with dependent(s) age 65 or over, or on Medicare	75.00
	IFB	Family Coverage with waiver of premium and dependent(s) age 65 or over, or on Medicare	74.00
	IW	Family Coverage with dependent(s) under age 65	168.00
	IWB	Family Coverage with waiver of premium and dependent(s) under age 65	167.00
	LI	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits	1.00
	LID	Life Insurance Only - no medical benefits	1.00
	LIB	Life Insurance Only - waiver of premium, must be covered as dependent under spouse's PEIA Coverage for medical benefits	0.00
	LIE	Life Insurance Only - waiver of premium and no medical benefits	0.00
RETIREE ANY AGE	ZS	Single Coverage - Non-Medicare - no life insurance benefits	121.00
HEALTH INSURANCE ONLY	ZSA	Single Coverage - Medicare - no life insurance benefits	44.00
	ZF	Family Coverage - Non-Medicare - no life insurance benefits	244.00
	ZFA	Family Coverage - Retiree Medicare and dependent non-Medicare - no life insurance benefits	167.00
	ZW	Family Coverage - Retiree non-Medicare and dependent Medicare, no life insurance benefits	167.00
	ZWA	Family Coverage - Medicare - no life insurance benefits	74.00

EFFECTIVE DATE OF REVISED RATE SCHEDULE: NOVEMBER 1, 1990

[redacted]:\RATESRET/th
REVISED: October 26, 1990

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for All Retirees,
Surviving Dependents and COBRA

SURVIVING DEPENDENT RATE SCHEDULE

WS	Surviving Spouse under age 65	$164.00
WO	Surviving spouse over age 65 with dependent child(ren)	167.00
WW	Surviving Spouse under age 65 on Medicare	44.00
WF	Surviving Spouse under age 65 with dependent child(ren)	349.00
WX	Surviving spouse over age 65	44.00
WM	Surviving Spouse under age 65 on Medicare with dependent child(ren)	167.00
YS	Surviving child/No parent	164.00
YF	Surviving children/No parent	349.00

COBRA RATE SCHEDULE

CES	COBRA Employee - Single Coverage	$167.00
CEF	COBRA Employee - Family Coverage	356.00
CDS	COBRA Dependent - Single Coverage	167.00
CDF	COBRA Dependent - Family Coverage	356.00
CMO	COBRA - Health Maintenance Organization	0.00
CSD	COBRA Employee - Single Disabled	246.00
CFD	COBRA Employee - Family Disabled	523.00

EFFECTIVE DATE OF REVISED RATE SCHEDULE: NOVEMBER 1, 1990

N:\RATESRET/th
REVISED: October 26, 1990

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

September 26, 1990

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Rate Schedule notebook a copy of a memorandum to Agency Heads, dated October 1, 1990, entitled "Health Insurance Premium Rate Increase."

Enclosed with the memorandum are new rate schedules effective November 1, 1990.

Thank you for your attention to this request.

Sincerely,

Sally K Richardson

Sally K. Richardson
Director

SKR:DPL:trs

Enclosures

Public Employees Insurance Agency

Capitol Complex
Building
Fourth Floor
Charleston
WV 25305
304 348 7850
Fax 304 348 2571

Gaston Caperton
Governor

Sally K. Richardson
Director

M E M O R A N D U M

To: Agency Head

From: Sally K. Richardson SKR
Director

Subject: **Health Insurance Premium Rate Increase**

Date: October 1, 1990

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During the August Special Session of the Legislature, the continued underfunding of the Public Employees Insurance Agency was addressed in a very significant manner. The Governor, the Legislature and representatives of employee organizations collaborated to pass both a supplemental appropriation for the short term and a revision of the Agency's authority mandating long term fiscal responsibility.

A Finance Board was created within the Agency which represents public employees, school personnel, and the public at large. The duty of this Board is to develop a financial plan which generates sufficient revenues to meet the total costs of the health insurance program. The plan will include:

a. the benefit design,
b. maximum levels of reimbursement to providers,
c. necessary cost containment measures,
d. levels of premium costs to employers and
e. types and levels of employee costs.

The responsibilities of the Board are mandatory and do not require the approval of the Legislature.

The first such plan will be completed by November 20, 1990 and will be implemented by the Agency on January 1, 1991. The plan for the 1992 Fiscal Year will be completed in the spring and implemented on July 1, 1991. Thereafter, the Board will modify plans on an annual basis, or as needed, to ensure that the Agency's expenditures do not exceed its financial resources.

The new law requires the Governor to provide an estimate of the total amount of general and special revenues which the State will make available to fund the Agency's health and basic life insurance programs for each fiscal year. The estimate for the current 1991 fiscal year

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includes an agency premium increase to provide a total of nearly $227,215,000 in PEIA general and special revenue funding.

Based on the Governor's estimate, the Legislature appropriated general revenues in the amount of $42,500,000 to provide the increased PEIA premium amounts for agencies and accounts funded from general revenues. Agencies and accounts funded with special revenues and non-state agencies are expected to provide the increased premium amounts from their revenues.

An August 1990 Ernst & Young Actuarial Study of the PEIA showed that health claims expenditures were exceeding revenues by approximately 50%. This Study estimated the PEIA's total 1991 revenue requirements at $298,000,000 (including the 1990 claims backlog). The new premiums, therefore, assume that the Finance Board's 1991 plan will produce an additional 30 to 35 million dollar savings either through cost reductions and/or increased employee contributions.

The schedule of new premium rates is attached. You will note that it includes a substantial increase in retired employee rates. Since these rates do not cover the actual costs incurred by the retired employees, one Finance Board goal must be to determine the most equitable options for the State's retired employees for 1992 and beyond.

The non-state agency rates have been established at the same level as the state agency rates for an interim period. Their actuarially-determined costs are much higher than the other branches of the program, but this interim rate will give the Finance Board time to consider more cost effective program alternatives for the non-state agencies.

Finally, in order not to change State, College and University, and County Board of Education employee costs prior to the development of the new financial plan by the Finance Board, the payment from those employees who are currently paying a 30%, 20%, or 10% portion of the premium rate will continue to be calculated at 30%, 20%, or 10% of the current rate that was put into effect on July 1, 1990. The premium billing for your agency reflects this calculation and employee premium deductions should not change. Your agency will not be billed for the uncollected difference between 30%, 20% or 10% of the old rate and the corresponding percentage of the new rate. The agency's portion of the premium will be billed at 70%, 80%, or 90% of the new rate for contributing employees and 100% of the new rate for non-contributing employees.

New State, College and University, and County Board of Education employees who enroll in the PEIA plan after November 1, 1990, will be billed for in the same manner as current participants.

If you have any questions, please let me know.

SKR/th
WP:\A:\NOVRATE.STA

cc: Payroll Clerk

Attachment

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees Of
State Agencies, Colleges and Universities, and County Boards of Education

			YEAR ONE		YEAR TWO		YEAR THREE & THEREAFTER		
	CODE	EXPLANATION OF COVERAGE CODE	30%* EMPLOYEE	70% AGENCY	20%* EMPLOYEE	80% AGENCY	10%* EMPLOYEE	90% AGENCY	100% TOTAL PREMIUM
EMPLOYEES UNDER	AS	Single Coverage	$ 31.80	$117.60	$21.20	$134.40	$10.60	$151.20	$168.00
AGE OF 65: AMOUNT OF	AF	Family Coverage	72.60	247.10	48.40	282.40	24.20	317.70	353.00
LIFE INSURANCE $10,000.00	LA	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits.	1.30	3.04	.88	3.46	.44	3.90	4.34
	LAD	Life Insurance Only - no medical benefits	1.30	3.04	.88	3.46	.44	3.90	4.34
	MS	Life Insurance Only-HMO Single	1.30	3.04	.88	3.46	.44	3.90	4.34
	MF	Life Insurance Only-HMO Family	1.30	3.04	.88	3.46	.44	3.90	4.34
EMPLOYEES AGES 65 THRU 69	BS	Single Coverage	$ 31.50	116.90	21.00	133.60	10.50	150.30	167.00
AMOUNT OF LIFE INSURANCE	BF	Family Coverage	$ 72.30	246.40	48.20	281.60	24.10	316.80	352.00
$6,500.00	LB	Life Insurance Only -must be covered as dependent under spouse's PEIA coverage for medical benefits	.86	1.96	.56	2.26	.28	2.54	2.82
	LBD	Life Insurance Only - no medical benefits	.86	1.96	.56	2.26	.28	2.54	2.82
	MA	Life Insurance Only-HMO Single	.86	1.96	.56	2.26	.28	2.54	2.82
	MB	Life Insurance Only-HMO Family	.86	1.96	.56	2.26	.28	2.54	2.82
EMPLOYEES AGES 70 AND OLDER	CS	Single Coverage	$ 31.20	116.20	20.80	132.80	10.40	149.40	166.00
AMOUUNT OF LIFE INSURANCE	CF	Family Coverage	$ 72.00	245.70	48.00	280.80	24.00	315.90	351.00
$5,000.00	LD	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits.	.66	1.51	.44	1.73	.22	1.95	2.17
	LDD	Life Insurance Only - no medical benefits	.66	1.51	.44	1.73	.22	1.95	2.17
	MC	Life Insurance Only-HMO Single	.66	1.51	.44	1.73	.22	1.95	2.17
	MD	Life Insurance Only-HMO Family	.66	1.51	.44	1.73	.22	1.95	2.17

*Employee contribution will remain at the July 1, 1990 amounts until changed by the PEIA Finance Board.

EFFECTIVE DATE OF REVISED RATE SCHEDULE: NOVEMBER 1, 1990

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West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees Of
State Agencies, Colleges and Universities, and County Boards of Education

Basic Rate Schedule for Retirees

	Code	Explanation of Coverage Code	Total Premium
RETIREE UNDER AGE 65	CS	Single Coverage	$125.00
AMOUNT OF LIFE INSURANCE	CSA	Single Coverage with Medicare	52.00
$5,000.00	CSB*	Single Coverage with Waiver of Premium	123.00
	CSC*	Single Coverage with Medicare and Waiver of Premium	49.00
*AMOUNT OF LIFE	CF	Family Coverage with dependent(s) under age 65	257.00
INSURANCE $10,000.00	CFA	Family Coverage with Medicare and dependent(s) under age 65	192.00
	CFB*	Family Coverage with Waiver of Premium and dependent(s) under age 65	255.00
	CFC*	Family Coverage with Medicare and Waiver of Premium and dependent(s) under age 65	190.00
	CW	Family Coverage with dependent(s) age 65 or over, or on Medicare	192.00
	CWA	Family Coverage with Medicare with dependent(s) age 65 or over, or on Medicare	86.00
	CWB*	Family Coverage with Waiver of Premium and dependent(s) age 65 or over, or on Medicare	190.00
	CWC*	Family Coverage with Medicare and Waiver of Premium and dependent(s) age 65 or over, or on Medicare	84.00
	LC	Life Insurance Only - Must be covered as dependent under spouse's PEIA coverage for medical benefits	2.00
	LCB*	Life Insurance only - Waiver of Premium - must be covered under spouse's PEIA coverage for medical benefits	0.00
	LCD	Life Insurance Only - No Medical Benefits	2.00
	LCE*	Life Insurance Only - Waiver of Premium - No Medical Benefits	0.00

EFFECTIVE DATE OF REVISED RATE SCHEDULE: NOVEMBER 1, 1990

A:\RATESACT/th

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees Of
State Agencies, Colleges and Universities, and County Boards of Education

Basic Rate Schedule for Retirees

	Code	Explanation of Coverage Code	Total Premium
RETIREE AGE 65-66	HS	Single Coverage	$ 52.00
AMOUNT OF LIFE	HSB	Single Coverage with Waiver of Premium	50.00
INSURANCE $5,000.00	HF	Family Coverage with dependent(s) age 65 or over, or on Medicare	86.00
	HFB	Family Coverage with Waiver of Premium and dependent(s) age 65 or over, or on Medicare	84.00
	HW	Family Coverage with dependent(s) under age 65	192.00
	HWB	Family Coverage with Waiver of Premium and dependent(s) under age 65	190.00
	LH	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits	2.00
	LHD	Life Insurance Only - no medical benefits	2.00
	LHB	Life Insurance Only - Waiver of Premium and must be covered as dependent under spouse's PEIA coverage for medical benefits	0.00
	LHE	Life Insurance Only - Waiver of Premium and No Medical Benefits	0.00
RETIREE AGE 67 OR OVER	IS	Single Coverage	51.00
AMOUNT OF LIFE INSURANCE	ISB	Single Coverage with Waiver of premium	50.00
$2,500.00	IF	Family Coverage with dependent(s) age 65 or over, or on Medicare	85.00
	IFB	Family Coverage with waiver of premium and dependent(s) age 65 or over, or on Medicare	84.00
	IW	Family Coverage with dependent(s) under age 65	191.00
	IWB	Family Coverage with waiver of premium and dependent(s) under age 65	190.00
	LI	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits	1.00
	LID	Life Insurance Only - no medical benefits	1.00
	LIB	Life Insurance Only - waiver of premium, must be covered as dependent under spouse's PEIA Coverage for medical benefits	0.00
	LIE	Life Insurance Only - waiver of premium and no medical benefits	0.00
RETIREE ANY AGE	ZS	Single Coverage - Non-Medicare - no life insurance benefits	123.00
HEALTH INSURANCE ONLY	ZSA	Single Coverage - Medicare - no life insurance benefits	50.00
	ZF	Family Coverage - Non-Medicare - no life insurance benefits	254.00
	ZFA	Family Coverage - Retiree Medicare and dependent non-Medicare - no life insurance benefits	190.00
	ZW	Family Coverage - Retiree non-Medicare and dependent Medicare, no life insurance benefits	190.00
	ZWA	Family Coverage - Medicare - no life insurance benefits	84.00

EFFECTIVE DATE OF REVISED RATE SCHEDULE: NOVEMBER 1, 1990

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West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees Of
State Agencies, Colleges and Universities, and County Boards of Education

SURVIVING DEPENDENT RATE SCHEDULE

WS	Surviving Spouse under age 65	164.00
WO	Surviving spouse over age 65 with dependent child(ren)	190.00
WW	Surviving Spouse under age 65 on Medicare	50.00
WF	Surviving Spouse under age 65 with dependent child(ren)	349.00
WX	Surviving spouse over age 65	50.00
WM	Surviving Spouse under age 65 on Medicare with dependent child(ren)	190.00
YS	Surviving child/No parent	164.00
YF	Surviving children/No parent	349.00

COBRA RATE SCHEDULE

CES	COBRA Employee - Single Coverage	$167.00
CEF	COBRA Employee - Family Coverage	356.00
CDS	COBRA Dependent - Single Coverage	167.00
CDF	COBRA Dependent - Family Coverage	356.00
CMO	COBRA - Health Maintenance Organization	0.00
CSD	COBRA Employee - Single Disabled	246.00
CFD	COBRA Employee - Family Disabled	523.00

EFFECTIVE DATE OF REVISED RATE SCHEDULE: NOVEMBER 1, 1990

A:\RATESRET/th

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees
of County Commissions, Municipalities and Other Political Subdivisions

	CODE	EXPLANATION OF COVERAGE CODES	TOTAL PREMIUM
EMPLOYEES UNDER AGE 65 AMOUNT OF LIFE INSURANCE $10,000.00	ASN	SINGLE COVERAGE	168.00
	AFN	FAMILY COVERAGE	353.00
	LA	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	4.34
	LAD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	4.34
	MS	LIFE INSURANCE ONLY - HMO SINGLE	4.34
	MF	LIFE INSURANCE ONLY - HMO FAMILY	4.34
EMPLOYEES AGES 65 THRU 69 AMOUNT OF LIFE INSURANCE $6,500.00	BSN	SINGLE COVERAGE	167.00
	BFN	FAMILY COVERAGE	352.00
	LB	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	2.82
	LBD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	2.82
	MA	LIFE INSURANCE ONLY - HMO SINGLE	2.82
	MB	LIFE INSURANCE ONLY - HMO FAMILY	2.82
EMPLOYEES AGES 70 OR OVER AMOUNT OF LIFE INSURANCE $5,000.00	CSN	SINGLE COVERAGE	166.00
	CFN	FAMILY COVERAGE	351.00
	LD	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	2.17
	LDD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	2.17
	MC	LIFE INSURANCE ONLY - HMO SINGLE	2.17
	MD	LIFE INSURANCE ONLY - HMO FAMILY	2.17

EFFECTIVE DATE OF REVISED RATE SCHEDULE: NOVEMBER 1, 1990

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West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees
of County Commissions, Municipalities and Other Political Subdivisions

Basic Rate Schedule for Retirees

	Code	Explanation of Coverage Code	Total Premium
RETIREE UNDER AGE 65	CS	Single Coverage	$125.00
AMOUNT OF LIFE INSURANCE	CSA	Single Coverage with Medicare	52.00
$5,000.00	CSB*	Single Coverage with Waiver of Premium	123.00
	CSC*	Single Coverage with Medicare and Waiver of Premium	49.00
*AMOUNT OF LIFE	CF	Family Coverage with dependent(s) under age 65	257.00
INSURANCE $10,000.00	CFA	Family Coverage with Medicare and dependent(s) under age 65	192.00
	CFB*	Family Coverage with Waiver of Premium and dependent(s) under age 65	255.00
	CFC*	Family Coverage with Medicare and Waiver of Premium and dependent(s) under age 65	190.00
	CW	Family Coverage with dependent(s) age 65 or over, or on Medicare	192.00
	CWA	Family Coverage with Medicare with dependent(s) age 65 or over, or on Medicare	86.00
	CWB*	Family Coverage with Waiver of Premium and dependent(s) age 65 or over, or on Medicare	190.00
	CWC*	Family Coverage with Medicare and Waiver of Premium and dependent(s) age 65 or over, or on Medicare	84.00
	LC	Life Insurance Only - Must be covered as dependent under spouse's PEIA coverage for medical benefits	2.00
	LCB*	Life Insurance only - Waiver of Premium - must be covered under spouse's PEIA coverage for medical benefits	0.00
	LCD	Life Insurance Only - No Medical Benefits	2.00
	LCE*	Life Insurance Only - Waiver of Premium - No Medical Benefits	0.00

EFFECTIVE DATE OF REVISED RATE SCHEDULE: NOVEMBER 1, 1990

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West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees
of County Commissions, Municipalities and Other Political Subdivisions

Basic Rate Schedule for Retirees

	Code	Explanation of Coverage Code	Total Premium
RETIREE AGE 65-66	HS	Single Coverage	$ 52.00
AMOUNT OF LIFE	HSB	Single Coverage with Waiver of Premium	50.00
INSURANCE $5,000.00	HF	Family Coverage with dependent(s) age 65 or over, or on Medicare	86.00
	HFB	Family Coverage with Waiver of Premium and dependent(s) age 65 or over, or on Medicare	84.00
	HW	Family Coverage with dependent(s) under age 65	192.00
	HWB	Family Coverage with Waiver of Premium and dependent(s) under age 65	190.00
	LH	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits	2.00
	LHD	Life Insurance Only - no medical benefits	2.00
	LHB	Life Insurance Only - Waiver of Premium and must be covered as dependent under spouse's PEIA coverage for medical benefits	0.00
	LHE	Life Insurance Only - Waiver of Premium and No Medical Benefits	0.00
RETIREE AGE 67 OR OVER	IS	Single Coverage	51.00
AMOUNT OF LIFE INSURANCE	ISB	Single Coverage with Waiver of premium	50.00
$2,500.00	IF	Family Coverage with dependent(s) age 65 or over, or on Medicare	85.00
	IFB	Family Coverage with waiver of premium and dependent(s) age 65 or over, or on Medicare	84.00
	IW	Family Coverage with dependent(s) under age 65	191.00
	IWB	Family Coverage with waiver of premium and dependent(s) under age 65	190.00
	LI	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits	1.00
	LID	Life Insurance Only - no medical benefits	1.00
	LIB	Life Insurance Only - waiver of premium, must be covered as dependent under spouse's PEIA Coverage for medical benefits	0.00
	LIE	Life Insurance Only - waiver of premium and no medical benefits	0.00
RETIREE ANY AGE	ZS	Single Coverage - Non-Medicare - no life insurance benefits	123.00
HEALTH INSURANCE ONLY	ZSA	Single Coverage - Medicare - no life insurance benefits	50.00
	ZF	Family Coverage - Non-Medicare - no life insurance benefits	254.00
	ZFA	Family Coverage - Retiree Medicare and dependent non-Medicare - no life insurance benefits	190.00
	ZW	Family Coverage - Retiree non-Medicare and dependent Medicare, no life insurance benefits	190.00
	ZWA	Family Coverage - Medicare - no life insurance benefits	84.00

EFFECTIVE DATE OF REVISED RATE SCHEDULE: NOVEMBER 1, 1990

A:\RATESRET.2/th

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees
of County Commissions, Municipalities and Other Political Subdivisions

SURVIVING DEPENDENT RATE SCHEDULE

WS	Surviving Spouse under age 65	164.00
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WW	Surviving Spouse under age 65 on Medicare	50.00
WF	Surviving Spouse under age 65 with dependent child(ren)	349.00
WX	Surviving spouse over age 65	50.00
WM	Surviving Spouse under age 65 on Medicare with dependent child(ren)	190.00
YS	Surviving child/No parent	164.00
YF	Surviving children/No parent	349.00

COBRA RATE SCHEDULE

CES	COBRA Employee - Single Coverage	$167.00
CEF	COBRA Employee - Family Coverage	356.00
CDS	COBRA Dependent - Single Coverage	167.00
CDF	COBRA Dependent - Family Coverage	356.00
CMO	COBRA - Health Maintenance Organization	0.00
CSD	COBRA Employee - Single Disabled	246.00
CFD	COBRA Employee - Family Disabled	523.00

EFFECTIVE DATE OF REVISED RATE SCHEDULE: NOVEMBER 1, 1990

A:\RATESRET.2/th

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

September 26, 1990

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Benefit Plan Document notebook, a September 18, 1990 memorandum to All Payroll Clerks and Benefit Coordinators, entitled "Attached Plan Document Revisions."

Enclosed with the memorandum are revised pages to insert in the Plan Document, as well as two revisions log pages.

Thank you for your cooperation and assistance in this matter.

Sincerely,

Sally K Richardson

Sally K. Richardson
Director

SKR:DPL:trs

Public Employees Insurance Agency

MEMORANDUM

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

TO: All Payroll Clerks and Benefit Coordinators

FROM: Sally K. Richardson
Director SKR

DATE: September 18, 1990

SUBJECT: Attached Plan Document Revisions

Attached please find the latest set of revisions to the PEIA Plan Document. Please insert these revised pages in the appropriate places in your copy of the Plan Document, and place the revision sheet at the front of the document for reference.

Also attached is the revision sheet which should have accompanied the revisions you received last month with the billing. This page was inadvertently omitted from the mailing. Please insert it in the proper place in your document.

It is important that you keep your copy of the Plan Document current, both for your benefit, and for your insureds'. We appreciate your efforts, and thank you for your continued cooperation.

If you have questions, please feel free to contact our office.

Revisions Log
PEIA Plan Document

Page(s)	Date	Subject
PT-3	November 1, 1990	Personal Leaves of Absence
PT-11 to PT-14	November 1, 1990	Effective date of coverage for newborns.
AC-5	November 1, 1990	Payment of premium for employee on a personal leave of absence.

LEAVES OF ABSENCE

A. Medical Leave:(W.Va. Code 5-16-18)

Any employee who is on a medical leave of absence approved by his/her employer, including any employee who is on medical leave due to a work-related injury or illness and who is receiving Workers' Compensation benefits, shall be entitled to continue coverage until he/she returns to work, provided the following conditions are met.

The insured employee and employer shall continue to pay the proportionate share of premium costs as provided by the law; provided that the employer shall be obligated to pay its proportionate share only for a period of one year, after which the employee must pay the full premium. During the period of the Leave of Absence, the employee shall, at least once each month, submit to his/her employer the statement of a qualified physician certifying that the employee is unable to return to work.

B. Personal Leave:

An employee may continue insurance coverage while on a personal leave of absence where such leave is approved by the agency where he/she is employed. Payment of monthly 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 Public Employees Insurance Agency results in termination of insurance coverage.

C. Family Leave: (W.Va. Code 25-5D)

An individual employee on family leave, approved by his or her employer, is entitled to continue health insurance coverage through the PEIA provided that the employee shall pay the employer the premium costs of such group health insurance coverage during this family leave period.

WHEN COVERAGE BEGINS

Active Employees:

Coverage for active employees who properly enroll is effective the first day of the month following the date of enrollment. If date of enrollment is the first day of the month, the effective date of coverage is the first day of the following month.

Dependent(s) of Active Employee:

Dependent coverage begins on the day the employee's own coverage begins, provided the dependent(s) have been enrolled by the employee. If the employee is not actively at work on the day coverage would normally become effective, coverage on the employee and dependent(s) will begin on the day the employee is actively at work. (see "Actively at Work" clause in this section)

> NOTE: If one or more of the dependents, except for newborns, is in a hospital, nursing home, etc., on the date coverage is to begin, coverage is delayed until the dependent(s) is discharged.

If the employee acquires a dependent after the initial effective date, such as a new spouse, coverage starts the first day of the month following the date of enrollment. In the case of biological newborn children of an employee covered by PEIA, the employee has the month that birth occurs and the following month to add the newborn to his/her plan to qualify for retroactive coverage to the date of birth. Charges for newborns are covered at birth through the date of discharge on an existing family plan. For newborn charges to be paid for an employee with a single plan, the employee must add the newborn to his/her plan to constitute a family plan within 30 days from the date of birth. (Family plan effective date will be the first day of the month in which the child was born.) Charges for a newborn who is not properly added to an existing single plan within the 30-day period will be denied.

> NOTE: Coverage for newborns enrolled outside the initial enrollment period will be effective the first day of the month following the date of enrollment, and pre-existing condition limitations will apply. A statement of health will be required for any life insurance amounts.

Retiree Effective Date of Insurance Coverage:

A retiree will have continuous coverage only if enrolled during the month he/she retires or the following month.

> NOTE: The effective date of coverage for all retirees who enroll after the stated enrollment period will be the first day of the month following completion of the proper enrollment materials, and pre-existing condition limitations will apply. A statement of health will be required for any life insurance amounts.

Dependents of Retirees Effective Date of Insurance Coverage:

If a retiree enrolls dependents for health coverage during the month of retirement or the following month, coverage will be continuous.

If a retiree enrolls dependents after that time, the coverage will be effective on the first day of the month following the date of enrollment with pre-existing condition limitations.

Surviving Dependents Effective Date of Insurance Coverage:

A surviving spouse or dependent will have continuous health coverage if enrolled during the month death occurs or the following month.

The effective date of coverage for all surviving dependents who enroll after the month death occurs or the following month will be the first day of the month following the date of enrollment with pre-existing condition limitations.

WHEN COVERAGE ENDS

Active Employee:

The coverage for the employee terminates when the employee is no longer eligible or when group coverage terminates, whichever happens first.

a. Voluntary Termination: The basic medical coverage for the employee and/or dependent(s) terminates at the end of the month in which the employee voluntary ceases his/her employment.

b. Involuntary Termination: The employee who is terminated from employment involuntarily or through a reduction of work force may continue coverage for 3 additional months after the end of the month in which the employee goes off of the payroll. Eligible dependent(s) who have been properly enrolled by the employee are included in the 3 months extension. This extension of basic coverage is provided at no additional cost to the employee.

Misconduct Discharge: The employee who is discharged for misconduct is not entitled or eligible for the 3 months extension of coverage as mentioned above. However, basic coverage may be extended to the employee and/or eligible dependent (s) up to the maximum period of 3 months, while administrative remedies contesting the charge of misconduct are pursued by the employee. If the misconduct is upheld, the full premium cost of the extended basic coverage must be reimbursed by the employee through their respective payroll location.

Retired Employee:

Coverage terminates at the end of the month in which the retiree elects to terminate his/her coverage, or when the group coverage terminates, or for failure to pay premium whichever happens first.

Dependents:

The coverage for dependent(s) terminates at the end of the month in which one of the following occur:

1. Employee terminates or loses coverage;
2. Divorce from spouse (at the end of the month in which the divorce is final);
3. Child attains age 19;
4. Child marries;
5. Child is no longer a full-time student or reaches age 25;

Surviving Dependents:

Coverage terminates at the end of the month in which one of the following occurs:

1. Spouse no longer elects to participate or remarries;
2. Child(ren) no longer elects to participate, marries, or is ineligible due to age.

Revised: January 1990

> NOTE: The coverage for employees and/or dependent(s) who are confined to a qualified facility on the date that coverage would have terminated, will continue through the date of discharge.

Non-State Agency Termination Provisions:

"When any non-state agency (employer) terminates or withdraws its participation with PEIA said non-state agency shall pay to PEIA an estimated sum of all incurred but not reported claims relating to coverage of employees and retirees of their agency as determined by the Director". W.Va. Code 5-16-13

Possible Coverage After Termination:

Under the PEIA Plan when coverage terminates under an active participant status, the participant may be eligible to continue under COBRA (addressed in a separate section of this document) or a conversion policy.

Conversion

When a policyholder has been continuously covered for an entire three-month period and health benefits terminate under the PEIA , the policyholder may apply for an individual health insurance policy. Application must be in writing and the first premium paid to the contracted underwriter within 31 days after such termination of coverage. Evidence of insurability is not required.

The policyholder cannot convert if:

a. coverage ends because policyholder fails to pay any required contribution for the coverage

b. the policyholder is 65 years of age or older

c. the West Virginia Benefit Plan is terminated.

The converted policy is at the sole discretion of the underwriter, if issued, and will become effective the day after such coverage terminates.

> IMPORTANT: The converted policy is not the same as provided under the West Virginia Public Employees Benefit Plan. For details concerning the converted policies, the policyholder must contact the underwriter. The name and address of the underwriter can be provided by a representative of the PEIA.

Active Employees On Personal Leave:

The premium must be remitted each month to PEIA with the correct monthly report.

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 Public Employees Insurance Agency results in termination of insurance coverage.

B. RETIREE PREMIUM

Retirees will remain on the agency's account until the former employee has exhausted all earned extended insurance coverage for which he/she is eligible.

All agencies are responsible to remit to the Public Employees Insurance Agency the monthly premium for retired employees qualifying for earned extended insurance coverage for the time period in which the employee is eligible for earned extended insurance coverage.

> NOTE: ANY AGENCY wishing to charge general revenue funds for insurance benefits for retirees must provide documentation to the Director that such benefits cannot be paid for by any special revenue account or that the retiring employee has been paid solely with general revenue funds for TWELVE MONTHS PRIOR TO RETIREMENT. W.Va. Code 5-16-13

C. PAYMENT OF PREMIUM BY PERSONAL CHECK

Insureds who are responsible for payment of monthly insurance premium by personal check through either their former payroll location, respective retirement system, or directly to PEIA must ensure that sufficient funds are available to cover the amount of the monthly premium.

Checks returned by the bank to PEIA for insufficient funds, closed account, etc., will be returned to the appropriate payroll location for replacement by either a postal money order or cashier's check.

If a replacement check is not remitted to PEIA within 30 days of payroll notification, insurance coverage provided by the PEIA will be terminated by the payroll location for failure to pay premium retroactive to the last day of the month for which premium was received.

The following steps are recommended for ensuring that the rights and benefits of

Revisions Log
PEIA Plan Document

Page(s)	Date	Subject
PT-10 to PT-17	7-1-90	Inserting new language regarding Retiree Optional Life Insurance enrollment guidelines.

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston
WV 25305
304-346-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

M E M O R A N D U M

TO: All Benefit Coordinators/Payroll Clerks

FROM: Sally K. Richardson
Director

SUBJECT: Retiree Optional Life Insurance Coverage

DATE: August 24, 1990

Effective July 1, 1990, the following policy will apply to all retirees electing to participate in the Optional Life Insurance Plan:

Retirement on/or after July 1, 1990

Employees who retire on/or after July 1, 1990, must elect Optional Life Insurance or continuation of Optional life coverage during the month of, or the month following retirement. **Non-election during this time period waives all rights to future participation in the Optional Life Insurance Plan.**

Employees who are participants in the Optional Life Insurance Plan as of the date of retirement will not be required to submit a Statement of Health. **However, employees who are not participants in the Optional Life Insurance Plan as of the date of retirement, or who request an increase in the amount of Optional Life Insurance coverage upon retirement are required to submit a Statement of Health.**

Retirement prior to July 1, 1990

Employees who retired with an effective date of retirement prior to July 1, 1990, may continue to elect to participate in the Optional Life Insurance Plan by completing the proper enrollment cards and a Statement of Health.

Enclosed is a memorandum for you to copy and distribute to all employees regarding this change. Please distribute it immediately. Also enclosed is the revised Plan Document Pages PT-10 - PT-17, reflecting this change and the updated revision log. Please insert in place of old Pages PT-10 - PT-17, and add revisions log at the front of your Plan Document.

If you have any questions, please do not hesitate to contact the PEIA at 348-7850.

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Enclosures

Optional Plan Choices:

Employees participating in one of the basic plan choices, may also elect to participate through their employer or retirement system in the following optional plan choices:

Active Employees:

1) Optional Life Insurance, Accidental Death and Dismemberment plan; and

2) Dependent Optional Life Insurance, Accidental Death and Dismemberment plan.

Retiree:

Optional Life Insurance only (no accidental death and dismemberment coverage)

Retirement on or after July 1, 1990

Employees who retire on or after July 1, 1990, must elect Optional Life Insurance or continuation of Optional Life Insurance coverage during the month of, or the month following retirement. **Non-election during this time period waives all rights to future participation in the Optional Life Insurance plan.**

Employees who are participants in the Optional Life Insurance Plan as of the date of retirement will not be required to submit a Statement of Health to continue coverage. **However, employees who are not participants in the Optional Life Insurance Plan as of the date of retirement, or who request an increase in the amount of Optional Life Insurance coverage upon retirement are required to submit a Statement of Health.**

Retirement prior to July 1, 1990

Employees who retired with an effective date of retirement prior to July 1, 1990, may continue to elect to participate in the Optional Life Insurance Plan by completing the proper enrollment cards and submitting a Statement of Health.

Non-Duplication of Coverage Plans Within Medical Plan

The State of West Virginia has a self-insured group medical plan with many participating employers. Because it is self-insured we do not coordinate benefits within our own benefit program.

WHEN COVERAGE BEGINS

Active Employees:

Coverage for active employees who properly enroll is effective the first day of the month following the date of enrollment. If date of enrollment is the first day of the month, the effective date of coverage is the first day of the following month.

Dependent(s) of Active Employee:

Dependent coverage begins on the day the employee's own coverage begins, provided the dependent(s) have been enrolled by the employee. If the employee is not actively at work on the day coverage would normally become effective, coverage on the employee and dependent(s) will begin on the day the employee is actively at work. (see "Actively at Work" clause in this section)

> NOTE: If one or more of the dependents, except for newborns, is in a hospital, nursing home, etc., on the date coverage is to begin, coverage is delayed until the dependent(s) is discharged.

If the employee acquires a dependent after the initial effective date, such as a new spouse, coverage starts the first day of the month following the date of enrollment. In the case of biological newborn children of an employee covered by PEIA, the employee has the month that birth occurs and the following month to add the newborn to his/her plan to qualify for retroactive coverage to the date of birth.

> NOTE: Coverage for newborns enrolled outside the initial enrollment period will be effective the first day of the month following the date of enrollment, and pre-existing condition limitations will apply. A statement of health will be required for any life insurance amounts.

Retiree Effective Date of Insurance Coverage:

A retiree will have continuous coverage only if enrolled during the month he/she retires or the following month.

> NOTE: The effective date of coverage for all retirees who enroll after the stated enrollment period will be the first day of the month following completion of the proper enrollment materials, and pre-existing condition limitations will apply. A statement of health will be required for any life insurance amounts.

Dependents of Retirees Effective Date of Insurance Coverage:

If a retiree enrolls dependents for health coverage during the month of retirement or the following month, coverage will be continuous.

If a retiree enrolls dependents after that time, the coverage will be effective on the first day of the month following the date of enrollment with pre-existing condition limitations.

Surviving Dependents Effective Date of Insurance Coverage:

A surviving spouse or dependent will have continuous health coverage if enrolled during the month death occurs or the following month.

The effective date of coverage for all surviving dependents who enroll after the month death occurs or the following month will be the first day of the month following the date of enrollment with pre-existing condition limitations.

WHEN COVERAGE ENDS

Active Employee:

The coverage for the employee terminates when the employee is no longer eligible or when group coverage terminates, whichever happens first.

a. Voluntary Termination: The basic medical coverage for the employee and/or dependent(s) terminates at the end of the month in which the employee voluntary ceases his/her employment.

b. Involuntary Termination: The employee who is terminated from employment involuntarily or through a reduction of work force may continue coverage for 3 additional months after the end of the month in which the employee goes off of the payroll. Eligible dependent(s) who have been properly enrolled by the employee are included in the 3 months extension. This extension of basic coverage is provided at no additional cost to the employee.

Misconduct Discharge: The employee who is discharged for misconduct is not entitled or eligible for the 3 months extension of coverage as mentioned above. However, basic coverage may be extended to the employee and/or eligible dependent (s) up to the maximum period of 3 months, while administrative remedies contesting the charge of misconduct are pursued by the employee. If the misconduct is upheld, the full premium cost of the extended basic coverage must be reimbursed by the employee through their respective payroll location.

Retired Employee:

Coverage terminates at the end of the month in which the retiree elects to terminate

his/her coverage, or when the group coverage terminates, or for failure to pay premium whichever happens first.

Dependents:

The coverage for dependent(s) terminates at the end of the month in which one of the following occur:

1. Employee terminates or loses coverage;
2. Divorce from spouse (at the end of the month in which the divorce is final);
3. Child attains age 19;
4. Child marries;
5. Child is no longer a full-time student or reaches age 25;

Surviving Dependents:

Coverage terminates at the end of the month in which one of the following occurs:

1. Spouse no longer elects to participate or remarries;
2. Child(ren) no longer elects to participate, marries, or is ineligible due to age.

Revised: January 1990

NOTE: The coverage for employees and/or dependent(s) who are confined to a qualified facility on the date that coverage would have terminated, will continue through the date of discharge.

Non-State Agency Termination Provisions:

"When any non-state agency (employer) terminates or withdraws its participation with PEIA said non-state agency shall pay to PEIA an estimated sum of all incurred but not reported claims relating to coverage of employees and retirees of their agency as determined by the Director". W.Va. Code 5-16-13

Possible Coverage After Termination:

Under the PEIA Plan when coverage terminates under an active participant status, the participant may be eligible to continue under COBRA (addressed in a separate section of this document) or a conversion policy.

Conversion

When a policyholder has been continuously covered for an entire three-month period and health benefits terminate under the PEIA , the policyholder may apply for an

individual health insurance policy. Application must be in writing and the first premium paid to the contracted underwriter within 31 days after such termination of coverage. Evidence of insurability is not required.

The policyholder cannot convert if:

a. coverage ends because policyholder fails to pay any required contribution for the coverage

b. the policyholder is 65 years of age or older

c. the West Virginia Benefit Plan is terminated.

The converted policy is at the sole discretion of the underwriter, if issued, and will become effective the day after such coverage terminates.

> IMPORTANT: The converted policy is not the same as provided under the West Virginia Public Employees Benefit Plan. For details concerning the converted policies, the policyholder must contact the underwriter. The name and address of the underwriter can be provided by a representative of the PEIA.

PARTICIPATION GUIDELINES

Going from Dependent to Policyholder Status:

An employee who is covered as a dependent under a family contract and desires to enroll or become the policyholder, that employee will be required to pay their proportionate share of the premium.

> NOTE: If a lapse of coverage is created when changing from dependent status to policyholder status, pre-existing conditions will apply.

Transfers (From One Participating Employer to Another):

Any participating employee (policyholder) who transfers from one participating agency to another and re-enrolls during the month of transfer or the immediate following month, will have continuous coverage.

NO additional premium will be assessed if health and/or life coverage is not changed or increased.

> NOTE: If coverage is increased by adding a spouse and/or additional dependent(s), the new dependent(s) will be subject to pre-existing conditions limitations, and the policyholder will be required to pay the proportionate share of family coverage.

Example: Changing from life only or single contract to family contract.

Dependents:

Employees must add all dependents to coverage by completing two (2) change of status cards at the payroll/personnel office, in order to receive benefits. The EMPLOYER is required to retain duplicate records of all enrollments and changes.

Enrollment Periods

Employee:

a. Health Coverage — No enrollment period required.

b. Basic and Optional Life Insurance Coverage — The month the employee is hired and the following month.

Dependent:

a. Health Coverage — No enrollment period is required.

b. Dependent Life Insurance Coverage — The month the insured is hired and the following month.

Retiree:

a. Health Coverage — No enrollment period

b. Basic and Optional Life Insurance Coverage — The month the employee retires and the following month.

NOTE: A retiree will have continuous coverage only if he/she enrolls during the month of retirement or the following month.

Dependents of Retirees

Health Coverage — No enrollment period required.

Surviving Dependents

Health Coverage — The month death occurs or the following month to avoid lapse of coverage and pre-existing condition limitations

Newborns and Adopted Children

Newborns:

The enrollment period for the biological newborn child of a participating employee is the month of birth and the following month.

If the newborn is added during the initial enrollment period the effective date will be retroactive to the date of birth.

Coverage for newborns enrolled outside of the above enrollment period will become effective the first day of the month following the completion of the change of status card, pre-existing condition limitations will apply.

Adopted Children:

The enrollment period for the adopted child of a participating employee is the month that the child is placed in the home and the following month.

If the adopted child is added with the completion of a change of status card during

the initial enrollment period, the effective date of coverage will be retroactive to the date the child was placed in the home.

Coverage for adopted children enrolled outside the initial enrollment period will become effective the first day of the month following the completion of a change of status card, and pre-existing condition limitations will apply.

Life Insurance (Employee & Dependent):

Proof of insurability (Statement of Health) will be required for life insurance enrollment after the initial enrollment period. The determination by the Life Insurance Underwriters is final.

Pre-Existing Condition Limitation

Any employee and/or dependent enrolling in PEIA on or after July 1, 1988 will be subject to pre-existing condition limitations.

A pre-existing condition is defined as any injury, sickness, or pregnancy or any condition relating to that injury, sickness or pregnancy, for which a participant receives treatment, incurs expenses or manifests symptoms within three (3) months preceding the effective date of insurance coverage. No payment shall be made for expenses incurred for, or in connection with a pre-existing condition unless expenses incurred after the expiration of a one year period following the effective date.

Pre-existing conditions shall not include a condition which meets the definition of a handicap as provided in this Section of the Plan Document, or a participating employee who returns from extended authorized leave as provided in this Plan Document. W.Va. Code 5-16-12e

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

M E M O R A N D U M

TO: All PEIA Insureds

FROM: Sally K. Richardson SKR
Director

SUBJECT: Retiree Optional Life Insurance Coverage

DATE: August 24, 1990

Effective July 1, 1990, the following policy will apply to all retirees electing to participate in the Optional Life Insurance Plan:

Retirement on/or after July 1, 1990

Employees who retire on/or after July 1, 1990, must elect Optional Life Insurance or continuation of Optional Life coverage during the month of, or the month following retirement. **Non-election during this time period waives all rights to future participation in the Optional Life Insurance Plan.**

Employees who are participants in the Optional Life Insurance Plan as of the date of retirement will not be required to submit a Statement of Health. **However, employees who are not participants in the Optional Life Insurance Plan as of the date of retirement, or who request an increase in the amount of Optional Life Insurance coverage upon retirement are required to submit a Statement of Health.**

Retirement prior to July 1, 1990

Employees who retired with an effective date of retirement prior to July 1, 1990, may continue to elect to participate in the Optional Life Insurance Plan by completing the proper enrollment cards and a Statement of Health.

If you have any questions, please do not hesitate to contact the PEIA at 348-7850.

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Enclosure

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

August 9, 1990

Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Rate Schedule notebook a copy of a memorandum sent to All Payroll Clerks and Benefit Coordinators, dated August 20, 1990.

The memorandum enclosed is the new monthly premium rate schedule for optional life and accidental death and dismemberment coverage, for both active and retired employees. These new rates will take effect September 1, 1990. A previous memorandum and schedule, filed with your office on July 31, 1990, contained only the new rates for active employees. These rates have not changed and the rates for retirees have been added.

Thank you for your attention to this request.

Sincerely,

Sally K. Richardson
Director

SKR:trs

Enclosure

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

M E M O R A N D U M

TO: All Payroll Clerks/Benefit Coordinators

FROM: Sally K. Richardson SKR
Director

SUBJECT: Monthly Premium Rate Schedule for Optional and Dependent Life Insurance

DATE: August 20, 1990

Enclosed is the new monthly premium rate schedule for both active employees and retirees which becomes effective September 1, 1990. Please note that the active rates are the same as those provided by PEIA Memorandum of July 30, 1990.

Retirees are being notified individually by separate memorandum of the increase in their life insurance rates.

If you have questions about this change, please do not hesitate to contact the PEIA at 348-7850.

Enclosure

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West Virginia Public Employees Insurance Agency
Optional Life and Accidental Death & Dismemberment
(NO AD & D FOR RETIREES)
Rate Schedule

AGE	PLAN I	PLAN II	PLAN III	PLAN IV	PLAN V	PLAN VI
Under 65	$5,000.00	$10,000.00	$20,000.00	$30,000.00	$40,000.00	$50,000.00
65 - 69	$3,250.00	$ 6,500.00	$13,000.00	$19,500.00	$26,000.00	$32,500.00
70 & Over	$2,250.00	$ 4,500.00	$ 9,000.00	$13,500.00	$18,000.00	$22,500.00

SCHEDULE OF MONTHLY PREMIUM RATES FOR ACTIVE EMPLOYEES

Under 30	A1	$0.44	A2	$ 0.86	A3	$ 1.70	A4	$ 2.56	A5	$ 3.40	A6	$ 4.26
30 - 34	B1	$0.48	B2	$ 0.94	B3	$ 1.88	B4	$ 2.82	B5	$ 3.76	B6	$ 4.70
35 - 39	C1	$0.58	C2	$ 1.14	C3	$ 2.26	C4	$ 3.40	C5	$ 4.52	C6	$ 5.66
40 - 44	D1	$0.90	D2	$ 1.80	D3	$ 3.58	D4	$ 5.38	D5	$ 7.16	D6	$ 8.96
45 - 49	E1	$1.16	E2	$ 2.32	E3	$ 4.62	E4	$ 6.94	E5	$ 9.24	E6	$11.56
50 - 54	F1	$1.74	F2	$ 3.46	F3	$ 6.92	F4	$10.38	F5	$13.84	F6	$17.30
55 - 59	G1	$2.82	G2	$ 5.62	G3	$11.22	G4	$16.84	G5	$22.44	G6	$28.06
60 - 64	H1	$3.98	H2	$ 7.94	H3	$15.88	H4	$23.82	H5	$31.76	H6	$39.70
65 - 69	I1	$4.06	I2	$ 8.12	I3	$16.24	I4	$24.36	I5	$32.47	I6	$40.60
70 & Over	J1	$8.28	J2	$16.56	J3	$33.12	J4	$49.68	J5	$66.24	J6	$82.80

SCHEDULE OF MONTHLY PREMIUM RATES FOR RETIREES

Under 30	K1	$ .35	K2	$ .70	K3	$ 1.40	K4	$ 2.10	K5	$ 2.80	K6	$ 3.50
30 - 34	L1	$ .41	L2	$ .82	L3	$ 1.64	L4	$ 2.46	L5	$ 3.28	L6	$ 4.10
35 - 39	M1	$ .53	M2	$ 1.05	M3	$ 2.10	M4	$ 3.15	M5	$ 4.20	M6	$ 5.25
40 - 44	N1	$ .92	N2	$ 1.83	N3	$ 3.66	N4	$ 5.49	N5	$ 7.32	N6	$ 9.15
45 - 49	O1	$1.27	O2	$ 2.53	O3	$ 5.06	O4	$ 7.59	O5	$10.12	O6	$12.65
50 - 54	P1	$1.99	P2	$ 3.98	P3	$ 7.96	P4	$11.94	P5	$15.92	P6	$19.90
55 - 59	Q1	$3.34	Q2	$ 6.67	Q3	$13.34	Q4	$20.01	Q5	$26.68	Q6	$33.35
60 - 64	R1	$4.80	R2	$ 9.59	R3	$19.18	R4	$28.77	R5	$38.36	R6	$47.95
65 - 69	S1	$4.98	S2	$ 9.96	S3	$19.93	S4	$29.89	S5	$39.86	S6	$49.82
70 & Over	T1	$10.29	T2	$20.58	T3	$41.17	T4	$61.75	T5	$82.33	T6	$102.92

COMBINED DEPENDENT COVERAGE:

SPOUSE	EACH CHILD	
$5,000.00	$2,000.00	$1.82

EFFECTIVE DATE OF REVISED RATE SCHEDULE: SEPTEMBER 1, 1990

A:\RATESOPT/th

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

July 31, 1990

Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Rate Schedule notebook a copy of a memorandum sent to All Payroll Clerks and Benefits Coordinators, dated July 30, 1990.

The memorandum announces that the PEIA has selected The Prudential Life Insurance Company of America as our new life insurance carrier, and includes a new rate schedule for optional life and accidental death and dismemberment coverage. These new rates will take effect September 1, 1990.

Thank you for your attention to this request.

Sincerely,

Sally K. Richardson
Director

SKR:trs

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor
Sally K. Richardson
Director

FILED

MEMORANDUM

TO: All Payroll Clerks/Benefits Coordinators

FROM: Sally K. Richardson SKR
Director

DATE: July 30, 1990

SUBJECT: New Life Insurance Carrier

The PEIA has selected the Prudential Life Insurance Company of America as the new life insurance carrier for basic life and accidental death and dismemberment insurance, as well as the optional life insurance program.

This change took effect on July 1, 1990, and was made because of a substantial premium increase requested by EQUICOR, the former carrier.

Aside from a premium increase, this change will have little effect on you, since the coverage will be identical to that provided by EQUICOR. The life insurance rate schedule is attached.

You will be receiving new life insurance booklets, new Statement of Health forms, new claim forms and some new life insurance enrollment cards. Please continue to use the existing cards and forms until you receive your new supplies.

Statement of Health forms, which were mailed to EQUICOR directly before, must now be mailed to PEIA upon completion.

Enclosed is a memo for you to copy and distribute to all employees regarding this change. Please distribute it immediately.

If you have questions about this change, please do not hesitate to contact the PEIA at 348-7850.

West Virginia Public Employees Insurance Agency
Optional Life and Accidental Death & Dismemberment
Rate Schedule

AGE	PLAN I	PLAN II	PLAN III	PLAN IV	PLAN V	PLAN VI
Under 65	$5,000.00	$10,000.00	$20,000.00	$30,000.00	$40,000.00	$50,000.00
65 - 69	$3,250.00	$ 6,500.00	$13,000.00	$19,500.00	$26,000.00	$32,500.00
70 & Over	$2,250.00	$ 4,500.00	$ 9,000.00	$13,500.00	$18,000.00	$22,500.00

SCHEDULE OF MONTHLY PREMIUM RATES FOR ACTIVE EMPLOYEES

Under 30	A1	$0.44	A2	$ 0.86	A3	$ 1.70	A4	$ 2.56	A5	$ 3.40	A6	$ 4.26
30 - 34	B1	$0.48	B2	$ 0.94	B3	$ 1.88	B4	$ 2.82	B5	$ 3.76	B6	$ 4.70
35 - 39	C1	$0.58	C2	$ 1.14	C3	$ 2.26	C4	$ 3.40	C5	$ 4.52	C6	$ 5.66
40 - 44	D1	$0.90	D2	$ 1.80	D3	$ 3.58	D4	$ 5.38	D5	$ 7.16	D6	$ 8.96
45 - 49	E1	$1.16	E2	$ 2.32	E3	$ 4.62	E4	$ 6.94	E5	$ 9.24	E6	$11.56
50 - 54	F1	$1.74	F2	$ 3.46	F3	$ 6.92	F4	$10.38	F5	$13.84	F6	$17.30
55 - 59	G1	$2.82	G2	$ 5.62	G3	$11.22	G4	$16.84	G5	$22.44	G6	$28.06
60 - 64	H1	$3.98	H2	$ 7.94	H3	$15.88	H4	$23.82	H5	$31.76	H6	$39.70
65 - 69	I1	$4.06	I2	$ 8.12	I3	$16.24	I4	$24.36	I5	$32.47	I6	$40.60
70 & Over	J1	$8.28	J2	$16.56	J3	$33.12	J4	$49.68	J5	$66.24	J6	$82.80

COMBINED DEPENDENT COVERAGE:

SPOUSE	EACH CHILD
$5,000.00	$2,000.00

$1.82

EFFECTIVE DATE OF REVISED RATE SCHEDULE: SEPTEMBER 1, 1990

A:\RATESOPT.002

Public Employees Insurance Agency

... Complex
... 5
... Bldg
...
...
...-7850

Gaston Caperton
...

Sally K. Richardson
Director

M E M O R A N D U M

TO: ALL PAYROLL LOCATIONS

FROM: Sally K. Richardson SKR
Director

SUBJECT: **Important Policy Changes . . . Effective August 1, 1990**

DATE: June 25, 1990

The attached notice is regarding PEIA policy changes effective August 1, 1990.

W. Va. Code §5-16-8(11) requires all participating employers give written notice to each covered employee prior to the institution of any changes in benefits to employees. Accordingly, we request your participation in providing a copy of the attached notice to each of your employees as quickly as possible, but not later than **July 31, 1990.**

Your assistance in this matter is greatly appreciated.

SKR/DJA/th
A:\CHANGES.615 SKR

Attachment

Public Employees Insurance Agency

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Gaston Caperton
Governor

Sally K. Richardson
Director

N O T I C E

TO: ALL PARTICIPATING INSUREDS OF PEIA

FROM: Sally K. Richardson SKR
Director

SUBJECT: **Important Policy Changes**

DATE: June 25, 1990

The State of West Virginia Group Medical Benefit Plan, administered by the Public Employees Insurance Agency, is advising that the following changes will be effective August 1, 1990, under the major medical portion of the plan.

#11. Allergy testing and treatment

#15. Hepatitis inoculation is the only eligible medical service related to employment. This benefit is available to insured employees when exposure occurs in the work place.

SKR/DJA/th
A:\CHANGES.801

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

May 9, 1990

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Benefit Plan Document notebook, the following two documents:

1. A memorandum dated May 1, 1990, to all payroll locations, regarding "Important Policy Changes Effective July 1, 1990;"

2. A memorandum dated May 2, 1990, to all payroll clerks, benefit coordinators and interested parties, with attached plan document revisions and revisions log.

Thank you for your cooperation and assistance in this matter.

Sincerely,

Sally K. Richardson
Director

SKR:DPL:trs

Enclosures

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

M E M O R A N D U M

TO: ALL PAYROLL LOCATIONS

FROM: Sally K. Richardson, Director SKR

SUBJECT: **Important Policy Changes . . . Effective July 1, 1990**

DATE: May 1, 1990

The attached notice is regarding PEIA policy changes effective July 1, 1990.

W. Va. Code §5-16-8(11) requires that all participating employers give written notice to each covered employee prior to the institution of any changes in benefits to employees. Accordingly, we request your participation in providing a copy of the attached notice to each of your employees as quickly as possible, but not later than May 31, 1990.

Your assistance in this matter is greatly appreciated.

SKR/DJA/th

Attachment

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

N O T I C E

TO: ALL PARTICIPATING INSUREDS OF PEIA

FROM: Sally K. Richardson, Director SKR

SUBJECT: **Important Policy Changes**

DATE: May 1, 1990

The State of West Virginia Group Medical Benefit Plan, administered by the Public Employees Insurance Agency, is advising that the following changes will be effective July 1, 1990.

1) Charges for the surgical procedure "Gastric Stapling" are no longer an eligible expense under the West Virginia Group Medical Plan.

2) Personal checks returned by the bank to PEIA for insufficient funds, closed account, etc., will be returned to the appropriate payroll location for replacement within thirty (30) days by either a postal money order or cashier's check.

   If a replacement check is not remitted to PEIA within thirty (30) days of payroll notification, insurance coverage provided by the PEIA will be terminated by the payroll location for failure to pay premium retroactive to the last day of the month for which premium was received.

SKR/DJA/th

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

MEMORANDUM

TO: All payroll clerks, benefit coordinators and interested parties

FROM: Sally K. Richardson SKR
Director

DATE: May 2, 1990

SUBJECT: Attached Plan Document revisions

Attached are the latest revisions to your PEIA Benefit Plan Document. Please take a few moments to replace the appropriate pages in your copy to keep it up to date.

The changes are outlined on the attached Revision Log, but two of the changes are especially noteworthy: the benefit change in Gastric Stapling and the policy change regarding payment of premium by personal check. Please familiarize yourself with these changes.

As always, we appreciate all of the work you do to keep your insureds informed about their benefit program.

If you have questions, please feel free to contact PEIA at 348-7850.

SKR:jl

Attachments

Revisions Log
PEIA Plan Document

Page(s)	Date	Subject
GI-7	5/1/90	NOTE has been changed to reflect "inpatient" deductible
PT-7	5/1/90	Students who voluntarily withdraw from school
PT-9	5/1/90	Changing policyholder of family plan when both spouses are eligible employees and one takes a personal leave of absence
SB-7	3/8/90	Typographical error in item "g"
SB-9	7/1/90	Gastric stapling -- item "l"
AC-5 to 8	5/1/90	Payment of premium by personal check
GL-1 to 13	5/1/90	Changes in definitions of: Alcohol and substance abuse treatment facility, birthing center, free standing facility, home health care, hospice, hospital, medically necessary, pre-existing conditions and rehabilitation hospital.

Major Medical Copayment:

The plan will pay, where applicable, charges up to 80% of the PEIA Fee Schedule rate for medically necessary expenses (after required deductible is satisfied by the policyholder). The 20% balance or remaining expenses are the responsibility of the policyholder and cannot be applied toward other deductibles within this Plan.

Outpatient Laboratory and X-Ray Percentage Payment:

Each insured shall pay 10% of the PEIA Fee Schedule rate for each covered outpatient lab or x-ray charge up to a maximum of $100 per calendar year. After meeting the $100 maximum, the PEIA will pay all eligible outpatient lab and x-ray expenses at the PEIA Fee Schedule rate.

Prescription Drug Copayment:

The Plan will pay the following percentages of covered prescription drug charges:

90% of generic drug charge.

80% of brand name drug charge when no lower cost generic is available, or when the physician requires a brand name drug.

75% of brand name drug charge when a lower cost generic is available

The remaining percentage (either 10%, 20% or 25%) or remaining expenses are the responsibility of the policyholder and cannot be applied toward other deductibles within this Plan.

NOTE: No co-payment may be used to satisfy any Plan deductibles. The inpatient, major medical and prescription drug deductibles, and outpatient lab and x-ray co-payments must be satisfied separately.

Guidelines:

The deductible is applied to the eligible charges. The claim is calculated in the usual manner to determine the amount payable.

Student (Temporary Leave):

Full-time students who must withdraw from a college, university or other school for medical reasons may continue coverage as long as medically necessary. In order to continue coverage under this provision, the attending physician must certify, in writing on a monthly basis, that said student is unable to attend on a full-time basis and state the medical diagnosis.

If the Claims Administrator verifies that the diagnosis does not warrant continuous coverage under this provision, proper notice terminating the student status will be forwarded to the policyholder.

Students who, after the attainment of age 19, voluntarily withdraw from school for any reason other than medical are not eligible for health benefit coverage .

Should the student later re-enroll as a full-time student, he/she may be reinstated for health benefit coverage if dependent status is maintained. Student health benefit coverage will become effective the first day of the month following the date of enrollment and will be subject to pre-existing condition limitations for a period of one year.

Mentally Retarded/Physically Disabled Dependent Children

Dependent children may be covered after age 19 while incapable of self-support because of mental retardation, mental illness, or a physical disability that began prior to age 19 (or prior to age 25 while a full-time student), if the child was dependent upon the employee for support and maintenance at the onset of the mental retardation, mental illness or physical disability. Contact the PEIA office within 31 days before coverage terminates for the appropriate form to continue coverage.

When our policy allows for the continuation of coverage for mental retardation, mental illness, or handicapped children, the requirements are as follows:

1. The child must be insured prior to the attainment of the limiting age.

2. Disability must commence prior to the attainment of the limiting age.

3. The child must be incapable of self-sustaining employment and chiefly dependent on the employee for support and maintenance.

ENROLLMENT

How to Enroll:

Participation in the PEIA health insurance plan is voluntary.

Employees and retirees who are eligible and desire coverage, must complete proper enrollment forms at their place of employment or respective retirement system. The enrollment will authorize the employer to deduct from the salary or pension annuity the premium cost of the elected coverage.

The participating employee or retired person is responsible for notifying the employer or respective retirement system when any change of address, marital or dependent status occurs. All changes require completion of a change of status card with the valid signature of the employee or retiree.

Basic Choices Available:

The eligible employee or retiree may elect to participate in one of the following basic plan choices:

1) Single Health Coverage - Employee or Retiree

2) Family Health Coverage - Employee or Retiree and 1 or more dependent(s)

3) Life Insurance Only - 1 Employee or 1 Retiree

NOTICE: Husband and Wife Health Participation: Married couples who are employed by participating agencies may (1) each enroll for single health coverage, or (2) both be covered under 1 family health plan, with the other spouse enrolling for basic life insurance, if both desire life insurance coverage.

In addition, when a husband and wife are both PEIA participants with one having the family health insurance plan and the other having basic life insurance, they are **restricted** from exchanging coverages except annually on January 1, or when one or the other loses health coverage due to termination of employment, death or divorce; or when the family member having the family health insurance coverage is on an authorized personal leave of absence and is required to contribute 100% of the health insurance premium during the above leave of absence.

Husband and wife ARE NOT ELIGIBLE TO ENROLL FOR DUPLICATE (Family) HEALTH INSURANCE COVERAGE under PEIA IN THAT ONLY ONE (1) CAN ELECT TO INSURE THE CHILDREN.

Reconstructive surgery is covered under the PEIA Plan only for:

1) Correction of birth defects; and

2) Accidental bodily injury or disease occurring while insured or covered by PEIA.

No reconstructive surgery will be paid unless it has been pre-certified as medically necessary by the Case Management Program.

Additional consideration is given to dermabrasion for acne, incision and drainage of abscesses and mammoplasty.

Mammoplasty charges are to be accepted for consideration only if the procedure can be classified as augmentation (breast implants) after a partial or total mastectomy, necessitated by disease.

Otoplasty to correct birth defects and/or deformities is eligible under the PEIA plan.

A letter stating the medical necessity specifically identifying the birth defect, accidental injury, disease, etc, with date of onset is to be obtained from the operating surgeon before the claims administrator will process payment.

Exclusions under Surgical Benefits

No benefits are payable for:

a. Charges for cosmetic or reconstructive surgery unless such charges are incurred as the result of accidental bodily injury or disease occurring while covered or unless the surgery is performed to correct birth defects;

b. Charges for dental work or treatment except as specifically provided in the PEIA Plan;

c. Charges for injury or sickness connected with employment with any employer;

d. Pregnancy-related conditions for dependent children;

e. Elective abortions;

f. Reversal of sterilization;

g. Diagnosis and/or treatment by any method of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint;

h. Removal of calluses.

i. Incidental surgery performed through the course of a surgery performed due to medical necessity.

j. Charges for in vitro fertilization, or artificial insemination.

k. Radial Keratotomy.

l. Gastric stapling.

m. Surgery to relieve a patient of emotional stress and/or psychological disorders.

n. Charges incurred in a federal hospital for service-related injuries/disabilities or on account of war, or for treatment in any state-supported institution.

o. Weight loss

Active Employees On Personal Leave:

The premium must be remitted to the payroll location each month so that it may be sent to PEIA with the correct monthly report.

The premium must be indicated on the report in the column under "Employee Contribution". This indicates that the employee is on leave and paying the full premium.

The agency contribution should be lined through since the employee is paying 100% of the premium. When calculating correct premium due, this amount should be deducted from the agency contribution. Failure to remit the premium due each month to the Public Employees Insurance Agency results in termination of insurance coverage.

B. RETIREE PREMIUM

Retirees will remain on the agency's account until the former employee has exhausted all earned extended insurance coverage for which he/she is eligible.

All agencies are responsible to remit to the Public Employees Insurance Agency the monthly premium for retired employees qualifying for earned extended insurance coverage for the time period in which the employee is eligible for earned extended insurance coverage.

> NOTE: ANY AGENCY wishing to charge general revenue funds for insurance benefits for retirees must provide documentation to the Director that such benefits cannot be paid for by any special revenue account or that the retiring employee has been paid solely with general revenue funds for TWELVE MONTHS PRIOR TO RETIREMENT. W.Va. Code 5-16-13

C. PAYMENT OF PREMIUM BY PERSONAL CHECK

Insureds who are responsible for payment of monthly insurance premium by personal check through either their former payroll location, respective retirement system, or directly to PEIA must ensure that sufficient funds are available to cover the amount of the monthly premium.

Checks returned by the bank to PEIA for insufficient funds, closed account, etc., will be returned to the appropriate payroll location for replacement by either a postal money order or cashier's check.

If a replacement check is not remitted to PEIA within 30 days of payroll notification, insurance coverage provided by the PEIA will be terminated by the payroll location for failure to pay premium retroactive to the last day of the month for which premium was received.

The following steps are recommended for ensuring that the rights and benefits of

both the insured and the employing payroll location are protected:

1) Upon notification by PEIA of a check returned for insufficient funds, closed account, etc., notify the insured by certified mail (return receipt requested) that a replacement postal money order or cashier's check is to be remitted within 15 days or subsequently his/her insurance coverage will be terminated for failure to pay premium.

2) Inform insured that if PEIA coverage is terminated for failure to pay premium, the termination date will be retroactive to the last day of the month for which premium was received. Any claims incurred after the effective date of termination will be the sole financial responsibility of the insured.

PREMIUM CREDIT

The following guidelines apply to employees who elected to participate in the Public Employees Insurance Plan **prior to July 1, 1988.**

A. Single (AS) Contract to Family (AF) Contract

The Public Employees Insurance Agency allows a premium credit for the 30% employee contribution for any insured who changes from a single contract to a family contract under the Public Employees Insurance Program. This credit applies only to the 30% contribution made by an employee, and is based on applicable premiums during the credit period.

NOTE: The employee must pay 12 months from the effective date of the family coverage.

Example:

$28.80			Monthly single premium (previously paid)
66.00			Monthly family premium
$37.20			Monthly difference which employee must pay
66.00	x 12 months =	$792.00	(one year family coverage premium)
$28.80	x 12 months =	$345.60	(one year single coverage premium)
37.20	x 12 months =	446.40	(one year single premium credit)
		$792.00	(same as one year family premium)

Family coverage:

$66.00	Employee monthly contribution
154.00	Agency monthly contribution
$220.00	Total monthly premium

THE PUBLIC EMPLOYEES INSURANCE AGENCY WILL COMPUTE THE NUMBER OF MONTHS IN WHICH AN EMPLOYEE IS ENTITLED TO RECEIVE A CREDIT.

When an employee changes from Single coverage to Family coverage and receives a credit for the 30% contribution made while the employee had Single coverage the agency's contribution will be increased proportionally by the amount credited in order that 100% of the required monthly premium is received by the Public Employees Insurance Agency for the employee.

Example: If the employee is paying $37.20 per month, the agency contribution must be increased from $154.00 to $182.20 per month so the family premium of $220.00 per month is remitted to PEIA.

$ 37.20	Employee contribution
182.80	Agency contribution
$220.00	Total monthly premium remitted

B. Family (AF) Contract to Single (AS) Contract to Family (AF) Contract
(Effective November 1, 1989)

If an employee has paid 12 months on a family plan, and must revert to a single plan due to death or divorce of his/her spouse, or dependent becomes ineligible due to attainment of age 19 (or age 25 while maintaining full-time student status), he/she will not be required to contribute a percentage of the premium again upon changing back to a family plan.

C. Life Insurance Only (LA) Contract to Single (AS)/Family (AF) Contract

If an employee is currently enrolled for "Life Insurance Only" (LA) coverage (insured as a dependent under his/her spouse's PEIA coverage), and the one spouse's health coverage should terminate, the LA enrollee may enroll for the medical portion of the insurance program, and will not be required to contribute a percentage of the premium or be subject to the pre-existing condition limitations. In order to take advantage of this premium credit, the LA enrollee must make this election prior to or during the month following the termination date of the spouse's insurance coverage.

D. Life Insurance Only (LAD) Contract to Single (AS)/Family (AF) Contract

If an employee is currently enrolled for "Life Insurance Only" (LAD) coverage (not covered as a dependent under his/her spouse's coverage) and later wishes to enroll for the medical portion of the Insurance Program, that employee will be subject to the pre-existing condition limitations. In addition, the enrollee is required to pay 30% of the premium of the new contract (AS/AF) for a period of one year from the date of election on the new contract.

No premium credit is allowed for premiums paid on the LAD contract.

E. Dependent Status to Single (AS)/Family (AF) Contract

(Effective November 1, 1989)

An employee who meets the guidelines stated below will be allowed to enroll as the policyholder without having to contribute a percentage of the premium:

1) was covered as a dependent under his/her spouse's PEIA group health plan prior to July 1, 1988, and has remained continuously covered as a dependent.

2) was employed prior to July 1, 1988, and remained continuously with PEIA participating State agency.

3) loses health coverage through spouse's termination of employment, death or divorce.

If the employee meets all three of the above guidelines, and enrolls in his/her plan during the month of loss of coverage or the following month, a percentage of the monthly premium will not apply.

Should he/she fail to enroll in the plan during the above period, premium guidelines in effect for new enrollees on or after July 1, 1988 will apply. In addition, new enrollees will be subject to the pre-existing condition limitations.

F. Premium Credit Exclusions

Premium credit does NOT apply if employee voluntarily resigns, has a lapse of coverage, and is later re-employed with a participating agency.

G. Involuntary Terminations

An employee who is involuntarily terminated or laid off from employment and returns to employment within one year from the date off the payroll will not be considered as a new enrollee for premium purposes. That employee will be reinstated in the insurance program with the same status as of the last day in the program.

H. Transfer (From one Participating Employer to Another)

Any participating employee (policyholder) who transfers from one participating agency to another and re-enrolls during the month of transfer or the immediate following month, will have continuous coverage.

No additional premium will be assessed if health and/or life insurance coverage is not changed or increased.

GLOSSARY OF TERMS

A

Accidental Injury:

Trauma or damage to some part of the body resulting from an unforeseen or unexpected occurrence or mishap.

Accommodation Charges:

Charges made by a hospital for room (not to exceed the allowance for a semi-private room), general nursing services, meals (including special diets), housekeeping services, minor medical and surgical supplies, medical and psychiatric social services and the use of equipment, facilities and/or services for which a separate charge is not customarily made by hospitals.

Administrator:

Director of PEIA who is empowered and authorized to establish group hospital and surgical insurance plan (s), a group major medical plan(s) and group life and accidental death plan (s) for employees made eligible.

Alcohol and Substance Abuse Treatment Facility

An Alcohol and Substance Abuse Treatment Facility is a licensed institution or a hospital established to provide medical treatment for patients who require inpatient care on account of alcoholism or substance abuse, which has permanent facilities for inpatient medical care on the premises, including 24-hour nursing service under the supervision of a full-time Registered Nurse (R.N.), and maintains daily medical records on all patients.

In no event will the term include any institution or part thereof which is used principally as a rest or nursing facility, or a facility for the aged, or one providing primarily custodial care.

B

Benefit Period:

The period of time during which charges for covered services must be incurred in order to be eligible for payment by the Plan. A charge shall be considered incurred on the date the service or supply was provided to the insured. January through December of any given year.

Birthing Center:

The term "birthing center" shall mean any licensed facility (other than a hospital) organized to provide facilities and staff to support a birthing service for pregnant clients.

A birthing center is to be able to provide prenatal, intrapartum, and post-partum care provided for individuals with low risk births, uncomplicated pregnancy, labor and vaginal birth and newborn care during the recovery period.

C

Calendar Year:

January 1 through December 31 of each year.

Case Management:

For patients who have high-cost, long term and/or complicated discharge planning cases, this program will locate and assess medically appropriate alternative settings in which service can be provided. Case management also assists in managing patients' health care benefits as cost-effectively as possible. The program also may provide extra-contractual benefits when necessary.

Chiropractic:

A system of manipulative treatment which teaches that all diseases are caused by impingement on spinal nerves and can be corrected by spinal adjustments.

COBRA:

Consolidated Omnibus Budget Reconciliation Act

Copayment:

The percentage of expenses paid by an insured after satisfaction of the deductible.

Cosmetic Surgery:

Surgery intended solely to improve the appearance of the individual, but not to restore bodily function or correct deformity. Cosmetic surgery does not become "Reconstructive Surgery" because of psychological or psychiatric reasons.

Covered Service:

A service or supply which qualifies for payment by the PEIA under the terms of this program.

Custodial Care:

Expenses incurred for care comprised of accommodations (including room and other institutional services) and nursing services provided to an insured, because of age or other mental or physical condition, primarily to assist the insured in the activities of daily living, shall be deemed custodial care. Custodial care encompasses bathing, feeding, massage, turning/changing positions, primary setter, etc. The fact that the insured is concurrently receiving medical service which is merely maintenance care that cannot reasonably be expected to contribute substantially to the improvement of a medical condition shall not preclude the application of this limitation.

Current Procedural Terminology (CPT) Code:

A system of terminology and coding developed by the American Medical Association used for describing medical services and procedures.

D

Day:

For the purposes of this plan document, "Day" is defined as one 24-hour period.

Deductible:

A specified amount of charges for covered services, expressed in dollars, that must be incurred by a member during a benefit period, before the PEIA becomes liable for payment of remaining charges for covered services.

Dependent:

Eligible persons (spouse or child) other than the policyholder who are covered under the plan.

Discharge Planning:

The process of assessing a patient's need for medically appropriate treatment after hospitalization and effecting an appropriate and timely discharge.

Duplication of Benefits:

Overlapping or identical coverage of the same insured under two or more health plans, usually the result of contracts from different insurance carriers, service organizations or pre-payment plans; also known as multiple coverage.

E

Effective Date of Coverage:

The date on which coverage for an insured begins under this program.

Elective Surgery:

Surgery which may be medically necessary, but does not need to be performed on an emergency basis because reasonable delays will not adversely affect the outcome of the surgery.

Eligible Dependent:

Eligible dependent is as defined as:

a) The policyholder's spouse under a legally valid, existing marriage.

b) The unmarried children, including newborn children, stepchildren, children legally placed for adoption, legally adopted children of the policyholder or the policyholder's spouse, or any children fully dependent upon the policyholder for support and maintenance and residing in the household of the policyholder who are:

1) Under nineteen (19) years of age; or

2) nineteen (19) years of age or older provided that any such child in the sole judgment of the PEIA, is incapable of self-support by reason of physical handicap, developmental disability or mental retardation provided such child was eligible for coverage prior to attaining age nineteen (19). The PEIA may require proof of such disability from time to time; or

3) under twenty-five (25) years of age, who are enrolled as full-time students in an accredited educational institution which is recognized as such by the PEIA.

Employee:

An individual who meets the requirements of active employee as defined within this Plan Document who is eligible to enroll for coverage.

Exclusions:

Medical service, treatment or supplies not eligible for consideration under the PEIA program.

Explanation of Benefits:

A form sent to the insured person after a claim for payment has been evaluated or

processed by the Third Party Administrator which explains the action taken on the claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, etc.

Extended Care Facility:

An Extended Care Facility is an institution that for a fee furnishes room, board and skilled nursing services for medical care; has one or more licensed nurses on duty at all times under the supervision of a doctor or Registered Nurse (R.N.) on a 24-hour basis. The Extended Care Facility must also have available at all times under an established agreement the services of a licensed physician. The institution must maintain daily medical records on all patients and comply with the legal requirements applicable to the operation of an Extended Care Facility.

F

Family Coverage:

Coverage for a policyholder and one or more eligible dependents.

Family Leave:

Leave provided because of the birth of a son or daughter of the employee, or because of placement of a son or daughter with the employee for adoption, or in order to care for the employee's son, daughter, spouse, parent or dependent who has a serious health problem.

Free Standing Facility (FSF):

The term "Free Standing Facility" means an institution (other than a hospital) which is established, equipped, and operated primarily for the purpose of performing outpatient elective procedures of an uncomplicated nature. It does not provide beds for overnight confinement. A FSF is considered a qualified facility when it is licensed by the state or jurisdiction in which it operates or is certified by the Social Security Administration as a provider under Medicare.

H

Handicap:

A mental or physical impairment which substantially limits one or more of a person's major life activities. The term "major life activities" includes functions such as care for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. "Substantially limits" means interferes with or affects over a substantial period of time. Minor, temporary ailments or injuries shall not be considered physical or mental impairments which substantially limit a person's major life activities.

"Physical or mental impairment" includes such diseases and conditions as orthopedic, visual, speech and hearing impairments; cerebral palsy; epilepsy; muscular distrophy; autism; multiple sclerosis and diabetes. The term "handicap" does not include excessive use or abuse of alcohol, drugs or tobacco.

HMO (Health Maintenance Organization)

An organization that provides a wide range of comprehensive health care services for a specific group at a fixed periodic payment.

Home Health Care:

The term "home health care" refers to care provided by a licensed agency which offers an array of services to insureds and families at home for the purposes of making admission to a health care facility unnecessary by promoting, maintaining or restoring health or minimizing the effects of illness and disability. Services appropriate to the needs of the insured are planned, coordinated and made available by an organized health system through the use of agency-employed staff, contractual arrangements or a combination of administrative patterns.

The home health care agency providing the treatment must be accredited by the Joint Commission on the Accreditation of Health Organizations or certified by the Social Security Administration as a provider of home health care under Medicare.

Hospice:

A Hospice Care Program is a formal program directed by a doctor to help care for terminally ill persons through either:

1. A centrally administered, medically directed and nurse-coordinated program which:

    a. provides a coherent system primarily of home care;
    b. uses a hospice team;
    c. is available 24 hours a day, seven days a week.

2. Confinement in a hospice unit.

The program must meet standards set by the National Hospice Organization and be approved by PEIA and Case Management. If such a program is required by a state to be licensed, certified or registered, it must also meet that requirement to be considered a hospice care program.

Hospital:

A hospital is an institution accredited and licensed under the laws of the state in which it is situated, for the care and treatment of sick and injured persons by or under the supervision of a staff of licensed physicians with an R.N. on duty at all times.

I

Inpatient:

An insured who is admitted and treated as a registered bed patient with the reasonable expectation of remaining overnight in a hospital or other facility, and for whom an accommodation charge is made.

Insured:

A participating eligible employee, retiree, or surviving dependent or eligible dependent who is properly enrolled.

Intermittent Care:

To meet the requirement for "intermittent" skilled nursing care, an individual must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days.

L

Lifetime Maximum:

That amount of money which represents the maximum benefits payable by the PEIA, or on behalf of, an insured during the insured's lifetime.

M

Major Medical:

For the purposes of this Plan Document, Major Medical is that eligible portion of benefits which supplements the Hospital and Surgical benefits.

Maternity Care:

Prenatal, intrapartum and postpartum care rendered by a physician, hospital or other provider to a pregnant individual or newborn child during and following pregnancy and delivery.

Medical Emergency:

The sudden and unexpected onset of a condition or illness with severe symptoms requiring medical and/or surgical care as soon after the onset as possible, but in no event later than 24 hours after onset. This term may include, but is not limited to, such

conditions or symptoms as: heart attacks, cardiovascular accidents, acute chest pains, acute appendicitis, convulsions, loss of consciousness and diabetic coma.

Medical Leave of Absence:

As used herein, refers to an approved absence from the employer due to medical reasons, which the employee can document by way of a statement of a qualified physician certifying that the employee is unable to work.

Medically Necessary:

Services or supplies provided by a hospital, medical facility, physician, or other provider which are required to diagnose or treat an insured's illness, condition or injury and, as determined by PEIA, are:

a. consistent with the symptom or diagnosis and treatment of the insured's condition, illness or injuries;

b. appropriate with regard to standards of good medical practice;

c. not solely for the convenience of an insured, physician, hospital or other provider; and

d. the most appropriate supply or level of service which can be safely provided to the insured.

The fact that a physician has prescribed, ordered, or approved a service, treatment, hospitalization or supply as "medically necessary" does not make the charge a covered expense. PEIA reserves the right to make the final determination of medical necessity on the basis of the final diagnosis and supporting medical data.

Mental or Emotional Illness:

A mental or emotional disorder characterized by an abnormal functioning of the mind or emotions in which psychological, intellectual, emotional or behavioral disturbances are the dominating feature, but excluding mental retardation.

Mental Hospital (Psychiatric Hospital)

A facility which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the active inpatient treatment of mental or emotional illness, with services provided by, or under the supervision of, a licensed psychiatrist and providing continuous nursing services under the supervision of registered graduate nurses. This term does not include facilities which are primarily custodial or schools for the mentally retarded.

Midwife:

The term "midwife" means a person educated in the discipline of nursing and midwifery, certified by examination with the American College of Nurse-Midwives, and licensed by state authority to engage in the practice of midwifery (CNM); or, a person trained in midwifery and licensed by the state authority to engage in the practice of midwifery.

O

Other Provider:

A person or entity other than a hospital or physician which is licensed, as required, to render covered services.

Outpatient:

A patient who receives services or supplies while not an inpatient.

P

Participant:

An eligible employee or eligible dependent who is properly enrolled in the PEIA program.

PEIA

The Public Employees Insurance Agency, as created by act of the West Virginia Legislature to provide health and/or life insurance coverage to all employees of the State of West Virginia, its political subdivisions, and other eligible individuals as outlined in the West Virginia Code.

Personal Leave of Absence:

As used herein, refers to an approved absence other than a medical leave of absence, which has been granted and approved by the employer. Total premium dollar must be received each month from the employee, otherwise insurance coverage terminates.

Physical Therapist

An individual licensed to practice physical therapy, or where there is no license involved, an individual certified by an appropriate professional body to practice physical therapy.

Physical Therapy

The treatment by physical means, including hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices, to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of body part.

Physician

A duly licensed Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Surgery, Doctor of Podiatry, or Doctor of Chiropractic..

Policyholder:

An eligible individual who has actually enrolled for coverage and authorized his/her payroll clerk to make proper payroll deductions.

PPO (Preferred Provider Organization):

An arrangement whereby a third party payor contracts with a group of medical care providers who furnish services at lower-than-usual fees in return for prompt payment and a certain volume of patients.

Pre-Admission Certification:

Prior approval of any hospital stay. PEIA requires the insured, dependent, designee or physician to contact the certification program representative for verification of medical necessity and determination of the length of stay for each admission.

Pre-admission certification does not assure payment, eligibility, or type of services covered under this benefit plan.

Pre-Authorization:

Verification from the Claims Administrator in advance that a service is covered by the Plan.

Pre-Certification (also Pre-Approval)

Advance approval by the certification program representative required for specific services covered by the Plan.

Pre-existing Condition:

Any employee and/or dependent enrolling in the PEIA benefit plan on or after July 1, 1988 will be subject to pre-existing condition limitations.

A pre-existing condition is defined as any injury, sickness, or pregnancy or any condition relating to that injury, sickness or pregnancy, for which a participant receives treatment, incurs expenses or manifests symptoms within three (3) months preceding the effective date of insurance coverage. No payment shall be made for expenses incurred for, or in connection with a pre-existing condition until after the expiration of a one year period following the effective date.

Pre-existing conditions shall not include a condition which meets the definition of a handicap.

Primary Health Care Nursing:

Nursing care rendered by a non-salaried, duly licensed, registered professional nurse engaged in private nursing practice or partnership with other health care providers, acting within the lawful scope of his or her duties, provided such nurse, nurse-midwife or midwife is not related by blood or marriage to the insured, and not regularly residing in the household. "Midwife and nurse-midwife" shall be licensed as defined in the West Virginia Code 30-15-1.

Provider:

A hospital, physician or other provider, licensed where required and performing within the scope of the license.

R

Reasonable and Customary Fees (R & C)

As a basis for paying claims, determination of "reasonable and customary" fees for a particular service, supply or treatment shall be made by PEIA, and shall take into consideration the following factors:

1. The range of usual fees charged by most providers of similar training and experience located in the same geographic area for the same or comparable service, supply or treatment; and

2. Any unusual circumstances regarding the patient's condition which might require additional time, skill or experience on the provider's part to treat successfully; and

3. The rate of inflation using an accepted index.

Rehabilitation Hospital

A Rehabilitation Hospital is a facility primarily engaged in providing medical rehabilitation care services to those disabled by disease or injury to be able to achieve the

highest practicable level of functional ability. Such services are provided by, or under the supervision of, an organized staff of physicians with continuous nursing services provided under the supervision of a registered graduate nurse (R.N.).

S

Single Coverage

Coverage for the eligible employee, retiree, or surviving dependent only.

Special Care Units:

Areas of a hospital that are devoted to the care of specific medical conditions. Such units commonly include Intensive or Critical Care Units, Coronary Care Units, and Burn Units.

Speech Therapist

An individual licensed to practice speech therapy, or where there is no license involved, an individual certified by an appropriate professional body to practice speech therapy.

Speech Therapy

Treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies or previous therapeutic processes.

Subrogation:

The right to 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 the third party is, or may be, legally liable.

Surgery:

The treatment of disease, injury, or deformity by manual or instrumental operations performed by a licensed physician, such as the removal or repair of diseased parts or tissue by cutting. Surgery would include:

a) the performance of generally accepted operative and cutting procedures, including specialized instrumentations, and endoscopic examinations and other invasive procedures and injections into the bone or joint (but excluding injections or drugs, dyes or other substances);

b) the correction of fractures and dislocations;

c) usual and related preoperative and postoperative care; and

d) other procedures as reasonably approved by PEIA.

T

Third-Party Claims Administrator:

For the purpose of this Plan Document, a company, corporation or organization contracted by PEIA to evaluate, determine and process all medical claims incurred by eligible insureds of the PEIA according to plan policy provisions and contract agreement.

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

April 10, 1990

The Honorable Ken Hechler
Secretary of State
Building 1, Room 157-K
State Capitol Complex
Charleston, WV 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Rate Schedule notebook a copy of the memorandum sent to all Benefit Coordinators and Payroll Clerks, dated April 2, 1990.

This memorandum implements two (2) new rates, for disabled beneficiaries covered under the federal Consolidated Omnibus Budget Reconciliation Act ("COBRA"). As required by federal law, the new rates are effective January 1, 1990.

Thank you for your attention to this request.

Sincerely,

Sally K. Richardson
Director

SKR/DPL/th

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

M E M O R A N D U M

TO: All Benefit Coordinators/Payroll Clerks

FROM: Sally K. Richardson, Director

SUBJECT: Monthly Premium for Disabled COBRA Beneficiaries for 19th through 29th Month of Health Insurance Coverage

DATE: April 2, 1990

Please add the following two additional COBRA coverage codes to the current Premium Rate Schedule. These codes identify disabled COBRA beneficiaries and the monthly premium for continued health insurance coverage for months 19 through 29:

Coverage Code	Explanation of Coverage Code	Total Monthly Premium
CSD	COBRA Employee - Single Disabled	$140.00
CFD	COBRA Employee - Family Disabled	$326.00

The above reflects recent changes to the Consolidated Omnibus Budget Reconciliation Act (COBRA) which were passed by Congress in 1989 to be effective January 1, 1990.

If you have any questions, please contact the PEIA Premium Accounts Section at 348-7850.

SKR/DE/de

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

March 16, 1990

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Benefit Plan Document a March 8, 1990, memorandum to all payroll clerks and benefit coordinators, entitled "Attached Plan Document Revisions."

Enclosed with the memorandum are new and revised pages to be added to the Plan Document.

Thank you for your cooperation and assistance in this matter.

Sincerely,

Sally K. Richardson
Director

SKR:DPL:trs

cc: Donna Acord

Public Employees Insurance Agency

MEMORANDUM

Capitol Complex
Building 5
Tenth Floor
Charleston
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

TO: All Payroll Clerks and Benefit Coordinators

FROM: Sally K. Richardson SKR
Director

DATE: March 8, 1990

SUBJECT: Attached Plan Document Revisions

Attached please find the latest set of revisions to the PEIA Plan Document. Please insert these revised pages in the appropriate places in your copy of the Plan Document, and place the revision sheet at the front of the document for reference.

It is important that you keep your copy of the Plan Document current, both for your benefit, and for your insureds'. We appreciate your efforts, and thank you for your continued cooperation.

If you have questions, please feel free to contact our office.

Revisions Log
PEIA Plan Document

Page(s)	Date	Subject
GI-6	04/15/90	Inpatient Deductible
GI-9	03/08/90	Pre-Certification and Re-Certification
PT-6	03/08/90	Dependent Qualifications
FA-2, FA-7, FA-9, Fa-14	04/15/90	Inpatient Deductible; Pre-Certification
FA-3	03/08/90	Professional Fees; Experimental Medical Care
FA-5	03/08/90	Exclusion "f"
FA-6	03/08/90	Birthing Center/Midwife Benefit Payable
FA-8	03/08/90	Exclusion "e"
FA-10	03/08/90	Exclusion "d"
SB-1 to SB-5	03/08/90	Pre-Certification
SB-8	03/08/90	Exclusion "n"
MB-1	03/08/90	Exclusion "f"
OB-2	03/08/90	Exclusion "d"
OB-4	03/08/90	Benefit Payable #2

Revisions Log
PEIA Plan Document

Page(s)	Date	Subject
OB-6	03/08/90	Case Management Not Required
MM-1 to MM-2	03/08/90	Eligible Major Medical Expenses
MM-5	03/08/90	Air Ambulance Benefit Criteria
MM-10	03/08/90	Exclusion "b"

DEDUCTIBLES AND CO-PAYMENTS

PEIA benefits contained herein are paid based upon the proper deductibles and/or co-payments being satisfied.

Inpatient Admission Deductibles:

Single Coverage:

Each insured shall pay the first $100 of all covered expenses for the first inpatient admission per calendar year.

Family Coverage:

Each insured or dependent shall pay the first $100 of all covered expenses for the first inpatient admission per individual in a calendar year, not to exceed $200 per family.

Major Medical Deductibles:

Single Coverage:

Each insured shall pay the first $150 of all covered major medical expenses per calendar year.

Family Coverage:

Each insured or dependent shall pay the first $150 of all covered major medical expenses per individual per calendar year, not to exceed $300 per family.

Prescription Drug Deductible:

Single Coverage:

Each insured shall pay the first $50.00 of covered prescription drug expenses per calendar year.

Family Coverage:

Each insured or dependent shall pay the first $50.00 of covered prescription drug expenses per individual per calendar year, not to exceed $100 per family.

UTILIZATION MANAGEMENT

Pre-Admission Certification Program:

PEIA utilizes a pre-admission certification program which requires that any hospital admission have prior approval. The PEIA pre-certification program representative, in conjunction with the patient's physician, will determine, in advance, the length of stay for each admission. **The ultimate responsibility for pre-admission certification lies with the insured or dependent or designee.** Consult the PEIA medical identification card for the telephone number of the precertification program.

Pre-admission certification applies to all types of admissions:

- **SCHEDULED ADMISSION** — All elective surgeries or procedures which can be scheduled in advance are in this category. Notification must be given at least seven (7) days in advance.
- **URGENT ADMISSION** — Prompt medical attention is needed, but there is not immediate danger of loss of life or limb. Notification must be given within 48 hours of admission.
- **EMERGENCY** — An unplanned admission requiring immediate medical attention. There is immediate danger of loss of life or limb. Notification must be given within 48 hours of admission.
- **MATERNITY** — No pre-admission certification is necessary for normal vaginal delivery. Automatic two days of coverage. A two day stay is as follows:

Day of Admission	1 day
Day two of admission	1 day
Discharge day	0 (not counted)
	2 days

All Caesarean sections (C-sections) require certification, whether planned in advance or performed in an emergency.

- **EXTENDED** — Requests for additional hospital days will be considered by the precertification program based on medical necessity. Should the physician decide to extend the inhospital stay longer than originally certified, the patient, a family member or the physician must obtain approval to assure maximum benefits.

Failure to obtain pre-admission certification within the specified time periods will result in the total hospital confinement being paid at 80% of PEIA contracted fee.

Days which are not re-certified through the pre-certification program for an extended confinement are not eligible for payment.

Pre-certification does not assure payment, eligibility, or type of services covered under this benefit plan.

Dependent Qualifications:

For all benefits, the term "dependent" includes:

a. Spouse (if legally married)

b. Employee's or retiree's own child

c. A legally adopted child (including a child living with the parents during the period of probation)

d. Stepchild residing in the employee's or retiree's household

e. A child fully dependent upon the employee or retiree for support and maintenance and residing in the household of which the employee or retiree is the head and actually being supported by the employee or retiree.

The term "dependent" does not include father, mother, or other person that does not fall within the definition of dependent as stated within this Plan Document.

> NOTE: PEIA reserves the right to request proof of marriage, copies of birth certificates and legal documents indicating responsibility for child support and/or showing legal custody.

Full-time Unmarried Student:

Coverage for children terminates at the end of the month in which age 19 is attained. However, children are included after age 19 through the attainment of age 25 if they are enrolled as full-time students, are unmarried and are fully dependent upon the employee for support and maintenance.

A full-time student is defined as a student attending courses full-time in a graduate or undergraduate college or university, or when in attendance at a trade or professional school as the child's full-time occupation.

Student Status Between Ages 19 and 25:

Verification of full-time student status is required. The Claims Administrator will request that the policyholder arrange for a letter from the college, university or other school verifying that the dependent is a full-time student, and indicating the student's expected date of graduation. In this way we are requesting verification from the college through the policyholder, rather than from the college directly.

Room and board benefits are limited to the number of days authorized by PEIA's Pre-Admission Certification Program, up to 365 days for any one confinement.

Hospital Ancillary Charges:

Ancillary charges for additional hospital services and supplies necessary for the treatment of an illness, injury or pregnancy are covered if incurred during the period for which room and board benefits are payable.

Deductible:

Inpatient deductibles are $100 per person per calendar year with family plan deductible capped at $200 per calendar year.

Benefit Payable:

After the insured satisfies the inpatient deductible, the PEIA Plan will pay the hospital's contracted charges for those days approved by the Pre-certification Program.

The PEIA Plan will pay 80% of the hospital's contracted charges for hospital admissions which are not pre-certified. Days which are not re-certified through the pre-certification program for an extended confinement are not eligible for payment.

Minimum Stay:

Surgery	None required
Sickness	18 hours
Accident	None, if treated at the hospital within 48 hours of accident. Otherwise 18 hours

Weekend Hospital Admission Restricted:

Hospital admission on a Friday or Saturday is not a covered medical expense except when:

1. The admission is for a surgical procedure that will be performed within 24 hours of admission, or

2. The admission is medically necessary.

Pre-Admission Testing:

If a patient reports on an outpatient basis for pre-confinement laboratory and x-ray work, the charges are paid in full providing all of the following requirements are met:

1) The person is confined within ten days following the date of the test; and,

2) The tests are normally required as a part of a scheduled hospital confinement and would be considered covered expenses if made during the period of hospital confinement or for outpatient surgery.

3) The tests are billed by the provider as pre-admission testing.

Pre-admission testing may be performed in the doctor's office for covered procedures.

Professional Fees:

Many charges formerly made by hospitals are now made by non-hospital-based providers such as anesthesiologists, pathologists, therapists, radiologists, medical equipment and special drugs, etc. These charges are reimbursed up to the PEIA Fee Schedule rate, provided they were incurred during the period for which room and board benefits are payable or for outpatient surgery.

Blood Transfusion:

This type of expense is paid in several different ways. For details refer to "Blood Transfusions" in the Surgical Guidelines section of this Plan Document.

Experimental Medical Care — Pre-Certification is Required.

Charges for treatments which are experimental in nature will not be paid unless they are approved by pre-certification and monitored by the Case Management Program.

Patient Deceased - Hospital Charges

In the event an insured or dependent dies in the emergency room, charges relating to the emergency room and related x-ray and laboratory charges will be paid at 100% of the hospital's contracted rate.

FREE STANDING FACILITY (FSF)

General:

The purpose of a Free Standing Facility is to provide a setting where certain surgery or other diagnostic or treatment procedures can be performed without requiring an overnight hospital stay. The type of procedure performed in a FSF would normally be of the type which could not be effectively performed in a doctor's office and would otherwise require hospital confinement if FSF services were not available.

Definition:

The term "Free Standing Facility" means an institution (other than a hospital) which is established, equipped, and operated primarily for the purpose of performing outpatient elective procedures of an uncomplicated nature. It does not provide beds for overnight confinement. A FSF is considered a qualified facility when it is licensed by the state or jurisdiction in which it operates or is certified by the Social Security Administration as a provider under Medicare.

Benefit Payable:

Reasonable and customary charges for necessary services, supplies and treatment in connection with a procedure will be paid. For Professional services, PEIA will pay charges up to the PEIA Fee Schedule rate.

Exclusions Under Free Standing Facility:

No benefits are payable for:

a. Charges due to injury or sickness connected with employment with any employer;

b. Pregnancy related conditions for dependent children;

c. Elective abortions

d. Diagnosis and/or treatment by any method of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint;

e. Charges incurred for cosmetic or reconstructive surgery other than those resulting from accidental injury, disease, or unless the surgery is performed to correct birth defects;

f. Charges incurred in a federal hospital for service related injuries/disabilities or on account of war or for treatment in any state-supported institution;

BIRTHING CENTERS AND MIDWIVES

General:

Pregnant insureds may choose to have their delivery at a Birthing Center or at home by a Physician or Midwife.

Definition:

The term "birthing center" shall mean any licensed facility (other than a hospital) organized to provide facilities and staff to support a birthing service for pregnant clients.

A birthing center is to be able to provide prenatal, intrapartum, and post partum care provided for individuals with low risk births, uncomplicated pregnancy, labor and vaginal birth and newborn care during the recovery period.

The term "midwife" means a person educated in the discipline of nursing and midwifery, certified by examination with the American College of Nurse-Midwives, and licensed by state authority to engage in the practice of midwifery (CNM); or, a person trained in midwifery and licensed by the state authority to engage in the practice of midwifery.

Benefit Payable:

Birthing Center services, which include professional services, will be paid up to the PEIA Fee Schedule rate.

Mid-wife services performed outside a Birthing Center will be paid up to 60% of the PEIA Fee Schedule rate.

Exclusions:

a. Pregnancy related conditions for the dependent children;

b. Elective abortions

ALCOHOL AND SUBSTANCE ABUSE TREATMENT FACILITY

PRE-ADMISSION CERTIFICATION AND CASE MANAGEMENT ARE REQUIRED.

General:

This benefit provides medical treatment for insureds who require inpatient care in an Inpatient Alcohol and Substance Abuse Treatment Facility or hospital unit established for the treatment of alcoholism and substance abuse when recommended by a licensed physician.

Definition:

An Alcohol and Substance Abuse Treatment Facility is a licensed institution or a hospital established to provide medical treatment for patients who require inpatient care on account of alcoholism or substance abuse, which has permanent facilities for inpatient medical care on the premises, including 24-hour nursing service under the supervision of a full-time Registered Nurse (R.N.), and maintains daily medical records on all patients.

In no event will the term include any institution or part thereof which is used principally as a rest or nursing facility, or a facility for the aged, or one providing primarily custodial care.

> NOTE: Benefits for alcoholism and/or substance abuse are payable only if a person, while covered, becomes confined to an inpatient facility or hospital unit for the treatment of alcoholism or substance abuse. Length of treatment is established by the attending physician and may not exceed 31 days per calendar year.

Benefit Payable:

After the inpatient deductible has been satisfied, PEIA will pay the reasonable and customary fee of the institution's daily room and board charge for each day of confinement to a ward or semiprivate room. For confinement to a private room, PEIA will reimburse the institution's daily room and board charge for each day of confinement up to an amount equal to the institution's average charge for semiprivate accommodations. Payment will be made for not more than 31 days of confinement during any calendar year and is limited to a maximum lifetime benefit of 90 days.

PEIA will pay the reasonable and customary fee for the institution's necessary additional charges only during the period for which room and board benefits are payable.

> **NOTE: Failure to pre-certify admission will result in reduction of benefits to 80%. Days which are not re-certified through the pre-certification program for an extended confinement are not eligible for payment.**

Exclusions Under Alcohol and Substance Abuse Treatment Benefits:

No benefits are payable for charges:

a. not recommended and approved by a licensed provider (i.e. physician, psychologist, etc), or

b. incurred when patient leaves against medical advice, or

c. for personal or convenience items; or

d. related to employment; or

e. incurred in a federal hospital for service-related injuries/disabilities or on account of war or for treatment in any state-supported institution.

EXTENDED CARE FACILITY

PRE-ADMISSION CERTIFICATION AND CASE MANAGEMENT ARE REQUIRED.

General:

This benefit provides for extended care in a skilled nursing facility when such care is determined to be medically necessary for the insured's improvement or stabilization.

Definition:

An Extended Care Facility is an institution that, for a fee, furnishes room, board and skilled nursing services for medical care; has one or more licensed nurses on duty at all times under the supervision of a doctor or Registered Nurse (R.N.) on a 24-hour basis. The Extended Care Facility must also have available at all times under an established agreement the services of a licensed physician. The institution must maintain daily medical records on all patients and comply with the legal requirements applicable to the operation of an Extended Care Facility.

Covered Benefits:

Benefits are payable if an insured incurs charges for confinement to an Extended Care Facility due to accidental injury or sickness.

NOTE: Failure to pre-certify the admission or to obtain prior approval from Case Management will result in reduction of benefits to 80%.

Benefit Payable:

After the insured has satisfied the inpatient deductible, benefits are payable for room and board up to the average semiprivate room rate of the Extended Care Facility. The policyholder will also be reimbursed (in full) for other covered charges (except nurses' and doctor's fees) made on a day for which room and board benefits are payable. The confinement and charges must be recommended as medically necessary by a licensed physician. **No one confinement can exceed 180 days.**

Room and board charges will be reimbursed at 100%, of the facility's charge for semiprivate accommodations, for the first sixty days of the confinement. During the next 120 days such charges will be paid at 80%.

All Extended Care Facility confinements due to the same or related cause and not separated by more than 14 days during which the insured is not confined to an Extended Care Facility or to a hospital shall be considered as the same Extended Care Facility confinement.

Extended care confinements after a 14 day separation from an Extended Care Facility or hospital due to the same or related cause are paid at 80% for days 181 through 365.

A 365-day lifetime limit applies for all Extended Care Facility confinements.

Professional Fees:

Professional fees for physicians' and other providers' services will be paid under other appropriate plan benefits within this Plan Document.

Exclusions:

No benefits are payable for:

a. Charges for any institution or part thereof used principally as a rest facility for the aged, an intermediate nursing care facility ,facility providing custodial or educational care or a facility for treatment of alcoholism or drug addiction;

b. Charges unless certification is made by the patient's attending physician that 24-hour a day skilled nursing care is essential and the patient is actually receiving such skilled nursing service;

c. Charges incurred in connection with private duty nursing;

d. Charges incurred in a federal hospital for service related injuries/disabilities or on account of war or for treatment in any state-supported institution;

e. Charges due to injury or sickness connected with employment;

f. Custodial care.

g. Elective services and supplies such as telephone, television, etc.

MEDICAL REHABILITATION

PRE-CERTIFICATION AND CASE MANAGEMENT ARE REQUIRED.

General:

The purpose of this benefit is to provide for inpatient and outpatient rehabilitation treatment. Inpatient rehabilitation hospitals must be JCAH and/or CARF accredited. Outpatient treatment must be in a CARF-approved facility. The admission date and treatment must be pre-approved and continually certified by Case Management.

Definition:

A Rehabilitation Hospital is a facility which, for compensation, is primarily engaged in providing rehabilitation care services on an inpatient basis, for those disabled by disease or injury to be able to achieve the highest practicable level of functional ability. Such services are provided by, or under the supervision of, an organized staff of physicians with continuous nursing services provided under the supervision of a registered graduate nurse (RN).

Benefit Payable:

Benefits are payable if a covered person incurs charges for confinement to a medical facility licensed as a rehabilitation hospital due to an accidental injury or sickness.

After the inpatient deductible has been satisfied, room and board charges will be reimbursed at 100% up to 60 days of the facility's charge for semi-private accommodations. During the next 90 days of the same confinement, such charges will be paid at 80%.

All rehabilitation confinements due to the same or related cause must be separated by at least 14 days. At no time can rehabilitation and extended care confinement be greater than 365 days.

Outpatient treatment will be paid at 80% under Major Medical after satisfying required deductible.

NOTE: Failure to obtain pre-certification and Case Management approval will result in reduction of benefits to 80%.

Exclusions:

No benefits are payable for:

a. Charges incurred at a rest facility or for custodial care;

b. Charges for private duty nursing;

SURGICAL BENEFITS

PRE-CERTIFICATION IS REQUIRED for all inpatient surgeries, certain outpatient surgeries and certain major diagnostic procedures.

Benefits Covered:

A. Surgical procedures consisting of operative and cutting procedures, treatment of fractures and dislocations, and endoscopic procedures including pre-and post-operative care which are performed in or out of a hospital by a qualified physician on an insured, as the result of an accidental injury or sickness.

B. Reconstructive surgery performed for correction of birth defects, disease, or accidental injury.

C. Dental procedures are not generally covered, however, listed below are certain dental procedures which will be covered as surgical procedures:

1. The surgical extraction of impacted teeth performed either in or out of a hospital.

2. Maxillofacial and mandibular jaw ridge surgery is reimbursed according to the class indicated by oral surgeon and ADE review. See Guidelines.

A list of certain outpatient surgeries and/or major diagnostic procedures which must be pre-certified is included in Appendix A.

Benefit Payable:

PEIA will pay charges up to 100% of the PEIA Fee Schedule rate for all eligible surgical procedures for accidental injury and sickness, providing pre-certification requirements are met. Surgeon's Visits, including pre-and post-operative care are combined with the surgical procedure charge for reimbursement purposes.

Failure to meet pre-certification requirements will result in reduction of benefits to 80%.

Two or More Surgical Procedures:

When two or more surgical procedures are performed during the course of a single operation through the same incision or in the same natural body orifice, PEIA will pay charges up to 40% of the PEIA Fee Schedule rate for the second and each additional medically necessary surgical procedure.

Maternity:

Maternity benefits are payable as surgery covering both pre-natal and post-partum care. If the patient changes physicians, the visits to the first physician are paid according to PEIA maximum fee schedule as pre-natal and deducted from the full benefits of the second physician if he/she bills for full charges.

Assistant Surgeons:

Benefits for an assistant surgeon will be available for a licensed physician who actively assists the operating surgeon in the performance of a surgical procedure included in "A"on the previous page when the following conditions are met:

1. such services are certified as necessary by the primary operating surgeon; and
2. the type of surgical service requires such assistance; and
3. interns, residents, or house staff are not available.

Assistant surgeon benefits are only allowable while an insured is an admitted inpatient in a hospital.

When deemed medically necessary for a surgical procedure, the services of an assistant surgeon are covered at 20% of the primary surgeon's PEIA Fee Schedule rate.

Stand-By Surgeons:

A maximum charge of $400 is allowed for a stand-by surgeon for angioplasty.

Second and Third Surgical Opinions:

PEIA retains the right to require a second or third opinion on any surgical procedure, if it is believed there is marginal medical necessity.

> NOTICE: No amount is payable under this plan if surgery is determined not to be medically necessary.

Requirements for Additional Opinions:

When a physician recommends a surgical procedure, the physician or patient must call for pre-certification.

An experienced medical professional will call the patient's physician and evaluate the need for a second or third surgical opinion based upon information provided by the

physician. If a second or third opinion is required, it must be rendered by a board-certified specialist not associated with the primary physician.

The employee/patient will be sent a second or third surgical opinion form. Employee/patient must complete Part I of the form and give it to the physician providing the second or third opinion. The physician should complete Part II of the form.

Benefit Payable:

PEIA will pay charges up to the PEIA Fee Schedule rate for the second or third opinion and charges up to 100% of the PEIA Fee Schedule rate for the surgical procedure, if authorized.

> NOTE: Duplicate testing charges (x-ray and laboratory) related to same diagnosis, are not covered unless documented as necessary by the consulting physician.

Outpatient Surgery and Major Diagnostic Procedures:

General:

The plan requires that prior approval be obtained from the Pre-certification Program for certain outpatient surgical and major diagnostic procedures to receive maximum benefits.

Outpatient surgery means:

a) no room and board charge is made to the insured, and

b) surgery is performed in an Free Standing Facility, an outpatient surgery section of a hospital or a physician's office.

In all instances, the patient should discuss outpatient surgery and major diagnostic procedures with the physician prior to the procedure.

A list of those certain surgeries and/or major diagnostic procedures which must receive prior approval from the Pre-certification Program is included in this document as Appendix A.

Note: If the physician recommends, and the Pre-certification Program determines and approves that it is medically necessary (because of heart condition, hemophilia or other medical complications) for the patient to be admitted to the hospital for the procedure, charges will be paid PEIA's contract rate.

Benefit Payable:

PEIA will pay charges up to the PEIA Fee Schedule rate if the procedure is performed on an outpatient basis with pre-authorization from the Pre-certification Program. **If the procedure is performed on an inpatient basis or outpatient basis without prior approval, PEIA will pay charges up to 80 % of the PEIA Fee Schedule rate.**

Note: For x-ray and imaging procedures the insured shall pay 10% of eligible charges or of PEIA Fee Schedule rate, whichever is less, up to a maximum of $100 per person per calendar year. After satisfying the $100 maximum, all eligible outpatient x-ray or imaging procedures are payable at 100% of the PEIA Fee Schedule rate.

Blood Transfusions:

Charges by a Physician - Charges by a physician for the administration of a blood transfusion are to be paid as a surgical procedure.

Charges by a Hospital - Charges made by a hospital for whole blood, processed blood product (i.e. packed cells, plasma) and services in connection with the processing of blood and administration of a blood transfusion, whether incurred on an inpatient or outpatient basis, are paid according to the hospital's contracted rate. Because our Plan is written on a reimbursement basis, if credit is shown on the hospital bill for replaced blood, covered charges are to be reduced by the amount credited.

Organ and Tissue Transplants -- Case Management is Required

Pre-certification and Case Management approval must be obtained at least 7 days in advance of the scheduled procedure.

Claims are administered as follows:

1. Where the donor does not have Health Insurance coverage and PEIA insures the recipient, we will recognize the donor's medical expenses as part of the recipient's claim. We 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.

   a. Under Hospital and Surgical Coverage - In determining donor benefits, we will add the donor's room and board and ancillary charges to the recipient's ancillary charges. 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.

   b. Under Major Medical Expense Plans - In determining Major Medical Expense benefits, the excess of any covered hospital or surgical charges over the amount paid

for the donor by the recipient's basic plan will be considered for Major Medical coverage under the recipient's plan.

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

3. Where both the donor and recipient have health coverage and PEIA insures the recipient, we 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.

4. 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.

the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint;

h. Removal of calluses.

i. Incidental surgery performed through the course of a surgery performed due to medical necessity.

j. Charges for in vitro fertilization, or artificial insemination.

k. Radial Keratotomy.

l. Gastric stapling unless insured is more than 100 pounds over weight.

m. Surgery to relieve a patient of emotional stress and/or psychological disorders.

n. Charges incurred in a federal hospital for service-related injuries/disabilities or on account of war, or for treatment in any state-supported institution.

o. Weight loss

PHYSICIAN (IN-HOSPITAL) MEDICAL BENEFITS

To be covered, the visits must be made while the insured is confined to a licensed hospital or facility as an admitted in-patient. Benefits are payable only if a licensed physician charges the insured for visits because of an accidental injury or sickness.

Benefit Payable:

PEIA will pay up to the PEIA Fee Schedule rate for charges incurred beginning the first day of confinement to and including the day of discharge.

> NOTE: The number of visits must not exceed the number of days of hospital confinement.

Charges for professional visits by the attending physician after diagnostic surgery will be paid up to the PEIA Fee Schedule rate. Visits by the surgeon after diagnostic surgery are not eligible for payment, but are included in the surgical fee.

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 paid under the Major Medical portion of the Plan after satisfying the required major medical deductible.

Exclusions Under Physician (Inhospital) Medical Benefits:

No benefits are payable for:

a. Any injury or illness connected with employment with any employer;

b. Pregnancy related conditions for dependent children;

c. Elective abortions;

d. Diagnosis or treatment of jaw joint disorders, including temporomandibular joint and craniomandibular disorders or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint;

e. Treatment by a physician for weight loss.

f. Charges incurred in a federal hospital for service-related injuries/ disabilities or on account of war or for treatment in any state-supported institution.

OUTPATIENT LABORATORY AND X-RAY BENEFITS

The PEIA Plan is designed to provide on a co-payment basis for outpatient diagnostic x-ray and laboratory examinations generally accepted in medical practice as necessary for the diagnosis or treatment of an accident or disease as determined by the Claims Administrator.

Allowable Expenses:

A. Outpatient diagnostic x-ray examinations in connection with injury or sickness are covered. The examinations must be recommended by a licensed physician and made by a hospital, a radiologist or a physician qualified to perform and interpret radiological examinations within the confines of a single specialty.

B. Laboratory examinations in connection with injury or sickness are covered. The examinations must be made or recommended by a licensed physician.

This specifically includes pap smear and mammograms for cancer or diagnostic purposes when recommended by a licensed physician. W.Va. Code 33-15-4c.

Benefit Payable - Co-Payment Provision:

Insureds shall pay 10% of eligible outpatient lab or x-ray charges or PEIA Fee Schedule rate , whichever is less, up to a maximum of $100 per person per calendar year. After satisfying the $100 maximum, all eligible outpatient lab and x-ray charges will be paid up to 100% of the PEIA Fee Schedule rate.

Pre-admission testing is paid in full if the tests are required as part of a scheduled confinement and the insured person is confined to the hospital within 10 days from the date of the tests.

> NOTE: The 10% co-payment cannot be applied or used to satisfy other Plan deductibles or copayments.

Exclusions Under X-Ray and Laboratory Benefits:

a. Routine eye examinations;

b. Charges for dental x-rays;

c. Charges due to injury or sickness connected with employment with any employer;

d. Charges incurred in a federal hospital for service-related injuries/disabilities or on account of war or for treatment in any state-supported institution;

ACCIDENTAL INJURIES (OUTPATIENT)

The initial visit by an insured receiving emergency outpatient care within 48 hours of a non-occupational accidental injury is covered.

Benefit Payable:

PEIA will pay for the following services:

1. One hundred percent (100%) of contracted hospital rates for the initial visit.

2. Physician's charges up to 100% of the PEIA Fee Schedule rate for the initial visit.

Where an insured sustains an accidental bodily injury, the physician's bill may indicate treatment of a surgical nature, as that rendered for fractures and lacerations, and also medical treatment for conditions such as abrasions, contusions, etc. Payment is to be made for the surgical, physician and medical treatments.

Outpatient Follow-up (after an accident):

When an injury, initially treated within 48 hours of an accident, results in further outpatient care, hospital charges for this care are allowed as hospital ancillary charges. This rule covers only those charges necessary to complete the work, initially performed, such as removal of a cast or sutures, additional x-rays for a fracture or the re-application of a cast.

> Note: Follow-up treatment does not include charges for injections, diathermy and other therapeutic treatments or physical medicines.

General Guidelines:

Sprains, Bee Stings and Electrical Shock - Claims for these conditions are to be considered the result of an accident.

Strains - A strain may be the result of natural physical weakness or the result of an accident. Where the insured or physician indicates a strain is due to an accident, the claim is to be accepted.

Sunburns, Poison Ivy, Ingestion of Sleeping Pills, Nose Bleeds and Similar Occurrences - Any of these conditions are to be considered as sickness where additional information is not submitted to substantiate an accident claim.

CARDIAC REHABILITATION

The PEIA benefit program provides limited coverage for cardiac rehabilitation. Coverage is limited to insureds meeting the requirements outlined below and referred by the attending physician. One of the following conditions must be documented in writing by the attending physician.

1) The insured must have had an acute myocardial infarction (MI) in the preceding twelve (12) months; or

2) The insured has had coronary bypass surgery; or

3) The insured has stabilized angina pectoris.

Cardiac rehabilitation programs are covered in the following facilities.

a. Free Standing Clinic

b. Cardiac Rehabilitation Clinic

c. Outpatient Hospital Departments

Maximum Benefit:

Duration of the benefit is limited to 36 sessions per calendar year. (Limit of 3 sessions per week for 12 weeks)

Benefit Payable:

Insureds shall pay 10% of eligible outpatient lab or x-ray PEIA Fee Schedule rate up to a maximum of $100.00 per calendar year. After satisfying the $100.00 maximum, all eligible outpatient lab and x-ray charges will be paid up to 100% of the PEIA Fee Schedule rate.

All Other Charges:

Eligible charges are paid up to 80% of the PEIA Fee Schedule rate or the reasonable and customary amount, whichever is applicable, after satisfying required major medical deductible.

MAJOR MEDICAL

Major Medical supplements the Hospital and Surgical Expense benefits. Eligible expenses under Major Medical must be prescribed by a licensed physician in connection with the treatment of injury or sickness.

Maximum Lifetime Major Medical Benefit:

The maximum lifetime major medical benefit is $500,000 per insured.

Deductible:

Major medical deductibles are $150 per person per calendar year with the family plan total deductible capped at $300 per calendar year.

Benefit Payable:

Eligible services are paid at 80% according to either the PEIA Fee Schedule or the reasonable and customary fee schedule, whichever is appropriate. The required deductible amount must be satisfied before services can be eligible for reimbursement.

Eligible Major Medical Expenses:

The following services, supplies and treatment are included as eligible major medical expenses if they are prescribed by a physician in connection with an illness or injury.

1. Preventive pediatric health care office visits and immunizations from birth through age twelve. See Major Medical guidelines for covered services.

2. Office visits and services for diagnosis and treatment of medical conditions only.

3. Services of a Chiropractor including office visits limited to a maximum reimbursement of $750 per calendar year. Charges in excess of PEIA maximum are considered non-covered services.

4. Consultations in or out of the hospital.

5. Private duty skilled nursing by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) provided outside of a hospital by a person not related by blood or marriage or regularly residing in the household of the insured. ($30,000 yearly maximum.) **Must obtain prior approval from Case Management.**

6. Treatment by a registered physical or occupational therapist.

7. Treatment by x-ray, radium, or other radioactive substances.

8. Ground ambulance service to the hospital for inpatient care, for outpatient accident care,or from a hospital to the nearest facility able to provide needed services not available at the transferring hospital. Air ambulance, when medically necessary, is covered when moving the patient to the nearest facility providing necessary treatment (See Major Medical Guidelines).

9. Artificial eyes, limbs, larynx, and other prosthetic devices.

10. Durable medical equipment when accompanied by a statement of medical necessity from the attending physician **and when authorized by case management.**

11. Allergy testing and the related injections. (Vaccine covered under Prescription Drug program.)

12. Repair of accidental injury to sound natural teeth.

13. Service for outpatient psychiatric treatment or testing rendered by a physician or clinical psychologist limited to 50% of the eligible charge up to, but not more than $1,000 per calendar year. Charges in excess of the PEIA maximum benefits are considered non-covered services.

14. Charges for speech therapy rendered by a qualified speech therapist for speech impairment due to any injury, sickness or functional disorders when recommended by a licensed physician and **authorized by case management.**

15. Hepatitis inoculation is the only covered medical service that is allowable under the PEIA plan that is related to employment. (EXAMPLE: School Health Nurse)

16. Hemodialysis

17. X-ray interpretation

18. IV Therapy -- **Must obtain prior approval from Case Management.**

3. Billing must be itemized with charges noted for each of the following:

   a. Lift-off charge (if any)

   b. Total mileage charged, noting rate per mile and miles traveled.

   c. Number in medical crew and charges incurred. Also note rate per hour for each medical crew member (i.e. paramedic, EMT, etc.) and number of hours or fractional hours charged.

   d. Medical supply charges by item.

Benefit Criteria:

a. No benefit for lift-off charges.

b. Maximum mileage rate allowable is $25.00 per mile, payable at 80%.

c. Medical crew charges are payable up to a maximum rate of $75.00 per hour for each medical crew member (up to a maximum of two medical personnel) providing medical treatment to the patient being transported.

d. Medical supplies paid at 80%.

Exclusions Under Major Medical Expense Benefits

Covered services shall not include expenses for:

a. Services, supplies and treatment unless prescribed as necessary by a physician licensed to practice medicine and surgery or by a Doctor of Dental Surgery as indicated for oral surgery;

b. Charges incurred in a federal hospital for service-related injuries/disabilities or on account of war or for treatment in any state-supported institution;

c. Routine dental and optical work, routine office visits, routine physical examinations (except pap smears and mammograms) transportation other than local ambulance service, air ambulance not deemed medically necessary, hearing aids, articles of clothing, eye glasses, contact lenses or examinations for fitting or prescription thereof.

d. The difference between private and semiprivate accommodations;

e. Surgical services for which benefits are payable under the provisions of this contract entitled Surgical Services Benefits, nor will such charges be applied toward the Cash Deductible;

f. Treatment for marital counseling;

g. Pregnancy and all related conditions for dependent children;

h. Elective abortions;

i. Treatment of weak, strained, or flat feet or instability or imbalance of the feet, or any tarsalgia, metatarsalgia or bunion, other than surgery involving the exposure of bones, tendons or ligaments;

j. Treatment (including cutting or removal by any method) of toe nails or of superficial lesions of the feet including corns, callouses, pedicures and hyperkeratoses, other than the removal of nail matrix or root;

k. Charges due to injury or sickness connected with employment with any employer, except when denied by Workers' Compensation;

l. Treatment for weight loss;

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

January 31, 1990

The Honorable Ken Hechler
Secretary of State
Building 1, Suite 157-K
Charleston, W. Va. 25305

Re: **Filing of Public Employees Insurance Agency Benefit Plan Document and Insurance Rate Schedules**

Dear Secretary Hechler:

Enclosed please find for filing copies of the following documents: (1) a new Public Employees Insurance Agency Plan Document, to be effective March 1, 1990; (2) a January 31, 1990, memorandum to Non-State Agency Payroll Clerks/Benefit Coordinators, notifying them of a premium rate increase, effective March 1, 1990; and (3) the PEIA's current premium rate schedules, effective July 1, 1989.

As you may know, rules and regulations of the Public Employees Insurance Agency generally are exempt from the rule-making provisions of the State Administrative Procedures Act. See W. Va. Code §5-16-18. Only a rule which would impose a premium assessment on State employees and employees of county boards of education must be promulgated in accordance with W. Va. Code §29A-1-1 et seq. See W. Va. Code §5-16-13a(c).

Even though the PEIA is not required by law to file its Plan Document or rate schedules with your Office, we are committed to the principles of public notice and of having these documents on file in a central location. For this reason, I am requesting that the Plan Document and rate schedules be filed in your Office together with the existing rules and regulations of the PEIA.

Thank you very much for your cooperation and assistance.

Sincerely,

Sally K. Richardson
Director

SKR:trs

Enclosures

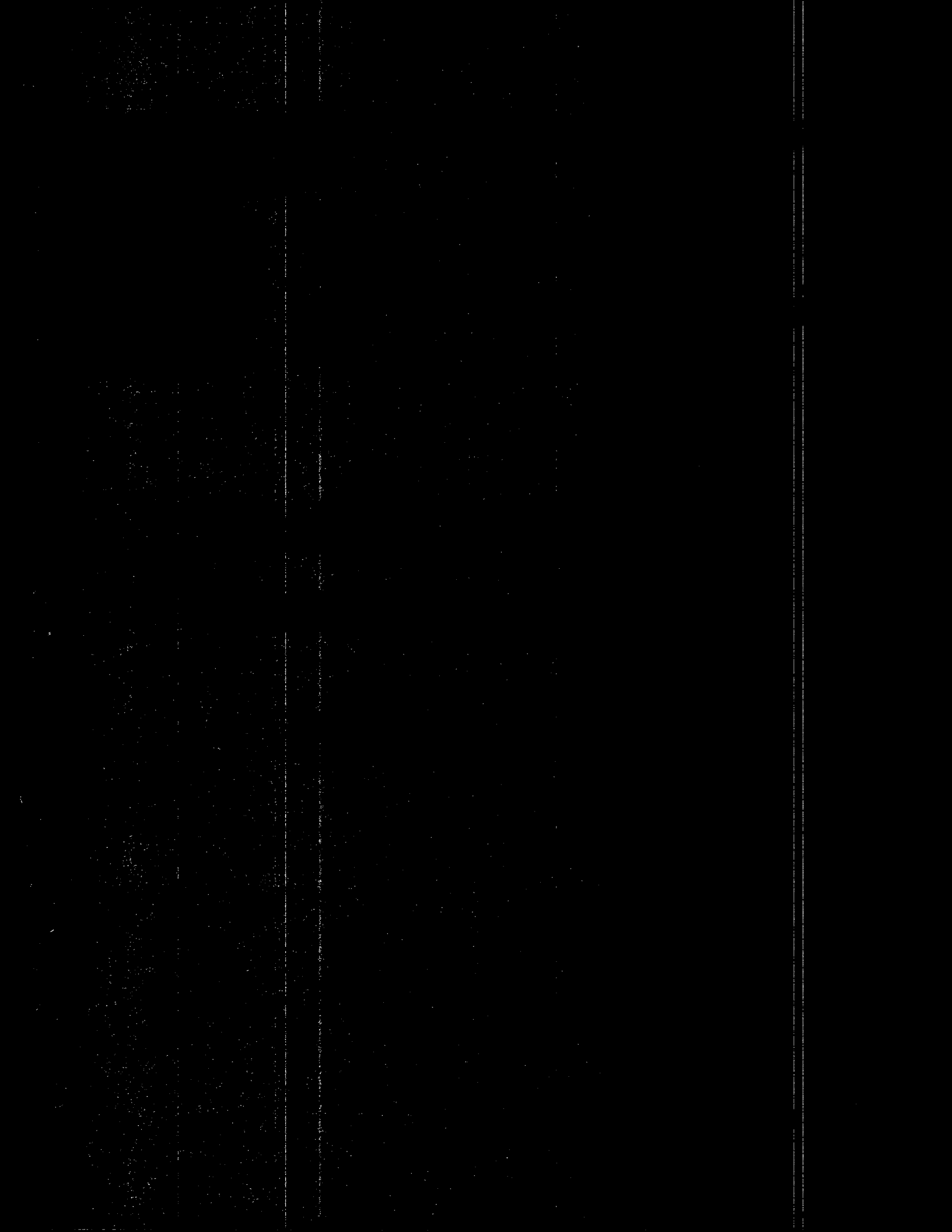

Table of Contents

General Information

INTRODUCTION

This document describes in detail the Benefit Plan of the West Virginia Public Employees Insurance Agency (hereinafter PEIA) which is effective on March 1, 1990. A policyholder's manual which will describe the plan in "user's terms" will be distributed to each policyholder prior to the effective date of this revised Benefit Plan. A "Glossary of Terms" is included as the last section of this document for clarification of terms.

The PEIA is a self-insured health insurance trust fund which offers hospital, surgical, major medical, prescription drug and other medical care benefit coverage, as well as basic and optional life insurance to employees and retirees of all state agencies, organizations, universities and colleges, county boards of education and those county and municipal agencies and organizations which elect to participate. This represents 12% of West Virginia's population.

PEIA has recently completed a most difficult period, when its backlog of unpaid claims reached over $100,000,000. This backlog has been paid and the Legislature has given PEIA sufficient funds to pay its medical claims on a timely basis this year. The Administration's top priority is to keep PEIA in this same solvent financial condition, without diminishing the quality of health care available to public employees and retirees.

The increasing cost of health care is an economic fact of life for all employers and employees and retirees. The revised PEIA Benefit Plan seeks to maintain an equitable balance between the State's responsibility to adequately fund its insurance benefit, the responsibility of providers to offer effective and cost-effective services and the insureds' responsibility to use the Plan in a cost-saving manner. Following are some important features which assist PEIA in attaining these balanced goals.

COST MANAGMENT

Managing health care dollars is the responsibility of both the Public Employees Insurance Agency and its insureds. The PEIA has implemented several utilization management programs, such as hospital precertification, medical case management and a prescription drug program. A preferred provider organization (PPO) is also being developed. These programs ensure that quality health care is available to insureds at an affordable cost. Cost saving measures not only reduce Plan expenditures, but also reduce the insured's out-of-pocket expenses.

Personal health care decisions greatly impact the Benefit Plan. Insureds must become actively involved in evaluating the necessity and the cost of recommended health care services. The following are some suggestions for becoming a conscientious health care consumer:

1. Become familiar with the benefits before they are needed. Know what services require precertification or pre-authorization.

2. Learn about health care costs by asking not only if a service is covered by insurance, but also what the recommended service will cost. Do price comparisons if necessary.

3. Ask the physician if services can be arranged at home by the Medical Case Management program versus being admitted to a hospital.

4. Consider treatment of medical conditions by non-surgical methods before surgical means are pursued.

5. Call the precertification program to help determine if a second opinion is necessary before consent is given for surgery.

6. Use outpatient and ambulatory surgical facilities for many common surgical treatments when appropriate.

7. Have pre-admission testing whenever possible.

8. Advise the physician, if admitted, that the Medical Case Management program can arrange for home care services to assist with early discharge.

9. Use a doctor's office or hospital outpatient facility for medical treatment versus an emergency room.

10. Consult with the Medical Case Management program if it becomes apparent that health care dollars could be saved.

BASIC AND OPTIONAL PROGRAM CHOICES

PEIA currently offers the following benefit choices to employees:

Basic Benefit Choices

1) Basic Health and Life Insurance: This benefit provides basic hospital, surgical, major medical, prescription drug and other medical expense benefits, and a $10,000.00 decreasing term life insurance policy with accidental death and dismemberment benefits.

2) Basic Life Insurance Only: This benefit provides for a $10,000 decreasing term life insurance policy with an accidental death and dismemberment benefit.

Employees who elect to participate in one of the basic choices may also elect to enroll for one or more of the optional benefit choices offered. The employee must pay the total premium for any and all optional benefits.

Optional Benefit Choices:

Active Employees:

1) Optional Life Insurance: This benefit provides for a decreasing term life insurance policy in amounts from $5,000 to $50,000 with an accidental death and dismemberment benefit.

2) Dependent Optional Life Insurance: This benefit provides term life insurance policies for eligible dependent(s) in the amount of $5,000 for his/her spouse and $2,000 for each dependent child with accidental death and dismemberment benefits. If a dependent child or spouse of a policyholder is himself/herself an eligible employee, then he/she may enroll for the full optional life insurance benefits indicated in paragraph 1 above.

Retiree:

1) Optional Life Insurance: This benefit provides for a decreasing term life insurance policy in amounts from $2,250 to $50,000 (no accidental death and dismemberment coverage).

MEDICALLY NECESSARY EXPENSES

The PEIA plan provides reimbursement of expenses which are medically necessary.

Medically Necessary Expenses are:

Services or supplies provided by a hospital, medical facility, physician, or other provider which are required to identify or treat an insured's illness, condition or injury and, as determined by PEIA, are:

a. consistent with the symptom or diagnosis and treatment of the insured's condition, disease, ailments or injuries;

b. appropriate with regard to standards of good medical practice;

c. not solely for the convenience of an insured, physician, hospital or other provider; and

d. the most appropriate supply or level of service which can be safely provided to the insured.

The fact that a physician has prescribed, ordered, recommended, or approved a service, treatment, hospitalization or supply as "medically necessary" does not make the charge a covered expense. PEIA reserves the right to make the final determination of medical necessity on the basis of the final diagnosis and supporting medical data.

PAYMENTS

PEIA Fee Schedule:

Generally, PEIA will pay physicians and other non-institutional providers according to the PEIA "80th percentile" Fee Schedule. Under this schedule, PEIA will pay these providers their actual rates charged, up to a maximum allowable amount. The maximum amount is set at that level which includes the full rates charged by 80% of PEIA's providers (based on 1988 claims data).

The PEIA Fee Schedule applies only to health care services for which a Current Procedure Terminology (CPT-4) Code exists. Services provided by physicians, podiatrists, chiropractors, dentists and oral surgeons generally have CPT-4 codes.

For services for which there is no CPT-4 code, PEIA will pay providers according to a reasonable and customary fee schedule. Charges for medical supplies, durable medical equipment, and outpatient facilities usually do not have CPT-4 codes, and, therefore, are paid according to the reasonable and customary fee schedule.

For certain services, PEIA provides only limited benefits. For these services, PEIA will pay based upon either the PEIA Fee Schedule or the reasonable and customary fee schedule, whichever is applicable, up to the limits of the particular benefit. These services are explained in detail within this document.

Unless otherwise noted, a provider may not collect from the patient any balance of charges over and above what PEIA pays, except for deductibles and copayments.

Hospitals:

PEIA will pay hospitals at a pre-determined individual rate based on individual contracts with PEIA.

Payments:

As a general rule, PEIA will pay the following percentages of eligible charges:

Inpatient facility charges	100%
Surgery charges	100%
Major Medical expenses	80%
Prescription drugs:	
generic	90%
brand name (required by physician)	80%
brand name (no generic equivalent)	80%
brand name (selected by patient)	75%
Other medical charges	as specified in this document.

DEDUCTIBLES AND CO-PAYMENTS

PEIA benefits contained herein are paid based upon the proper deductibles and/or co-payments being satisfied.

In-Hospital Admission Deductibles:

Single Coverage:

Each insured shall pay the first $100 of all covered expenses for the first hospital admission per calendar year.

Family Coverage:

Each insured or dependent shall pay the first $100 of all covered expenses for the first in-hospital admission per individual in a calendar year, not to exceed $200 per family.

Major Medical Deductibles:

Single Coverage:

Each insured shall pay the first $150 of all covered major medical expenses per calendar year.

Family Coverage:

Each insured or dependent shall pay the first $150 of all covered major medical expenses per individual per calendar year, not to exceed $300 per family.

Prescription Drug Deductible:

Single Coverage:

Each insured shall pay the first $50.00 of covered prescription drug expenses per calendar year.

Family Coverage:

Each insured or dependent shall pay the first $50.00 of covered prescription drug expenses per individual per calendar year, not to exceed $100 per family.

Major Medical Copayment:

The plan will pay, where applicable, charges up to 80% of the PEIA Fee Schedule rate for medically necessary expenses (after required deductible is satisfied by the policyholder). The 20% balance or remaining expenses are the responsibility of the policyholder and cannot be applied toward other deductibles within this Plan.

Outpatient Laboratory and X-Ray Percentage Payment:

Each insured shall pay 10% of the PEIA Fee Schedule rate for each covered outpatient lab or x-ray charge up to a maximum of $100 per calendar year. After meeting the $100 maximum, the PEIA will pay all eligible outpatient lab and x-ray expenses at the PEIA Fee Schedule rate.

Prescription Drug Copayment:

The Plan will pay the following percentages of covered prescription drug charges:

90% of generic drug charge.

80% of brand name drug charge when no lower cost generic is available, or when the physician requires a brand name drug.

75% of brand name drug charge when a lower cost generic is available

The remaining percentage (either 10%, 20% or 25%) or remaining expenses are the responsibility of the policyholder and cannot be applied toward other deductibles within this Plan.

NOTE: No co-payment may be used to satisfy any Plan deductibles. The in-hospital, major medical and prescription drug deductibles, and outpatient lab and x-ray co-payments must be satisfied separately.

Guidelines:

The deductible is applied to the eligible charges. The claim is calculated in the usual manner to determine the amount payable.

ASSIGNMENT OF BENEFITS

(W.Va. Code 16-29D-4; 5-16-1l)

Pursuant to the requirements of the Omnibus Health Care Act, health care providers providing covered services, supplies or treatments to PEIA participants are required to accept assignment of the participant's right to receive payment of benefits. Consequently, benefits payable for covered services, supplies and treatments will generally be paid directly to the provider.

PEIA insureds may decide to pay for their care at the time of service, and submit a claim for reimbursement. This payment arrangement is an option for the insured, and may not be required by the provider.

UTILIZATION MANAGEMENT

Pre-Admission Certification Program

PEIA utilizes a pre-admission certification program. This program requires that any hospital admission must have prior approval. The PEIA certification program representative, in conjunction with the patient's physician, will determine ahead of time the length of stay for each admission. **The ultimate responsibility for pre-admission certification lies with the insured or dependent or designee.** Consult the PEIA medical identification card for the telephone number of the precertification program.

Pre-admission certification applies to all types of admissions:

SCHEDULED ADMISSION — All elective surgeries and term pregnancies are in this category. Notification must be given at least seven (7) days in advance.

URGENT ADMISSION — Prompt medical attention is needed, but there is not immediate danger of loss of life or limb. Notification must be given within 48 hours of admission.

EMERGENCY — An unplanned admission requiring immediate medical attention. There is immediate danger of loss of life or limb. Notification must be given within 48 hours of admission.

MATERNITY — No pre-admission certification is necessary for normal vaginal delivery. Automatic two days of coverage. A two day stay is as follows:

Day of Admission	1 day
Day two of admission	1 day
Discharge day	0 (not counted)
	2 days

All Caesarean sections (C-sections) require certification, whether planned in advance or performed in an emergency.

EXTENDED — Requests for additional hospital days will be considered by the precertification program based on medical necessity. Should the physician decide to extend the inhospital stay longer than originally certified, the patient, a family member or the physician must obtain approval to assure maximum benefits.

Failure to obtain pre-admission certification or request an extension within the specified time periods will result in the total hospital confinement being paid at 80% of PEIA contracted fee.

Pre-certification does not assure payment, eligibility, or type of services covered under this benefit plan.

Medical Case Management

Medical Case Management is an important part of this benefit package. The purpose of case management is to ensure that employees receive quality health care in the most cost-effective manner. Case management, by design, works with patients who are experiencing long-term illness, including, but not limited to:

* Organ transplants
* Spinal cord injuries
* Brain damage
* Severe burns
* Strokes - CVA
* Multiple fractures - amputees
* Pre-term or high-risk infants
* Chronic obstructive pulmonary disease
* Confinements over 30 days
* IV Antibiotic, chemo or hydration therapy
* Debilitating diseases
* Cancer or terminal illness such as, but not exclusive of, those noted to be end stages and those with poor prognoses.

When dealing with the shock of an accident or severe illness, employees may fail to realize all the avenues available to them for treatment. Early identification of potential cases provides:

* Time to develop individualized programs which can reduce future medical expenses
* maximum efficiency in the use of available resources
* early support for the family when it is most needed
* a way to contain medical costs affecting an employee's out-of-pocket expenses.

Case management can also:

* arrange home care to prevent hospitalization
* arrange services in the home to allow for early discharge
* obtain discounts for special medical equipment
* locate appropriate services to meet the health care needs of the insureds.

TIMELY SUBMISSION OF CLAIMS

Written proof of all claims incurred must be furnished to the Claims Administrator of the PEIA within twelve (12) months from the date of service, if PEIA is the primary insurance, and within 24 months if PEIA is the secondary insurance.

Failure to submit incurred claims within the prescribed time period shall invalidate the claim and payment thereof shall be the responsibility of the claimant.

PATIENT AUDIT PROGRAM

The Patient Audit Program is intended to help detect and correct overcharges or other errors discovered by employees or retirees.

Awards under the Patient Audit Program have a maximum of $1,000 annually.

Two types of charges qualify for this program.

1) Charges for services not received, and

2) Overcharges or overpayments resulting from clerical error or miscalculation.

Reported errors must be at least $50.00 to qualify for the Patient Audit Program.

A patient audit report form (supplied by PEIA) outlining the steps to follow, must be completed by the policyholder when filing for this possible benefit. Participants in HMOs are not eligible to participate in the Patient Audit Program.

The policyholder must submit the completed patient audit form along with detailed itemization of charges, the corrected bill (or explanation of disagreement) and a copy of the Claims Administrator's explanation of benefits to PEIA.

The hospital or health care provider will be billed for the overcharge. If a refund is received from the hospital or health care provider, the insured will be paid up to 50% of the recovered amount (up to $1,000 annually).

NOTE: This Patient Audit benefit only applies to charges incurred on or after July 1, 1988.

PREFERRED PROVIDER ORGANIZATION (PPO)

A Preferred Provider Organization (PPO) is generally a corporate provider structure whose primary purpose is to deliver cost-effective health care services to employees and retirees or other groups of individuals. The strategy most often used is for the provider organization to offer reduced rates (and sometimes other benefits) in exchange for a greater volume of patients. In this way, even though the employer, employees, or retirees may be paying less, the provider, by seeing more patients, may make as much or more. To some extent, PPO's try to be a win/win solution to the problem of increasing health care costs.

Preferred Provider Organizations come in many forms. The most common are organizations of both hospitals and physicians. But many contain just one type of provider. For example, the PEIA pharmacy program is an organization of pharmacies who are willing to exchange a reduced rate in taking assignment from PEIA insureds for prompt payment.

At the time this revised benefit plan is going to press, PEIA is negotiating with a major Preferred Provider Organization made up of physicians, osteopaths and podiatrists. It will include a majority of those providers who practice in West Virginia. This PPO is called Preferred Medical Care Network (PMCN). Basically, its terms are spelled out by the Omnibus Health Care Act. PMCN will exchange reduced physicians' fees and participation by a substantial majority of physicians of all specialties and all regions, for prompt payment, a guaranteed payment level and the assurance that there will be plan incentives for employees and retirees that use PMCN services. We do not know the outcome of these negotiations, but will provide a benefit plan supplement when the PMCN contract is signed.

PEIA will also negotiate contracts with other PPO's. Our goal is to give employees and retirees a variety of cost savings and quality options by which to obtain health care services. We will inform insureds of our progress as other contracts are signed.

WITHDRAWN PHYSICIAN

A few physicians in West Virginia have such strong objections to the provisions of the 1989 Omnibus Health Care Act that they have chosen not to treat any patients whose care is paid for by the State of West Virginia. These physicians must notify PEIA in writing and must also notify their state patients in writing. Forty-five (45) days after the date of physician's withdrawal, PEIA may no longer pay for that physician's service. Charges for services received after the 45-day transition period from a withdrawn physician must be paid by the individual.

A list of withdrawn physicians will be provided to payroll locations or may be obtained by calling ERISCO at (304) 346-9703 in Charleston, (800) 344-5076 toll free in West Virginia or (800) 343-9807 toll free outside West Virginia, or by calling PEIA at (304) 348-7850.

Rules governing this withdrawal provision of the Omnibus Health Care Act allow for transition exceptions where the health of a PEIA insured might be harmed by the cessation of treatment by a withdrawing physician. Exceptions include pregnancies, as well as other valid medical circumstances. Questions about these exceptions should be discussed with the physician who should have a copy of the Rules. For a copy of the Rules, please contact the payroll location or the Secretary of State's Office (345-4000).

If the insured and the physician believe an exception should be made, the physician may request such an exception by letter to PEIA director, explaining the circumstances, based on appropriate medical judgment, under which the exception is necessary.

STATEMENT OF RIGHTS

The Director of the West Virginia Public Employees Insurance Agency, reserves the right to change, increase, decrease and/or alter the content of the policy provisions and procedures by giving written notice to policyholders and the Third Party Claims Administrator.

EMPLOYERS' NOTIFICATION RESPONSIBILITY

West Virginia Code 5-16-8 requires that all participating employers give written notice to each policyholder prior to the institution of any change in benefits to employees.

The notice must reach the employee within 15 days from date of receipt by the payroll location.

Employers will be assessed a $100 a day penalty for each day in excess of 15 days from date of receipt in which they have not provided benefit changes to an employee. For purposes of this provision, an employer shall be deemed to have given written notice to any employee if the employer either causes such notice to be delivered to the employee personally or mails such notice pre-paid to the employee's last known address.

EMPLOYEE OR PROVIDER MISREPRESENTATION

"Any person who shall knowingly secure or attempt to secure benefits payable under this article to which the person is not entitled, or who shall knowingly secure or attempt to secure greater benefits than those to which the person is entitled, by willfully misrepresenting the presence or extent of benefits to which the person is entitled under a collateral insurance source, or by willfully misrepresenting any material fact relating to any other information requested by the Director of PEIA, or by willfully overcharging for services provided, or by willfully misrepresenting the diagnosis or nature of the service provided, may be found to be overpaid and shall be civilly liable for any overpayment.

In addition to the civil remedy provided herein, PEIA shall withhold payment of benefits due to that person until any overpayment has been recovered or may directly set off, after holding internal administrative proceedings to assure due process, any such overcharges or improperly derived payment against benefits due such person hereunder. Nothing in this section shall be construed to limit any other remedy or civil or criminal penalty provided by law." W.Va. Code 5-16-11 a.

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Participation

ELIGIBILITY

Active Employee

All elected and regular, full-time employees of the State of West Virginia, the State colleges and universities, County Boards of Education, Counties, Cities or Towns, and other individuals and Government Bodies so specified in the West Virginia State Code, Chapter 5, Article 16 are eligible for enrollment in the PEIA Benefit Plan.

The term "full-time" shall mean a permanent position that is considered full-time by the participating agency and that requires at least twenty hours per week, or 1,040 hours per year in that position, unless otherwise exempt from this requirement by the Code. PEIA reserves the right to make the final determination on these matters.

> Exclusion: Temporary, substitute, and other part-time employees who do not meet the definitions as stated in this Plan Document are excluded, unless exempt from this requirement by Section 18A-4-15 of the Code.

Legislative Participation:

Members of the Legislature may participate in and be covered under any and all plans established by the PEIA.

All Legislative members must properly enroll, as all other eligible employees, and will pay the full cost for all group coverages on themselves, their spouses and dependents if properly enrolled, so that there will be no cost to the State of West Virginia. W.Va. Code 5-16-17A.

Enrollment period for legislature is December next succeeding their election and the following January. (West Virginia Constitution, Article 4, Section 7)

Actively at Work Clause:

For coverage on the employee and dependents to be effective, the employee must be actively at work.

To be actively at work, the employee must:

1. Be able to do the normal tasks of the job on a full-time basis for a full work day on the day coverage (or any increase in the coverage amount) is to begin; and

2. Be able to do such tasks at one of the normal places of business or at a location to which the employee must travel to do his/her job; and

3. Not be absent from work because of leave of absence or temporary lay-off.

If participant does not meet the above requirements, coverage (or any increase in the coverage amount) will begin on the next day on which he/she does meet these requirements.

> NOTE: In administering the actively-at-work requirement, when the effective date of eligibility of the employee's insurance falls on a Saturday, Sunday, legal holiday, vacation or normal day off, and the employee was actively at work on the last preceding scheduled working day, the actively-at-work requirement has been satisfied.

PEIA reserves the right to require proof of employment, retirement, marriage, copies of birth certificates and legal documents indicating responsibility for child support and/or showing legal custody.

LEAVES OF ABSENCE

A. Medical Leave:(W.Va. Code 5-16-18)

Any employee who is on a medical leave of absence approved by his/her employer, including any employee who is on medical leave due to a work-related injury or illness and who is receiving Workers' Compensation benefits, shall be entitled to continue coverage until he/she returns to work, provided the following conditions are met.

The insured employee and employer shall continue to pay the proportionate share of premium costs as provided by the law; provided that the employer shall be obligated to pay its proportionate share only for a period of one year, after which the employee must pay the full premium. During the period of the Leave of Absence, the employee shall, at least once each month, submit to his/her employer the statement of a qualified physician certifying that the employee is unable to return to work.

B. Personal Leave:

An employee will be granted insurance coverage while on a personal leave of absence for a period of 12 months where such leave is approved by the agency where he/she is employed. The employee must remit 100% of the premium for each month he/she is on personal leave. Failure to remit the premium due each month to the Public Employees Insurance Agency results in termination of insurance coverage.

C. Family Leave: (W.Va. Code 25-5D)

An individual employee on family leave, approved by his or her employer, is entitled to continue health insurance coverage through the PEIA provided that the employee shall pay the employer the premium costs of such group health insurance coverage during this family leave period.

Retired Employee

All eligible retirees may elect coverage upon retirement for themselves and their dependents. Participation in the PEIA Benefit Plan is not automatically continued at the time of retirement. The retiree must complete new enrollment cards at his/her respective retirement system or former payroll location and must receive a new medical identification card.

Retiree Qualifications

"Retired Employee" shall mean:

An employee of the State, the State colleges and universities or a County Board of Education who retired under a qualified State retirement system.

> NOTE: All other employees who are not covered by a state retirement system shall, in the case of education employees, meet the minimum eligibility requirements of the state Teachers Retirement System, and in all other cases, meet the minimum eligibility requirements of the Public Employees Retirement System.

The total premium cost of the coverage is the full responsibility of the retiree. W.Va. Code 5-16-12(g)

Retiree Dependent Qualifications:

The term "dependent" includes lawful spouse and unmarried children between birth and 19 years of age. For qualifications see "Dependent Qualifications" in this section.

Earned Extension of Insurance Coverage (Sick and Annual Leave)

State and Board of Education Retirees:

An active employee who elects to participate in the PEIA Benefit Plan prior to July 1, 1988, who voluntarily retires or is compelled or required by law to retire before age 65 is eligible to receive credit towards his/her health and/or life insurance benefits. Only that portion of sick and annual leave for which the employee has not been reimbursed at the time of "retirement" is eligible to be applied to the extension of insurance coverage. W.Va. Code 5-16-12(c)

FORMULA CALCULATION

2 days = 1 Month Life Insurance Only Coverage
2 days = 1 Month Single Plan Coverage
3 days = 1 Month Family Plan Coverage

Partial months are not acceptable.

When a new employee who elects to participate in the PEIA benefit plan on or after July 1, 1988, voluntarily retires or is compelled or required by law to retire before reaching age 65, he/she is eligible to receive credit toward group health and/or life insurance benefits. Only that portion of sick and annual leave for which the employee has not been reimbursed at the time of "retirement", is eligible to be applied to the extension of insurance coverage. An employee who has been a participant under spouse or dependent coverage, and who reenters the plan within twelve months after termination of his or her prior coverage, shall be considered to have elected to participate in the plan as of the date of commencement of the prior coverage. W.Va. Code 5-16-12(d)

FORMULA CALCULATION

2 days + 50% premium for 1 month Life Insurance Only
2 days + 50% premium for 1 month Single Plan Coverage
3 days + 50% premium for 1 month Family Plan Coverage

Fifty-percent of the premium for each month's coverage must be paid by the policyholder.

Higher Education Earned Extension of Insurance Coverage

Higher Education Retiree:

When an active employee, who is a higher education full-time faculty member, employed on an annual contract basis other than for twelve (12) months, voluntarily retires and/or is compelled or required by law to retiree before age 65, he/she is eligible to receive credit toward health and/or life insurance benefits based on years of teaching service. W.Va. Code 5-16-12(f)

FORMULA CALCULATION

3 1/3 years teaching service = 1 year Single Plan Coverage
5 years teaching service = 1 year Family Plan Coverage

Elected public officials are not entitled to any sick, annual and personal leave accumulation as it pertains to extended insurance coverage. W.Va. Code 5-16-16

Deferred Retirement:

A participating employee with a minimum of five years vested service, who leaves state employment after November 1, 1988, but does not immediately become a member of a state retirement system, is not entitled to apply unpaid accrued sick and annual leave toward extension of coverage.

Dependent Qualifications

For all benefits, the term "dependent" includes:

a. Spouse (if legally married)

b. Employee's own child

c. A legally adopted child (including a child living with the parents during the period of probation)

d. Stepchild residing in the employee's household

e. A child fully dependent upon the employee for support and maintenance and residing in the household of which the employee is the head and actually being supported by the employee.

The term "dependent" does not include father, mother, or other person that does not fall within the definition of dependent as stated within this Plan Document.

> NOTE: PEIA reserves the right to request proof of marriage, copies of birth certificates and legal documents indicating responsibility for child support and/or showing legal custody.

Full-time Unmarried Student:

Coverage for children terminates at the end of the month in which age 19 is attained. However, children are included after age 19 through the attainment of age 25 if they are enrolled as full-time students, are unmarried and are fully dependent upon the employee for support and maintenance.

A full-time student is defined as a student attending courses full-time in a graduate or undergraduate college or university, or when in attendance at a trade or professional school as the child's full-time occupation.

Student Status Between Ages 19 and 25:

Verification of full-time student status is required. The Claims Administrator will request that the policyholder arrange for a letter from the college, university or other school verifying that the dependent is a full-time student, and indicating the student's expected date of graduation. In this way we are requesting verification from the college through the policyholder, rather than from the college directly.

Student (Temporary Leave):

Full-time students who must withdraw from a college, university or other school for medical reasons may continue coverage as long as medically necessary. In order to continue coverage under this provision, the attending physician must certify, in writing on a monthly basis, that said student is unable to attend on a full-time basis and state the medical diagnosis.

If the Claims Administrator verifies that the diagnosis does not warrant continuous coverage under this provision, proper notice terminating the student status will be forwarded to the policyholder.

Mentally Retarded/Physically Disabled Dependent Children

Dependent children may be covered after age 19 while incapable of self-support because of mental retardation, mental illness, or a physical disability that began prior to age 19 (or prior to age 25 while a full-time student), if the child was dependent upon the employee for support and maintenance at the onset of the mental retardation, mental illness or physical disability. Contact the PEIA office within 31 days before coverage terminates for the appropriate form to continue coverage.

When our policy allows for the continuation of coverage for mental retardation, mental illness, or handicapped children, the requirements are as follows:

1. The child must be insured prior to the attainment of the limiting age.

2. Disability must commence prior to the attainment of the limiting age.

3. The child must be incapable of self-sustaining employment and chiefly dependent on the employee for support and maintenance.

Surviving Dependents

The purpose of this benefit is to provide health insurance to the surviving spouse and dependents of deceased active and retired employees.

Qualifications

1. Only those dependents who were enrolled and covered under the deceased employees' insurance coverage at the time of death are considered eligible to enroll as surviving dependents. A surviving spouse who is pregnant at the time of death of the policyholder shall be premitted to enroll the newborn child(ren).

2. Surviving dependents must forward the entire monthly premium to either the deceased employees' last payroll location, or retirement board each month.

3. Surviving spouse and dependents are not eligible for life insurance.

4. When surviving spouse/dependents become eligible for Medicare, benefits will be reduced by the amount of benefits payable under Medicare.

   NOTE: PEIA reserves the right to request proof of marriage, copies of birth certificates and legal documents indicating responsibility for child support and/or showing legal custody.

ENROLLMENT

How to Enroll:

Participation in the PEIA health insurance plan is voluntary.

Employees and retirees who are eligible and desire coverage, must complete proper enrollment forms at their place of employment or respective retirement system. The enrollment will authorize the employer to deduct from the salary or pension annuity the premium cost of the elected coverage.

The participating employee or retired person is responsible for notifying the employer or respective retirement system when any change of address, marital or dependent status occurs. All changes require completion of a change of status card with the valid signature of the employee or retiree.

Basic Choices Available:

The eligible employee or retiree may elect to participate in one of the following basic plan choices:

1) Single Health Coverage - Employee or Retiree

2) Family Health Coverage - Employee or Retiree and 1 or more dependent(s)

3) Life Insurance Only - 1 Employee or 1 Retiree

NOTICE: Husband and Wife Health Participation: Married couples who are employed by participating agencies may (1) each enroll for single health coverage, or (2) both be covered under 1 family health plan, with the other spouse enrolling for basic life insurance, if both desire life insurance coverage.

In addition, when a husband and wife are both PEIA participants with one having the family health insurance plan and the other having basic life insurance, they are **restricted** from exchanging coverages except annually on January 1, or when one or the other loses health coverage due to termination of employment, death or divorce.

Husband and wife ARE NOT ELIGIBLE TO ENROLL FOR DUPLICATE (Family) HEALTH INSURANCE COVERAGE under PEIA IN THAT ONLY ONE (1) CAN ELECT TO INSURE THE CHILDREN.

Optional Plan Choices:

Employees participating in one of the basic plan choices, may also elect to participate through their employer or retirement system in the following optional plan choices:

Active Employees:

1) Optional Life Insurance, Accidental Death and Dismemberment plan; and

2) Dependent Optional Life Insurance, Accidental Death and Dismemberment plan.

Retiree:

Optional Life Insurance only (no accidental death and dismemberment coverage)

Non-Duplication of Coverage Plans Within Medical Plan

The State of West Virginia has a self-insured group medical plan with many participating employers. Because it is self-insured we do not coordinate benefits within our own benefit program.

WHEN COVERAGE BEGINS

Active Employees:

Coverage for active employees who properly enroll is effective the first day of the month following the date of enrollment. If date of enrollment is the first day of the month, the effective date of coverage is the first day of the following month.

Dependent(s) of Active Employee:

Dependent coverage begins on the day the employee's own coverage begins, provided the dependent(s) have been enrolled by the employee. If the employee is not actively at work on the day coverage would normally become effective, coverage on the employee and dependent(s) will begin on the day the employee is actively at work. (see "Actively at Work" clause in this section)

> NOTE: If one or more of the dependents, except for newborns, is in a hospital, nursing home, etc., on the date coverage is to begin, coverage is delayed until the dependent(s) is discharged.

If the employee acquires a dependent after the initial effective date, such as a new spouse, coverage starts the first day of the month following the date of enrollment. In the case of biological newborn children of an employee covered by PEIA, the employee has the

month that birth occurs and the following month to add the newborn to his/her plan to qualify for retroactive coverage to the date of birth.

> NOTE: Coverage for newborns enrolled outside the initial enrollment period will be effective the first day of the month following the date of enrollment, and pre-existing condition limitations will apply. A statement of health will be required for any life insurance amounts.

Retiree Effective Date of Insurance Coverage:

A retiree will have continuous coverage only if enrolled during the month he/she retires or the following month.

> NOTE: The effective date of coverage for all retirees who enroll after the stated enrollment period will be the first day of the month following completion of the proper enrollment materials, and pre-existing condition limitations will apply. A statement of health will be required for any life insurance amounts.

Dependents of Retirees Effective Date of Insurance Coverage:

If a retiree enrolls dependents for health coverage during the month of retirement or the following month, coverage will be continuous.

If a retiree enrolls dependents after that time, the coverage will be effective on the first day of the month following the date of enrollment with pre-existing condition limitations.

Surviving Dependents Effective Date of Insurance Coverage:

A surviving spouse or dependent will have continuous health coverage if enrolled during the month death occurs or the following month.

The effective date of coverage for all surviving dependents who enroll after the month death occurs or the following month will be the first day of the month following the date of enrollment with pre-existing condition limitations.

WHEN COVERAGE ENDS

Active Employee:

The coverage for the employee terminates when the employee is no longer eligible or when group coverage terminates, whichever happens first.

a. Voluntary Termination: The basic medical coverage for the employee and/or dependent(s) terminates at the end of the month in which the employee voluntary ceases his/her employment.

b. Involuntary Termination: The employee who is terminated from employment involuntarily or through a reduction of work force may continue coverage for 3 additional months after the end of the month in which the employee goes off of the payroll. Eligible dependent(s) who have been properly enrolled by the employee are included in the 3 months extension. This extension of basic coverage is provided at no additional cost to the employee.

Misconduct Discharge: The employee who is discharged for misconduct is not entitled or eligible for the 3 months extension of coverage as mentioned above. However, basic coverage may be extended to the employee and/or eligible dependent (s) up to the maximum period of 3 months, while administrative remedies contesting the charge of misconduct are pursued by the employee. If the misconduct is upheld, the full premium cost of the extended basic coverage must be reimbursed by the employee through their respective payroll location.

Retired Employee:

Coverage terminates at the end of the month in which the retiree elects to terminate his/her coverage, or when the group coverage terminates, or for failure to pay premium whichever happens first.

Dependents:

The coverage for dependent(s) terminates at the end of the month in which one of the following occur:

1. Employee terminates or loses coverage;
2. Divorce from spouse (at the end of the month in which the divorce is final);
3. Child attains age 19;
4. Child marries;
5. Child is no longer a full-time student or reaches age 25;

Surviving Dependents:

Coverage terminates at the end of the month in which the surviving dependent no longer elects to participate, or is ineligible due to age.

NOTE: The coverage for employees and/or dependent(s) who are confined to a qualified facility on the date that coverage would have terminated, will continue through the date of discharge.

Non-State Agency Termination Provisions:

"When any non-state agency (employer) terminates or withdraws its participation with PEIA said non-state agency shall pay to PEIA an estimated sum of all incurred but not reported claims relating to coverage of employees and retirees of their agency as determined by the Director". W.Va. Code 5-16-13

Possible Coverage After Termination:

Under the PEIA Plan when coverage terminates under an active participant status, the participant may be eligible to continue under COBRA (addressed in a separate section of this document) or a conversion policy.

Conversion

When a policyholder has been continuously covered for an entire three-month period and health benefits terminate under the PEIA , the policyholder may apply for an individual health insurance policy. Application must be in writing and the first premium paid to the contracted underwriter within 31 days after such termination of coverage. Evidence of insurability is not required.

The policyholder cannot convert if:

a. coverage ends because policyholder fails to pay any required contribution for the coverage

b. the policyholder is 65 years of age or older

c. the West Virginia Benefit Plan is terminated.

The converted policy is at the sole discretion of the underwriter, if issued, and will become effective the day after such coverage terminates.

IMPORTANT: The converted policy is not the same as provided under the West Virginia Public Employees Benefit Plan. For details concerning the converted policies, the policyholder must contact the underwriter. The name and address of the underwriter can be provided by a representative of the PEIA.

PARTICIPATION GUIDELINES

Going from Dependent to Policyholder Status:

An employee who is covered as a dependent under a family contract and desires to enroll or become the policyholder, that employee will be required to pay their proportionate share of the premium.

> NOTE: If a lapse of coverage is created when changing from dependent status to policyholder status, pre-existing conditions will apply.

Transfers (From One Participating Employer to Another):

Any participating employee (policyholder) who transfers from one participating agency to another and re-enrolls during the month of transfer or the immediate following month, will have continuous coverage.

NO additional premium will be assessed if health and/or life coverage is not changed or increased.

> NOTE: If coverage is increased by adding a spouse and/or additional dependent(s), the new dependent(s) will be subject to pre-existing conditions limitations, and the policyholder will be required to pay the proportionate share of family coverage.

Example: Changing from life only or single contract to family contract.

Dependents:

Employees must add all dependents to coverage by completing two (2) change of status cards at the payroll/personnel office, in order to receive benefits. The EMPLOYER is required to retain duplicate records of all enrollments and changes.

Enrollment Periods

Employee:

a. Health Coverage — No enrollment period required.

b. Basic and Optional Life Insurance Coverage — The month the employee is hired and the following month.

Dependent:

a. Health Coverage — No enrollment period is required.

b. Dependent Life Insurance Coverage — The month the insured is hired and the following month.

Retiree:

a. Health Coverage — No enrollment period

b. Basic and Optional Life Insurance Coverage — The month the employee retires and the following month.

NOTE: A retiree will have continuous coverage only if he/she enrolls during the month of retirement or the following month.

Dependents of Retirees

Health Coverage — No enrollment period required.

Surviving Dependents

Health Coverage — The month death occurs or the following month to avoid lapse of coverage and pre-existing condition limitations

Newborns and Adopted Children

Newborns:

The enrollment period for the biological newborn child of a participating employee is the month of birth and the following month.

If the newborn is added during the initial enrollment period the effective date will be retroactive to the date of birth.

Coverage for newborns enrolled outside of the above enrollment period will become effective the first day of the month following the completion of the change of status card, pre-existing condition limitations will apply.

Adopted Children:

The enrollment period for the adopted child of a participating employee is the month that the child is placed in the home and the following month.

If the adopted child is added with the completion of a change of status card during the initial enrollment period, the effective date of coverage will be retroactive to the date the child was placed in the home.

Coverage for adopted children enrolled outside the initial enrollment period will become effective the first day of the month following the completion of a change of status card, and pre-existing condition limitations will apply.

Life Insurance (Employee & Dependent):

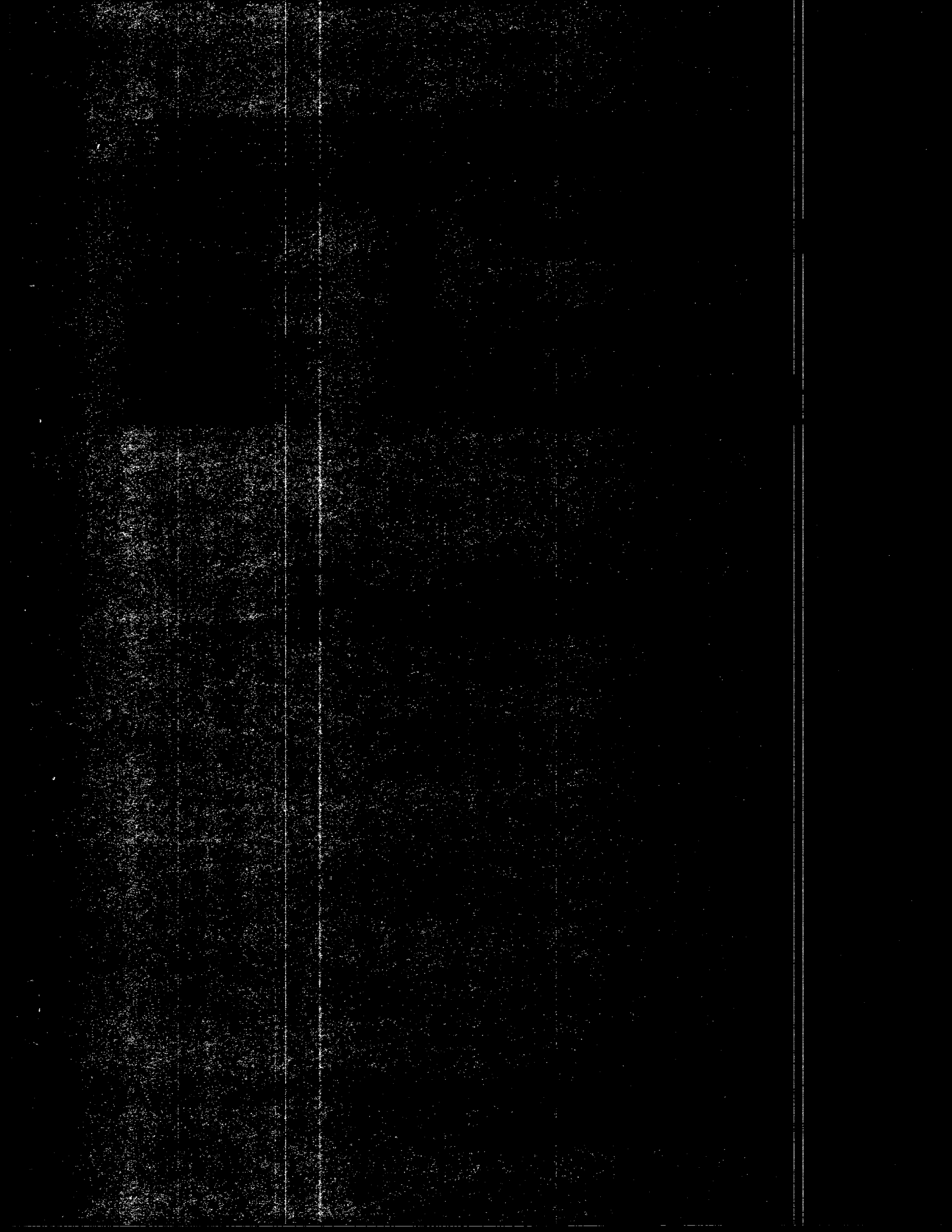
Proof of insurability (Statement of Health) will be required for life insurance enrollment after the initial enrollment period. The determination by the Life Insurance Underwriters is final.

Pre-Existing Condition Limitation

Any employee and/or dependent enrolling in PEIA on or after July 1, 1988 will be subject to pre-existing condition limitations.

A pre-existing condition is defined as any injury, sickness, or pregnancy or any condition relating to that injury, sickness or pregnancy, for which a participant receives treatment, incurs expenses or manifests symptoms within three (3) months preceding the effective date of insurance coverage. No payment shall be made for expenses incurred for, or in connection with a pre-existing condition unless expenses incurred after the expiration of a one year period following the effective date.

Pre-existing conditions shall not include a condition which meets the definition of a handicap as provided in this Section of the Plan Document, or a participating employee who returns from extended authorized leave as provided in this Plan Document. W.Va. Code 5-16-12e



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Facilities

HOSPITAL FACILITY

General:

The PEIA plan provides benefits when the insured requires hospital services for treatment of an illness, injury or pregnancy. This hospital care can be provided in a hospital on an inpatient or outpatient basis. Hospital admissions and services must be recommended by a licensed physician.

Definition:

A hospital is an institution accredited and licensed under the laws of the state in which it is situated, for the care and treatment of sick and injured persons by or under the supervision of a staff of licensed physicians with an R.N. on duty at all times.

Hospital In-Patient Acute Care:

PRE-ADMISSION CERTIFICATION REQUIRED

Inpatient coverage becomes effective when an insured is confined to a licensed hospital for at least 18 consecutive hours.

Room and Board:

Semiprivate - paid in full

Private - paid up to the hospital's most common charge for semiprivate accommodations.

Intensive Care, Coronary Care, Special Care - paid in full.

Intensive Care, Coronary Care or Special Care provides critical care after surgery or when a condition warrants careful supervision. The patient's stay in "intensive care" is usually for a limited number of days, and the critical care is provided by a single nurse or team of nurses.

The term "hospital intensive care unit, etc." shall mean only a section, ward, or wing within the hospital which is distinguished from the other hospital units because it:

1. is operated for the purpose of providing room, board and professional care and treatment of critically ill patients requiring constant observation and care by a Registered Nurse (R.N.) and other highly trained hospital personnel; and

2. has special supplies and equipment necessary for such care and treatment available for immediate use.

Room and board benefits are limited to the number of days authorized by PEIA's Pre-Admission Certification Program, up to 365 days for any one confinement.

Hospital Ancillary Charges:

Ancillary charges for additional hospital services and supplies necessary for the treatment of an illness, injury or pregnancy are covered if incurred during the period for which room and board benefits are payable.

Deductible:

Inhospital deductibles are $100 per person per calendar year with family plan deductible capped at $200 per calendar year.

Benefit Payable:

After the insured satisfies the inhospital deductible, the PEIA Plan will pay the hospital's contracted charges for those days approved by the Pre-certification Program.

The PEIA Plan will pay 80% of the hospital's contracted charges for hospital admissions or days which are not pre-certified or re-certified.

Minimum Stay:

Surgery	None required
Sickness	18 hours
Accident	None, if treated at the hospital within 48 hours of accident. Otherwise 18 hours

Weekend Hospital Admission Restricted:

Hospital admission on a Friday or Saturday is not a covered medical expense except when:

1. The admission is for a surgical procedure that will be performed within 24 hours of admission, or
2. The admission is medically necessary.

Pre-Admission Testing:

If a patient reports on an outpatient basis for pre-confinement laboratory and x-ray work, the charges are paid in full providing all of the following requirements are met:

1) The person is confined within ten days following the date of the test; and,

2) The tests are normally required as a part of a scheduled hospital confinement and would be considered covered expenses if made during the period of hospital confinement or for outpatient surgery.

3) The tests are billed by the provider as pre-admission testing.

Pre-admission testing may be performed in the doctor's office for covered procedures.

Professional Fees:

Many charges formerly made by hospitals are now made by non-hospital-based providers such as pathologists, therapists, radiologists, medical equipment and special drugs, etc. These charges are reimbursed up to the PEIA Fee Schedule rate, provided they were incurred during the period for which room and board benefits are payable or for outpatient surgery.

Anesthesiologists will be paid at the reasonable and customary fee.

Blood Transfusion:

This type of expense is paid in several different ways. For details refer to "Blood Transfusions" in the Surgical Guidelines section of this Plan Document.

Experimental Medical Care — Pre-Certification is Required.

Charges for treatment with drugs or technological medical devices which are experimental in nature must be pre-certified and monitored by the Case Management Program.

Patient Deceased - Hospital Charges

In the event an insured or dependent dies in the emergency room, charges relating to the emergency room and related x-ray and laboratory charges will be paid at 100% of the hospital's contracted rate.

Hospital Benefit Exclusions:

a. Admissions and charges not recommended and approved by a licensed physician or podiatrist;

b. Charges incurred in a federal hospital for service related injuries/disabilities or on account of war or for treatment in any state-supported institution;

c. Charges due to injury or sickness connected with employment with any employer;

d. The difference between private and semiprivate accommodations;

e. Elective hospital services and supplies, i.e., telephone, television, guest meals, etc.

f. Pregnancy related conditions for dependent children;

g. Elective abortions;

h. Diagnosis and/or treatment by any method of jaw joint problems, including tempo-romandibular joint and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint;

i. Charges incurred for cosmetic or reconstructive surgery other than those resulting from accidental injury, disease, or unless the surgery is performed to correct birth defects;

j. Room & Board charges incurred, but not determined or approved to be "medically necessary" by Pre-Admission Certification Program.

k. Therapeutic passes for leaves of absence when patients are confined.

l. Cot and meal charges for parents during a child's confinement.

m. Weight loss.

FREE STANDING FACILITY (FSF)

General:

The purpose of a Free Standing Facility is to provide a setting where certain surgery or other diagnostic or treatment procedures can be performed without requiring an overnight hospital stay. The type of procedure performed in a FSF would normally be of the type which could not be effectively performed in a doctor's office and would otherwise require hospital confinement if FSF services were not available.

Definition:

The term "Free Standing Facility" means an institution (other than a hospital) which is established, equipped, and operated primarily for the purpose of performing outpatient elective procedures of an uncomplicated nature. It does not provide beds for overnight confinement. A FSF is considered a qualified facility when it is licensed by the state or jurisdiction in which it operates or is certified by the Social Security Administration as a provider under Medicare.

Benefit Payable:

Reasonable and customary charges for necessary services, supplies and treatment in connection with a procedure will be paid. For Professional services, PEIA will pay charges up to the PEIA Fee Schedule rate.

Exclusions Under Free Standing Facility:

No benefits are payable for:

a. Charges due to injury or sickness connected with employment with any employer;

b. Pregnancy related conditions for dependent children;

c. Elective abortions

d. Diagnosis and/or treatment by any method of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint;

e. Charges incurred for cosmetic or reconstructive surgery other than those resulting from accidental injury, disease, or unless the surgery is performed to correct birth defects;

f. Charges incurred for service-related injuries/disabilities on account of war.

BIRTHING CENTERS AND MIDWIVES

General:

Pregnant insureds may choose to have their delivery at a Birthing Center or at home by a Physician or Midwife.

Definition:

The term "birthing center" shall mean any licensed facility (other than a hospital) organized to provide facilities and staff to support a birthing service for pregnant clients.

A birthing center is to be able to provide prenatal, intrapartum, and post partum care provided for individuals with low risk births, uncomplicated pregnancy, labor and vaginal birth and newborn care during the recovery period.

The term "midwife" means a person educated in the discipline of nursing and midwifery, certified by examination with the American College of Nurse-Midwives, and licensed by state authority to engage in the practice of midwifery (CNM); or, a person trained in midwifery and licensed by the state authority to engage in the practice of midwifery.

Benefit Payable:

Birthing Center services will be paid at the reasonable and customary fee. Professional services will be paid at a pre-authorized negotiated fee.

Exclusions:

a. Pregnancy related conditions for the dependent children;

b. Elective abortions

ALCOHOL AND SUBSTANCE ABUSE TREATMENT FACILITY

PRE-ADMISSION CERTIFICATION AND CASE MANAGEMENT ARE REQUIRED.

General:

This benefit provides medical treatment for insureds who require inpatient care in an Inpatient Alcohol and Substance Abuse Treatment Facility or hospital unit established for the treatment of alcoholism and substance abuse when recommended by a licensed physician.

Definition:

An Alcohol and Substance Abuse Treatment Facility is a licensed institution or a hospital established to provide medical treatment for patients who require inpatient care on account of alcoholism or substance abuse, which has permanent facilities for inpatient medical care on the premises, including 24-hour nursing service under the supervision of a full-time Registered Nurse (R.N.), and maintains daily medical records on all patients.

In no event will the term include any institution or part thereof which is used principally as a rest or nursing facility, or a facility for the aged, or one providing primarily custodial care.

> NOTE: Benefits for alcoholism and/or substance abuse are payable only if a person, while covered, becomes confined to an inpatient facility or hospital unit for the treatment of alcoholism or substance abuse. Length of treatment is established by the attending physician and may not exceed 31 days per calendar year.

PEIA will pay the reasonable and customary fee of the institution's daily room and board charge for each day of confinement to a ward or semiprivate room. For confinement to a private room, PEIA will reimburse the institution's daily room and board charge for each day of confinement up to an amount equal to the institution's average charge for semiprivate accommodations. Payment will be made for not more than 31 days of confinement during any calendar year and is limited to a maximum lifetime benefit of 90 days.

PEIA will pay the reasonable and customary fee for the institution's necessary additional charges only during the period for which room and board benefits are payable.

> **NOTE: Failure to pre-certify or re-certify admission will result in reduction of benefits to 80%.**

Exclusions Under Alcohol and Substance Abuse Treatment Benefits:

No benefits are payable for charges:

a. not recommended and approved by a licensed provider (i.e. physician, psychologist, etc), or

b. incurred when patient leaves against medical advice, or

c. for personal or convenience items; or

d. related to employment; or

e. incurred in a federal hospital for service-related injuries/disabilities on account of war or for treatment in any state-supported institution.

EXTENDED CARE FACILITY

PRE-ADMISSION CERTIFICATION AND CASE MANAGEMENT ARE REQUIRED.

General:

This benefit provides for extended care in a skilled nursing facility when such care is determined to be medically necessary for the insured's improvement or stabilization.

Definition:

An Extended Care Facility is an institution that, for a fee, furnishes room, board and skilled nursing services for medical care; has one or more licensed nurses on duty at all times under the supervision of a doctor or Registered Nurse (R.N.) on a 24-hour basis. The Extended Care Facility must also have available at all times under an established agreement the services of a licensed physician. The institution must maintain daily medical records on all patients and comply with the legal requirements applicable to the operation of an Extended Care Facility.

Covered Benefits:

Benefits are payable if an insured incurs charges for confinement to an Extended Care Facility due to accidental injury or sickness.

NOTE: Failure to pre-certify the admission or to obtain prior approval from Case Management will result in reduction of benefits to 80%.

Benefit Payable:

Benefits are payable for room and board up to the average semiprivate room rate of the Extended Care Facility. The policyholder will also be reimbursed (in full) for other covered charges (except nurses' and doctor's fees) made on a day for which room and board benefits are payable. The confinement and charges must be recommended as medically necessary by a licensed physician. **No one confinement can exceed 180 days.**

Room and board charges will be reimbursed at 100%, of the facility's charge for semiprivate accommodations, for the first sixty days of the confinement. During the next 120 days such charges will be paid at 80%.

All Extended Care Facility confinements due to the same or related cause and not separated by more than 14 days during which the insured is not confined to an Extended Care Facility or to a hospital shall be considered as the same Extended Care Facility confinement.

Extended care confinements after a 14 day separation from an Extended Care Facility or hospital due to the same or related cause are paid at 80% for days 181 through 365.

A 365-day lifetime limit applies for all Extended Care Facility confinements.

Professional Fees:

Professional fees for physicians' and other providers' services will be paid under other appropriate plan benefits within this Plan Document.

Exclusions:

No benefits are payable for:

a. Charges for any institution or part thereof used principally as a rest facility for the aged, an intermediate nursing care facility ,facility providing custodial or educational care or a facility for treatment of alcoholism or drug addiction;

b. Charges unless certification is made by the patient's attending physician that 24-hour a day skilled nursing care is essential and the patient is actually receiving such skilled nursing service;

c. Charges incurred in connection with private duty nursing;

d. Charges incurred in a Federal hospital for service-related injuries/disabilities on account of war or for treatment in any State supported institution;

e. Charges due to injury or sickness connected with employment;

f. Custodial care.

g. Elective services and supplies such as telephone, television, etc.

HOME HEALTH CARE

CASE MANAGEMENT IS REQUIRED.

General:

This benefit provides medical care for services rendered for treatment of an injury or sickness by a qualified Home Health agency.

NOTE: All services MUST be prescribed by a licensed physician who is personally attending the patient.

Approval from the Case Management program must be obtained for any combination of Home Health services (nursing, physical therapy, IV therapy, etc.) totalling more than $500. Case management should be notified at the time discharge planning begins when Home Health services totalling more than $500 are anticipated.

NOTE: See "Major Medical" benefits for Durable Medical Equipment.

Definition:

The term "home health care" refers to care provided by a licensed agency established to provide an array of services to individuals and families in their place of residence for the purposes of preventing disease and promoting, maintaining or restoring health or minimizing the effects of illness and disability. Services appropriate to the needs of the individual and his family are planned, coordinated and made available by an organized health system - through the use of agency employed staff, contractual arrangements or a combination of administrative patterns.

The home health care facility providing the treatment must be accredited by the Joint Commission on the Accreditation of Health Organizations or certified by the Social Security Administration as a provider of home health care under Medicare.

Eligible Benefits:

The services of a qualified Home Health Agency on an intermittent (two to three visits per week) basis are provided. A doctor must prescribe these medical services in place of hospital services.

Home Health Care Services Include:

1. Intermittent skilled nursing care rendered in the employee's home by:

    a. a licensed nurse (R.N. or L.P.N.); or

b. home health aide

2. Physical therapy, IV therapy, speech therapy, and the use of medical equipment and supplies provided in the employee's home by:

   a. a home health agency;

   b. a hospital or other facility, if arranged with a home health agency.

Benefit Payable:

Services are paid at the reasonable and customary fee with an annual maximum basic benefit of $1,500. Case Management may extend Home Health Care beyond the $1,500 maximum, however, benefits will be paid under Major Medical.

Exclusions:

No benefits are payable for surgical, medical or nursing fees, confinements and charges:

a. not recommended and approved by a physician;

b. due to injury or sickness connected with employment with any employer;

c. not considered reasonable and customary;

d. custodial care

e. personal or convenience items

f. services performed by a member related to the immediate family, by blood or marriage, or a person residing in the same household.

NOTE: Failure to obtain Case Management approval will result in reduction of benefits to 80%.

HOSPICE

CASE MANAGEMENT IS REQUIRED.

General:

Hospice is a medically directed program of services for terminally ill patients which stresses pain and symptom control. Services are provided by physicians, nurses, counselors, and therapists in the patient's home or hospice center. Patient must be given a prognosis of six months or less to live to be eligible for hospice benefits. Treatment must be pre-approved and continually certified by Case Management.

Definition:

A Hospice Care Program is a formal program directed by a doctor to help care for terminally ill persons. This may be available through either:

1. A centrally administered, medically directed and nurse-coordinated program which:

    a. provides a coherent system primarily of home care;
    b. uses a hospice team;
    c. is available 24 hours a day, seven days a week.

2. Confinement in a hospice unit.

The program must meet standards set by the National Hospice Organization and be approved by PEIA and Case Management. If such a program is required by a state to be licensed, certified or registered, it must also meet that requirement to be considered a hospice care program.

Benefit Payable:

$3,000 (in- or outpatient) in lieu of home health care benefits.

Up to 3 days respite care may be given under EXTENDED CARE FACILITY benefits for outpatients.

This benefit does not include a service performed by a member of the insured's family or person who normally resides in the insured's/patient's home.

NOTE: Failure to obtain Case Management approval will result in reduction of benefits to 80%.

MEDICAL REHABILITATION

CASE MANAGEMENT IS REQUIRED.

General:

The purpose of this benefit is to provide for inpatient and outpatient rehabilitation treatment. Inpatient rehabilitation hospitals must be JCAH and/or CARF accredited. Outpatient treatment must be in a CARF-approved facility. The admission date and treatment must be pre-approved and continually certified by Case Management.

Definition:

A Rehabilitation Hospital is a facility which, for compensation, is primarily engaged in providing rehabilitation care services on an inpatient basis, for those disabled by disease or injury to be able to achieve the highest practicable level of functional ability. Such services are provided by, or under the supervision of, an organized staff of physicians with continuous nursing services provided under the supervision of a registered graduate nurse (RN).

Benefit Payable:

Benefits are payable if a covered person incurs charges for confinement to a medical facility licensed as a rehabilitation hospital due to an accidental injury or sickness.

Room and Board charges will be reimbursed at 100% up to 60 days of the facility's charge for semi-private accommodations. During the next 90 days of the same confinement, such charges will be paid at 80%.

All rehabilitation confinements due to the same or related cause must be separated by at least 14 days. At no time can rehabilitation and extended care confinement be greater than 365 days.

Outpatient treatment will be paid at 80% under Major Medical after satisfying required deductible.

NOTE: Failure to obtain Case Management approval will result in reduction of benefits to 80%.

Exclusions:

No benefits are payable for:

a. Charges incurred at a rest facility or for custodial care;

b. Charges for private duty nursing;

c. Unapproved days;

d. Patient showing no therapy progression;

e. Education/cognitive only;

Rehabilitation Guidelines

1. There must be a definitive diagnosis prior to transfer to a rehabilitation facility. The prognosis of the patient must be stable or expected to improve with rehabilitation therapy. There must be an expected survival of at least one (1) year.

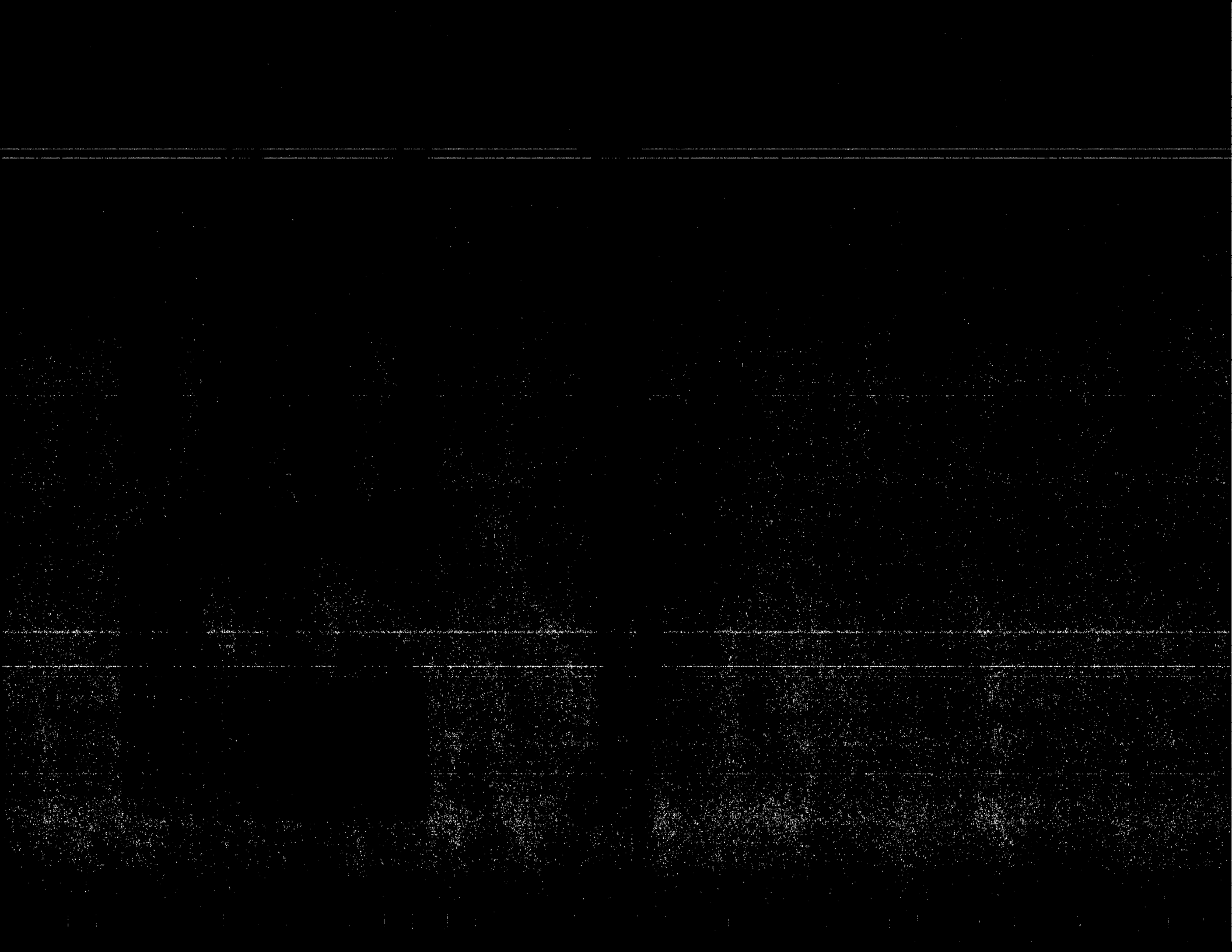
2. The patient must be able to tolerate speech, occupational, psychological or physical therapy, singly or in a combination for at least a total of 3 hours daily.

3. The patient must be reasonably expected to improve in level of functioning as a result of rehabilitation therapy.

4. The patient must be expected to return to a home environment.

5. Rehabilitation therapy certification for impatient continued treatment must be obtained for not longer than 14-day intervals.

6. Stated treatment plan with estimated length of stay will be required.



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Surgical Benefits

SURGICAL BENEFITS

PRE-CERTIFICATION IS REQUIRED.

Benefits Covered:

A. Surgical procedures consisting of operative and cutting procedures, treatment of fractures and dislocations, and endoscopic procedures including pre-and post-operative care which are performed in or out of a hospital by a qualified physician on an insured, as the result of an accidental injury or sickness.

B. Reconstructive surgery performed for correction of birth defects, disease, or accidental injury.

C. Dental procedures are not generally covered, however, listed below are certain dental procedures which will be covered as surgical procedures:

1. The surgical extraction of impacted teeth performed either in or out of a hospital.

2. Maxillofacial and mandibular jaw ridge surgery is reimbursed according to the class indicated by oral surgeon and ADE review. See Guidelines.

A list of certain outpatient surgeries and/or major diagnostic procedures which must be pre-certified is included in Appendix A.

Benefit Payable:

PEIA will pay charges up to 100% of the PEIA Fee Schedule rate for all eligible surgical procedures for accidental injury and sickness, providing pre-certification requirements are met. Surgeon's Visits, including pre-and post-operative care are combined with the surgical procedure charge for reimbursement purposes.

Failure to pre-certify surgical procedures will result in reduction of benefits to 80%.

Two or More Surgical Procedures:

When two or more surgical procedures are performed during the course of a single operation through the same incision or in the same natural body orifice, PEIA will pay charges up to 40% of the PEIA Fee Schedule rate for the second and each additional medically necessary surgical procedure.

Maternity:

Maternity benefits are payable as surgery covering both pre-natal and post-partum care. If the patient changes physicians, the visits to the first physician are paid according to PEIA maximum fee schedule as pre-natal and deducted from the full benefits of the second physician if he/she bills for full charges.

Assistant Surgeons:

Benefits for an assistant surgeon will be available for a licensed physician who actively assists the operating surgeon in the performance of a surgical procedure included in "A"on page one when the following conditions are met:

1. such services are certified as necessary by the primary operating surgeon; and
2. the type of surgical service requires such assistance; and
3. interns, residents, or house staff are not available.

Assistant surgeon benefits are only allowable while an insured is an admitted inpatient in a hospital.

When deemed medically necessary for a surgical procedure, the services of an assistant surgeon are covered at 20% of the primary surgeon's PEIA Fee Schedule rate.

Stand-By Surgeons:

A maximum charge of $400 is allowed for a stand-by surgeon for angioplasty.

Second and Third Surgical Opinions

PEIA retains the right to require a second or third opinion on any surgical procedure, if it is believed there is marginal medical necessity.

NOTICE: No amount is payable under this plan if surgery is determined not to be medically necessary.

Requirements for Additional Opinions:

When a physician recommends a surgical procedure, the physician or patient must call for pre-certification.

An experienced medical professional will call the patient's physician and evaluate the need for a second or third surgical opinion based upon information provided by the

physician. If a second or third opinion is required, it must be rendered by a board-certified specialist not associated with the primary physician.

The employee/patient will be sent a second or third surgical opinion form. Employee/patient must complete Part I of the form and give it to the physician providing the second or third opinion. The physician should complete Part II of the form.

Benefit Payable:

PEIA will pay charges up to the PEIA Fee Schedule rate for the second or third opinion and charges up to 100% of the PEIA Fee Schedule rate for the surgical procedure, if authorized.

> NOTE: Duplicate testing charges (x-ray and laboratory) related to same diagnosis, are not covered unless documented as necessary by the consulting physician.

Outpatient Surgery and Major Diagnostic Procedures

General:

The plan requires that prior approval be obtained from Utilization Management for certain outpatient surgical and major diagnostic procedures to receive maximum benefits.

Outpatient surgery means:

a) no room and board charge is made to the insured, and

b) surgery is performed in an Free Standing Facility, an outpatient surgery section of a hospital or a physician's office.

In all instances, the patient should discuss outpatient surgery and major diagnostic procedures with the physician prior to the procedure.

A list of those certain surgeries and/or major diagnostic procedures which must receive prior approval from Utilization Management is included in this document as Appendix A.

Note: If the physician recommends, and Utilization Management determines and approves that it is medically necessary (because of heart condition, hemophilia or other medical complications) for the patient to be admitted to the hospital for the procedure, charges will be paid PEIA's contract rate.

Benefit Payable:

PEIA will pay charges up to the PEIA Fee Schedule rate if the procedure is performed on an outpatient basis with pre-authorization from Utilization Management. **If the procedure is performed on an inpatient basis or outpatient basis without prior approval of Utilization Management, PEIA will pay charges up to 80 % of the PEIA Fee Schedule rate.**

Note: For x-ray and imaging procedures the insured shall pay 10% of eligible charges or of PEIA Fee Schedule rate, whichever is less, up to a maximum of $100 per person per calendar year. After satisfying the $100 maximum, all eligible outpatient x-ray or imaging procedures are payable at 100% of the PEIA Fee Schedule rate.

Blood Transfusions

Charges by a Physician - Charges by a physician for the administration of a blood transfusion are to be paid as a surgical procedure.

Charges by a Hospital - Charges made by a hospital for whole blood, processed blood product (i.e. packed cells, plasma) and services in connection with the processing of blood and administration of a blood transfusion, whether incurred on an inpatient or outpatient basis, are paid according to the hospital's contracted rate.

Because our Plan is written on a reimbursement basis, if credit is shown on the hospital bill for replaced blood, covered charges are to be reduced by the amount credited.

Organ and Tissue Transplants -- Case Management is Required

Claims are administered as follows:

1. Where the donor does not have Health Insurance coverage and PEIA insures the recipient, we will recognize the donor's medical expenses as part of the recipient's claim. We 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.

   a. Under Hospital and Surgical Coverage - In determining donor benefits, we will add the donor's room and board and ancillary charges to the recipient's ancillary charges. 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.

   b. Under Major Medical Expense Plans - In determining Major Medical Expense benefits, the excess of any covered hospital or surgical charges over the amount paid for the donor by the recipient's basic plan will be considered for Major Medical coverage under the recipient's plan.

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

3. Where both the donor and recipient have health coverage and PEIA insures the recipient, we 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.

4. 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.

Oral & Maxillofacial Surgery

Maxillary (Upper) and Mandibular (Lower) Jaw/Ridge Classification

Guidelines:

"Normal" edentulous jaw/ridge: adequate width (10-15mm) and height (30-45mm) of jaw bone, no undercuts; very acceptable for prosthesis wearing.

Class I atrophy: adequate height (30-45mm), but thin width (5-9mm) with undercuts; borderline acceptable for prosthesis; patient may experience discomfort with prosthesis.

NO BENEFITS AVAILABLE FOR CLASS I.

Class II atrophy: inadequate height (20-29mm), inadequate width (1-5mm) "knife-edge" ridge; patient usually has "electric" like pain in jaw upon chewing; prosthesis may cause ulcers or epulis tumor formation. Reconstructive surgery can improve these problems.

NO BENEFITS AVAILABLE FOR CLASS II.

Class III atrophy: complete ridge resorption, total height of jaw (10-12mm); width non-existent; patient experiences severe pain, paresthesias of jaw and lip, oral decubitus ulcers and/or epulis tumor formation. Ultimately cannot wear prosthesis. Negative emotional/psychological changes as well as negative diet changes occur. PATIENT IS DEFINITELY INDICATED FOR RECONSTRUCTIVE JAW SURGERY.

REVIEWED ON A CASE-BY-CASE BASIS FOR CLASS III.

Class IV atrophy: complete ridge resorption plus cortical basal bone resorption, width non-existent, total jaw height (3-9mm), i.e. flat upper or pencil thin lower jaw, prone for pathologic/spontaneous fracture. Patient is severely debilitated with irretractable pain, paresthesias, oral decubitus ulcers or epulis tumor formation. Patients cannot wear any prosthesis. Decreased vertical dimension on occlusion precipitates facial muscle spasms and degeneration of the masticatory apparatus. Diet consists of liquids or baby food consistency which leads to further progressive gastrointestinal disorders and blockage. PATIENT MUST HAVE RECONSTRUCTIVE SURGERY TO PREVENT FURTHER DEGENERATIVE CHANGES OR CATASTROPHIC PROBLEMS.

Approval by ADE for Class IV.

Exclusion: No benefits are available for pre-prosthetic surgery.

Reconstructive Surgery

Reconstructive surgery is covered under the PEIA Plan only for:

1) Correction of birth defects; and

2) Accidental bodily injury or disease occurring while insured or covered by PEIA.

No reconstructive surgery will be paid unless it has been pre-certified as medically necessary by the Case Management Program.

Additional consideration is given to dermabrasion for acne, incision and drainage of abscesses and mammoplasty.

Mammoplasty charges are to be accepted for consideration only if the procedure can be classified as augmentation (breast implants) after a partial or total mastectomy, necessitated by disease.

Otoplasty to correct birth defects and/or deformities is eligible under the PEIA plan.

A letter stating the medical necessity specifically identifying the birth defect, accidental injury, disease, etc, with date of onset is to be obtained from the operating surgeon before the claims administrator will process payment.

Exclusions under Surgical Benefits

No benefits are payable for:

a. Charges for cosmetic or reconstructive surgery unless such charges are incurred as the result of accidental bodily injury or disease occurring while covered or unless the surgery is performed to correct birth defects;

b. Charges for dental work or treatment except as specifically provided in the PEIA Plan;

c. Charges for injury or sickness connected with employment with any employer;

d. Pregnancy-related conditions for dependent children;

e. Elective abortions;

f. Reversal of sterilization;

g. Diagnosis and/or treatment by any method of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint;

h. Removal of calluses.

i. Incidental surgery performed through the course of a surgery performed due to medical necessity.

j. Charges for in vitro fertilization, or artificial insemination.

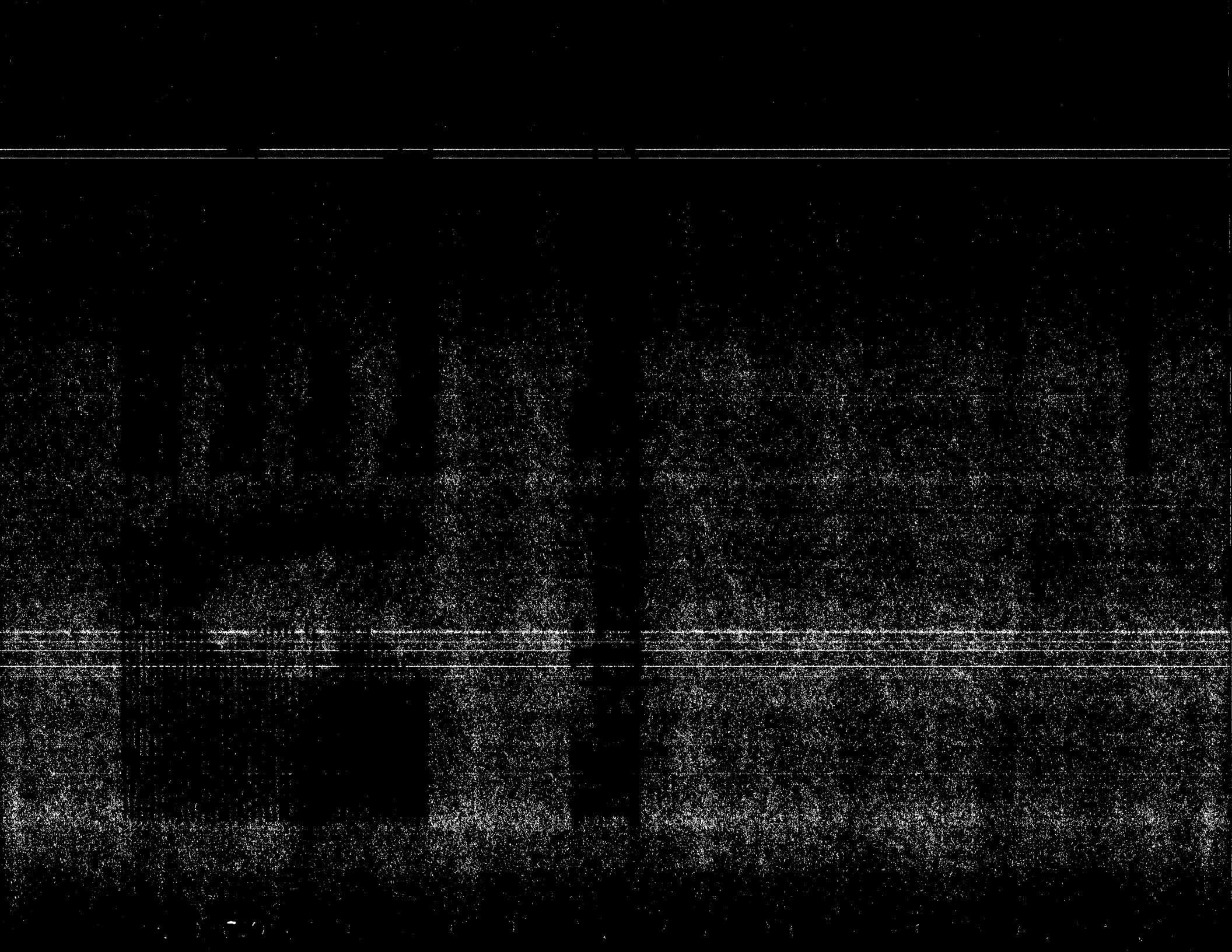
k. Radial Keratotomy.

l. Gastric stapling unless insured is more than 100 pounds over weight.

m. Surgery to relieve a patient of emotional stress and/or psychological disorders.

n. Charges incurred for service-related injuries/disabilities, or on account of war, or for treatment in any state-supported institution.

o. Weight loss



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Physician (In-Hospital) Medical Benefits

PHYSICIAN (IN-HOSPITAL) MEDICAL BENEFITS

To be covered, the visits must be made while the insured is confined to a licensed hospital or facility as an admitted in-patient. Benefits are payable only if a licensed physician charges the insured for visits because of an accidental injury or sickness.

Benefit Payable:

PEIA will pay up to the PEIA Fee Schedule rate for charges incurred beginning the first day of confinement to and including the day of discharge.

> NOTE: The number of visits must not exceed the number of days of hospital confinement.

Charges for professional visits by the attending physician after diagnostic surgery will be paid up to the PEIA Fee Schedule rate. Visits by the surgeon after diagnostic surgery are not eligible for payment, but are included in the surgical fee.

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 paid under the Major Medical portion of the Plan after satisfying the required major medical deductible.

Exclusions Under Physician (Inhospital) Medical Benefits

No benefits are payable for:

a. Any injury or illness connected with employment with any employer;

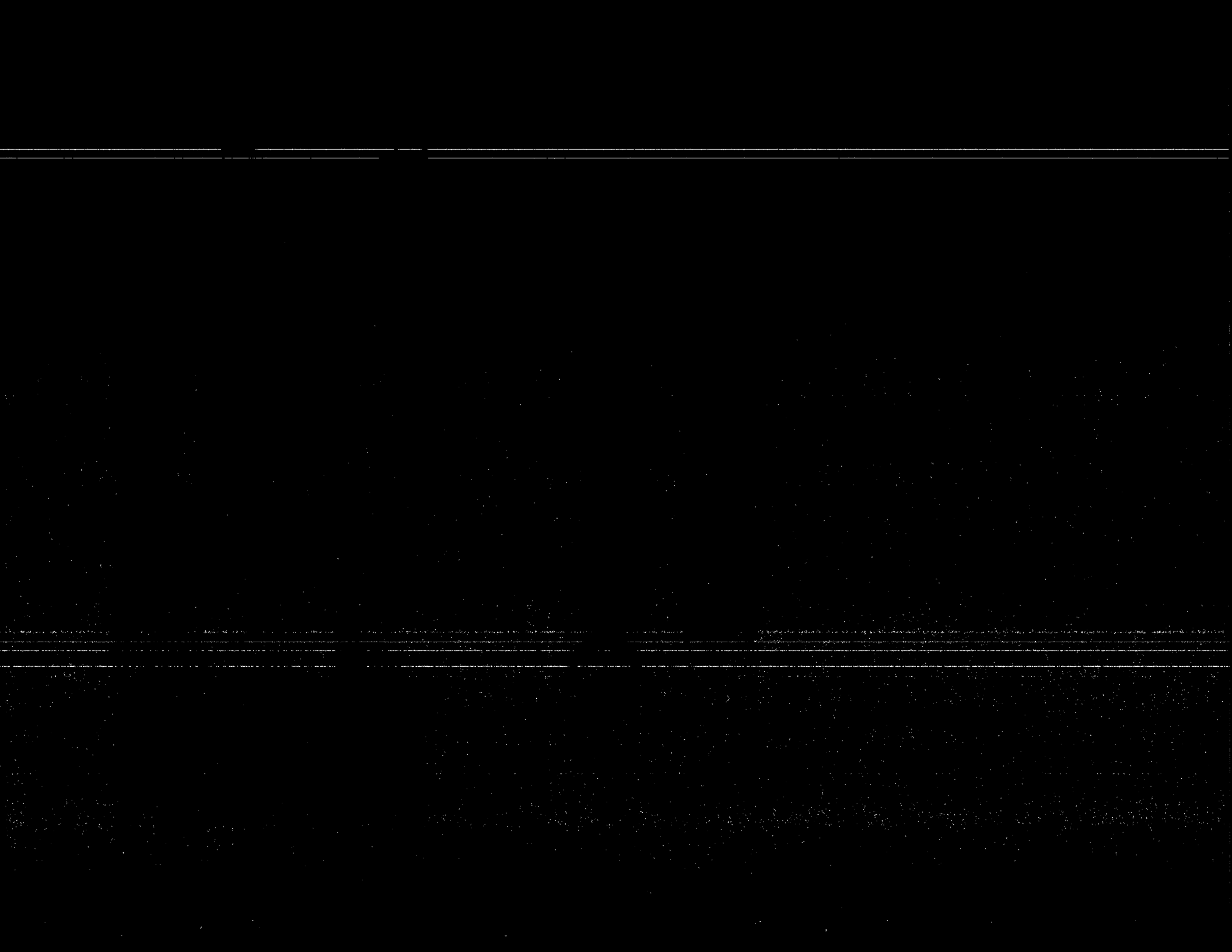
b. Pregnancy related conditions for dependent children;

c. Elective abortions;

d. Diagnosis or treatment of jaw joint disorders, including temporomandibular joint and craniomandibular disorders or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint;

e. Treatment by a physician for weight loss.

f. Charges incurred for service-related injuries/ disabilities, on account of war, or for treatment in any state-supported institution.



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Outpatient Benefits

OUTPATIENT PREADMISSION TESTING

If a patient reports on an outpatient basis for pre-confinement laboratory and x-ray work, the charges are paid in full providing all of the following requirements are met:

1) The person is confined within ten days following the date of the test; and,

2) The tests are normally required as a part of a scheduled hospital confinement and would be considered covered expenses if made during the period of hospital confinement or for outpatient surgery.

3) The tests are billed by the provider as pre-admission testing.

Pre-admission testing may be performed in the doctor's office for covered procedures.

OUTPATIENT LABORATORY AND X-RAY BENEFITS

The PEIA Plan is designed to provide on a co-payment basis for outpatient diagnostic x-ray and laboratory examinations generally accepted in medical practice as necessary for the diagnosis or treatment of an accident or disease as determined by the Claims Administrator.

Allowable Expenses:

A. Outpatient diagnostic x-ray examinations in connection with injury or sickness are covered. The examinations must be recommended by a licensed physician and made by a hospital, a radiologist or a physician qualified to perform and interpret radiological examinations within the confines of a single specialty.

B. Laboratory examinations in connection with injury or sickness are covered. The examinations must be made or recommended by a licensed physician.

This specifically includes pap smear and mammograms for cancer or diagnostic purposes when recommended by a licensed physician. W.Va. Code 33-15-4c

Benefit Payable - Co-Payment Provision:

Insureds shall pay 10% of eligible outpatient lab or x-ray charges or PEIA Fee Schedule rate , whichever is less, up to a maximum of $100 per person per calendar year. After satisfying the $100 maximum, all eligible outpatient lab and x-ray charges will be paid up to 100% of the PEIA Fee Schedule rate.

Pre-admission testing is paid in full if the tests are required as part of a scheduled confinement and the insured person is confined to the hospital within 10 days from the date of the tests.

> NOTE: The 10% co-payment cannot be applied or used to satisfy other Plan deductibles or copayments.

Exclusions Under X-Ray and Laboratory Benefits

a. Routine eye examinations;

b. Charges for dental x-rays;

c. Charges due to injury or sickness connected with employment with any employer;

d. Charges incurred in a Federal hospital for service-related injuries or disabilities, or for treatment in any state supported institution;

e. Pregnancy related conditions for dependent children;

f. Elective abortions;

g. Diagnosis and/or treatment of jaw joint disorders, including temporomandibular joint and craniomandibular disorders or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint;

h. Duplicate testing;

i. Handling fee for laboratory test;

j. Lab and x-ray for weight loss;

Note: X-ray interpretation is covered under the Major Medical plan.

ACCIDENTAL INJURIES (OUTPATIENT)

The initial visit by an insured receiving emergency outpatient care within 48 hours of a non-occupational accidental injury is covered.

Benefit Payable:

PEIA will pay for the following services:

1. One hundred percent (100%) of contracted hospital rates for the initial visit.

2. Physician's charges up to 100% of the PEIA Fee Schedule rate

Where an insured sustains an accidental bodily injury, the physician's bill may indicate treatment of a surgical nature, as that rendered for fractures and lacerations, and also medical treatment for conditions such as abrasions, contusions, etc. Payment is to be made for the surgical, physician and medical treatments.

Outpatient Follow-up (after an accident)

When an injury, initially treated within 48 hours of an accident, results in further outpatient care, hospital charges for this care are allowed as hospital ancillary charges. This rule covers only those charges necessary to complete the work, initially performed, such as removal of a cast or sutures, additional x-rays for a fracture or the re-application of a cast.

> Note: Follow-up treatment does not include charges for injections, diathermy and other therapeutic treatments or physical medicines.

General Guidelines:

Sprains, Bee Stings and Electrical Shock - Claims for these conditions are to be considered the result of an accident.

Strains - A strain may be the result of natural physical weakness or the result of an accident. Where the insured or physician indicates a strain is due to an accident, the claim is to be accepted.

Sunburns, Poison Ivy, Ingestion of Sleeping Pills, Nose Bleeds and Similar Occurrences - Any of these conditions are to be considered as sickness where additional information is not submitted to substantiate an accident claim.

Injury from Illegal Action:

In the event that an individual engages in an illegal action or is the aggressor in an altercation, bodily injury is an anticipated possible result. Inasmuch as the individual is considered responsible for his/her actions in these cases, the injury is not considered accidental as required by the policy, and no benefits are to be allowed.

CARDIAC REHABILITATION

CASE MANAGEMENT IS REQUIRED FOR CARDIAC REHABILITATION

The PEIA benefit program provides limited coverage for cardiac rehabilitation. Coverage is limited to insureds meeting the requirements outlined below and referred by the attending physician. One of the following conditions must be documented in writing by the attending physician.

1) The insured must have had an acute myocardial infarction (MI) in the preceding twelve (12) months; or

2) The insured has had coronary bypass surgery; or

3) The insured has stabilized angina pectoris.

Cardiac rehabilitation programs are covered in the following facilities.

a. Free Standing Clinic

b. Cardiac Rehabilitation Clinic

c. Outpatient Hospital Departments

Maximum Benefit:

Duration of the benefit is limited to 36 sessions per calendar year. (Limit of 3 sessions per week for 12 weeks)

Benefit Payable:

Insureds shall pay 10% of eligible outpatient lab or x-ray PEIA Fee Schedule rate up to a maximum of $100.00 per calendar year. After satisfying the $100.00 maximum, all eligible outpatient lab and x-ray charges will be paid up to 100% of the PEIA Fee Schedule rate.

All Other Charges:

Eligible charges are paid up to 80% of the PEIA Fee Schedule rate or the reasonable and customary amount, whichever is applicable, after satisfying required major medical deductible.

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Major Medical Benefits

MAJOR MEDICAL

Major Medical supplements the Hospital and Surgical Expense benefits. Eligible expenses under Major Medical must be prescribed by a licensed physician in connection with the treatment of injury or sickness.

Maximum Lifetime Major Medical Benefit:

The maximum lifetime major medical benefit is $500,000 per insured.

Deductible:

Major medical deductibles are $150 per person per calendar year with the family plan total deductible capped at $300 per calendar year.

Benefit Payable

Eligible services are paid at 80% according to either the PEIA Fee Schedule or the reasonable and customary fee schedule, whichever is appropriate. The required deductible amount must be satisfied before services can be eligible for reimbursement.

Eligible Major Medical Expenses:

The following services, supplies and treatment are considered eligible major medical expenses if they are prescribed by a physician in connection with an illness or injury.

1. Preventive pediatric health care office visits and immunizations from birth through age twelve. See Major Medical guidelines for covered services.

2. Office visits and services for diagnosis and treatment of medical conditions only.

3. Services of a Chiropractor including office visits limited to a maximum reimbursement of $750 per calendar year. Charges in excess of PEIA maximum are considered non-covered services.

4. Consultations in or out of the hospital.

5. Private duty skilled nursing by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) provided outside of a hospital by a person not related by blood or marriage or regularly residing in the household of the insured. ($30,000 yearly maximum.)

6. Treatment by a registered physical or occupational therapist.

7. Treatment by x-ray, radium, or other radioactive substances.

8. Ground ambulance service to the hospital for inpatient care, for outpatient accident care,or from a hospital to the nearest facility able to provide needed services not available at the transferring hospital. Air ambulance, when medically necessary, is covered when moving the patient to the nearest facility providing necessary treatment (See Major Medical Guidelines).

9. Artificial eyes, limbs, larynx, and other prosthetic devices.

10. Durable medical equipment when accompanied by a statement of medical necessity from the attending physician and when authorized by case management.

11. Allergy testing and the related injections. (Vaccine covered under Prescription Drug program.)

12. Repair of accidental injury to sound natural teeth.

13. Service for outpatient psychiatric treatment or testing rendered by a physician or clinical psychologist limited to 50% of the eligible charge up to, but not more than $1,000 per calendar year. Charges in excess of the PEIA maximum benefits are considered non-covered services.

14. Charges for speech therapy rendered by a qualified speech therapist for speech impairment due to any injury, sickness or functional disorders when recommended by a licensed physician and authorized by case management.

15. Hepatitis inoculation is the only covered medical service that is allowable under the PEIA plan that is related to employment. (EXAMPLE: School Health Nurse)

16. Hemodialysis

17. X-ray interpretation.

GUIDELINES FOR SPECIFIC MAJOR MEDICAL EXPENSES

Pediatric Health Care

All children must have access to an array of health care benefits that will ensure their optimal health and well being. The following services will be included in the PEIA health benefit plan. These services should be performed in a cost-effective manner that does not compromise the highest quality of care. They may be provided in a physician's office, in a clinic by the local Health Department, or in an outpatient or inpatient hospital -based or other facility.

Covered services as directed by a licensed physician will include:

1. A routine schedule for active immunization of normal infants and children from birth through age 12. Immunizations are recommended to be completed according to the schedule as outlined in Appendix C. The scheduled immunization program will include:

   DPT: Diptheria and tetanus toxoids with pertussis vaccine;
   OPV: Oral poliovirus vaccine containing attenuated poliovirus types 1, 2, & 3;
   MMR: live measles, mumps and rubella viruses in a combined vaccine;
   PRP-D: haemophilus b diptheria toxoid conjugate vaccine.

2. Routine office visits in conjunction with immunization testings and well-child visits as recommended by the American Academy of Pediatrics from birth through age 12. The frequency of visits, testing and immunizations will be covered benefits as described in Appendix C.

Outpatient Nursing Care: — MUST BE PRE-CERTIFIED

When services of an RN or LPN are required on an outpatient basis, the necessity of the service is to be reviewed in light of the type of service, based on the condition. Where there is doubt as to the necessity of the service, a complete statement from the attending physician is requested and a statement of medical necessity must be included.

Charges by an RN or LPN for local transportation are not payable. Transportation charges by a nurse required to accompany the patient due to the medical condition are to be referred to the claims administrator for review, with a full explanation of the circumstances.

Speech Therapy: -- MUST BE PRE-CERTIFIED BY CASE MANAGEMENT

Speech therapy for an injury or sickness is a covered service as indicated in the

guidelines below. Speech therapy for education or training (voice modulation, elimination of a lisp or similar training) is not covered.

A. Patient must meet all of the following criteria:

1. The inability to speak is the result of a non-occupational accidental injury or a non-occupational illness.

2. The speech therapy must be recommended and prescribed by a physician licensed to practice medicine and surgery, who exercises this continuing direction and control, and

3. The individual must have the facility to make verbal sound and the capacity (mental and physical) to verbally communicate (latent ability) at the time speech therapy is begun.

B. Acceptable length of treatment:

1. Until the individual can be verbally understood, or

2. Until it is recognized that understandable speech for that individual is not possible.

Once verbal understanding has been reached, continued speech therapy for voice modulation or voice improvement is considered training and is not covered. Therefore, if speech therapy continues beyond three (3) months, the attending physician's statement concerning criteria A and B is to be obtained at three (3) month intervals.

If it is not certain whether the prescribed speech therapy is treatment or training, the case should be referred to case management for review and determination.

Ambulance Service:

Charges for local ground ambulance to the nearest appropriate hospital are specifically covered under Major Medical whether made by a hospital or other agency.

Charges for other than local ambulance service from one hospital to the nearest hospital able to provide the services not available at the transferring hospital are covered.

Air Ambulance Guidelines: (Limited Benefit)

Claim filing criteria:

1. Must be medically necessary.

2. Must be to nearest facility providing necessary treatment.

3. Billing must be itemized with charges noted for each of the following:

   a. Lift-off charge (if any)

   b. Total mileage charged, noting rate per mile and miles traveled.

   c. Number in medical crew and charges incurred. Also note rate per hour for each medical crew member (i.e. paramedic, EMT, etc.) and number of hours or fractional hours charged.

   d. Medical supply charges by item.

Benefit Criteria:

a. No benefit for lift-off charges.

b. Maximum mileage rate allowable is $25.00 per mile, payable at 80%.

c. Medical crew charges are payable up to a maximum rate of $75.00 per hour reimbursable at 80%.

d. Medical supplies paid at 80%.

EQUIPMENT/APPLIANCES/SUPPLIES

Medical equipment, appliances and supplies are covered when prescribed by the attending physician as medically necessary in the treatment of a condition. The following is to be used as a guide:

1. Items prescribed by the physician as a convenience or as an accommodation to the patient, but not necessary in the treatment of the condition are not covered.

2. Items which are of a household nature, rather than a medical supply are not covered.

Obturators: (cleft palate)

When an insured has a cleft palate, the dentist constructs an artificial palate, an obturator. Under certain conditions this prosthesis is made part of a routine dental prosthesis (denture or bridge) for support. This prosthesis, along with its dental prosthesis is a covered service, since the cleft palate is a medical condition and its treatment is medical in nature.

Orthopedic Shoes/Boots:

Orthopedic shoes/boots are not a covered service. However, when the shoe/boot is an integral part of a brace required by the patient's condition, the entire cost of the brace and shoe/boot is reimbursable.

Surgical Support Hose:

Covered services are limited to surgical stockings which are usually worn under regular stockings and considered a medical supply item. The benefit is limited to two (2) pairs initially, and further coverage for two (2) pairs annually as replacements, subject to a physician's recommendation of necessity for the continued condition.

Supp-hose and other commercial-type support stockings are not items of medical supply because they are worn in place of every day wear or other apparel. Supp-hose are not covered.

Cataract Lenses:

Contact Lenses/Eyeglasses - Contact lenses or eyeglasses following cataract surgery may be considered prostheses where they replace the lenses of the eyes. In this case, initial pair of contact lenses or eyeglasses following cataract surgery would be a covered service.

If the cataract surgery involved a lens implant, contact lenses and/or eyeglasses are not covered by the Plan.

Durable Medical Equipment:

CASE MANAGEMENT IS REQUIRED

Items that are purchased for temporary use only, and which have monetary value to the patient after treatment, are to be reviewed carefully for rental versus purchase price. Rental cost is a covered service during the period of temporary use. When the item will be used for a prolonged period, the item is usually purchased because the cost would be lower than rental. The purchase cost, in such an instance, is a covered item. In no instance should the rental charge exceed the actual purchase price of the item.

The following Durable Medical Equipment for post-hospital care or care in the home requires pre-approval by the Case Management Program:

1. Any durable medical equipment purchase exceeding $500.

2. Any durable medical equipment requiring a rental period of more than three months.

Case Management will make the final decision on the cost-effectiveness of rental as opposed to purchase, based on the anticipated length of use.

The reasonable cost of the repair of an item is covered, instead of the purchase of a new piece of equipment.

If there is medical need to justify replacement of an item, the item is covered. Items replaced due to loss or negligence are not covered. Items replaced because a newer or more efficient model is available are not covered, unless a physician's statement is obtained stating the medical need for the replacement.

Insureds may be able to arrange for less costly negotiated charges for durable medical equipment by contacting the Case Management Program.

Appendix B is a list of the most frequently used durable medical equipment for which PEIA will pay 80% of the rental or purchase price up to the maximum reasonable and customary fee. All other approved equipment will be paid at 80% of the reasonable and customary fee.

NOTE: Failure to obtain prior approval from Case Management will result in reduction of benefits to 65%.

Durable Medical Equipment Items Not Covered:

Bathroom Equipment:
toilet seats, commodes, bathtub seats, rails, grab bars, etc.

Bath Paraffin (Units)

Chair, Recliner

Child's Stroller

Contour Chair

Craftmatic Beds

Diapers (Adult or infant)

Enureris Unit

Environmental Control Equipment:
air cleaner, air filters, air conditioner, dehumidifier, dust extractors, humdifiers, puritron air freshener, etc.

Escalator, Elevator or Stair lift

Exercise Bike, Exercycles

Food Liquidizer/Food Processor

Hearing Aids

Heating Pads

Hydraulic Van or Car Lift

Ice Bags

Language Master (Bell & Howell)

Lift Chair

Niagara Vibrator

Nutritional Supplements

Orthopedic Mattress

Portable Whirlpool Pump, Jacuzzi Whirlpool Equipment

Professional Medical Equipment:
blood pressure kit, stethoscope, etc.

Room Heaters (Portable)

Scale (Bathroom)

Thermometer

Treadmill Jogger

Trapeze Bars

Walking Cane with Seat

Wig, Wig Styling

Exclusions Under Major Medical Expense Benefits

Covered services shall not include expenses for:

a. Services, supplies and treatment unless prescribed as necessary by a physician licensed to practice medicine and surgery or by a Doctor of Dental Surgery as indicated for oral surgery;

b. Expenses of a Federal Hospital for service-related injuries/disabilities or for treatment in a State-supported institution;

c. Routine dental and optical work, routine office visits, routine physical examinations (except pap smears and mammograms) transportation other than local ambulance service, air ambulance not deemed medically necessary, hearing aids, articles of clothing, eye glasses, contact lenses or examinations for fitting or prescription thereof.

d. The difference between private and semiprivate accommodations;

e. Surgical services for which benefits are payable under the provisions of this contract entitled Surgical Services Benefits, nor will such charges be applied toward the Cash Deductible;

f. Treatment for marital counseling;

g. Pregnancy and all related conditions for dependent children;

h. Elective abortions;

i. Treatment of weak, strained, or flat feet or instability or imbalance of the feet, or any tarsalgia, metatarsalgia or bunion, other than surgery involving the exposure of bones, tendons or ligaments;

j. Treatment (including cutting or removal by any method) of toe nails or of superficial lesions of the feet including corns, callouses, pedicures and hyperkeratoses, other than the removal of nail matrix or root;

k. Charges due to injury or sickness connected with employment with any employer, except when denied by Workers' Compensation;

l. Treatment for weight loss;

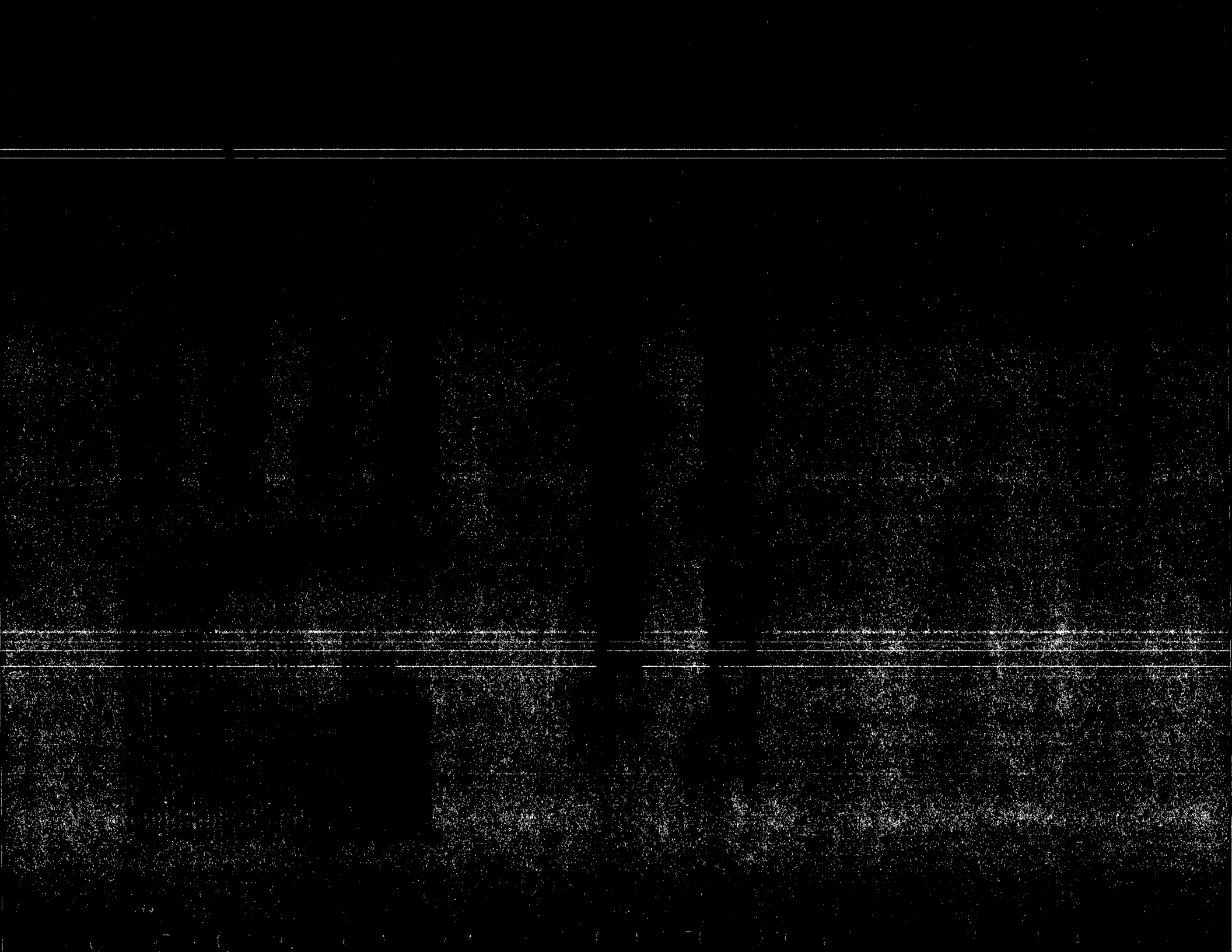
m. Diagnosis and/or treatment by any method of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves and other tissues related to that joint;

n. Hospital weekend admissions, all inhospital admissions which have not been precertified and surgical charges which exceed plan benefit;

o. Charges for cosmetic or reconstructive surgery unless such charges are incurred as the result of accidental bodily injury or disease occurring while covered or unless the surgery is performed to correct birth defects;

p. Treatment by hypnosis;

q. Tape, alcohol and miscellaneous materials purchased to change dressings by patients at home;



PRESCRIPTION DRUG PROGRAM

Effective August 1, 1989

Prescription drugs are a separate part of the West Virginia Group Medical Plan. Eligible prescription drugs must be prescribed by a licensed physician in connection with the treatment of an injury or sickness and dispensed by a licensed pharmacist.

Deductible:

$50.00 per person, per calendar year with family plan deductible capped at $100 per calendar year.

Benefit Payable:

- 75% of brand name drug charge when a lower cost generic is available
- 80% of brand name drug charge when physician specifies brand necessary or no lower cost generic is available, or
- 90% of generic drug charge.

NOTE: Drugs dispensed by a physician, mail order, out-of-state, or a non-preferred pharmacist will be paid according to the amount charged.

IMPORTANT REMINDER: The decision to use a generic drug is the responsibility of the prescribing physician and the patient. PEIA is not mandating the use of generic, but only encouraging the use with the physicians permission.

The preferred provider organization for the PEIA is the Preferred Pharmacy Network of West Virginia (PPNWV). The provider organization is made up of participating pharmacies located throughout West Virginia and are identified by the "PPNWV" sign displayed on the window or door.

Insureds are encouraged to use PPNWV pharmacies in that, the maximum allowable charge will be less for the insured and PEIA.

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Claims

TIMELY SUBMISSION OF CLAIMS

Written proof of all claims incurred must be furnished to the Claims Administrator of the West Virginia Public Employees Insurance Agency, (hereinafter PEIA) within twelve (12) months from the date of service, if PEIA is the primary insurance, and within 24 months if PEIA is the secondary insurance.

Failure to submit incurred claims within the prescribed time period shall invalidate the claim and payment thereof shall be the responsibility of the claimant.

EMPLOYEE OR PROVIDER MISREPRESENTATION

"Any person who shall knowingly secure or attempt to secure benefits payable under this article to which the person is not entitled, or who shall knowingly secure or attempt to secure greater benefits than those to which the person is entitled, by willfully misrepresenting the presence or extent of benefits to which the person is entitled under a collateral insurance source, or by willfully misrepresenting any material fact relating to any other information requested by the Director of PEIA, or by willfully overcharging for services provided, or by willfully misrepresenting the diagnosis or nature of the service provided, may be found to be overpaid and shall be civilly liable for any overpayment.

In addition to the civil remedy provided herein, PEIA shall withhold payment of benefits due to that person until any overpayment has been recovered or may directly set off, after holding internal administrative proceedings to assure due process, any such overcharges or improperly derived payment against benefits due such person hereunder. Nothing in this section shall be construed to limit any other remedy or civil or criminal penalty provided by law." W.Va. Code 5-16-11(a)

COORDINATION OF BENEFITS

The payment of benefits under this health plan is coordinated with other health plans. Coordination of benefits will occur if the employee or his/her dependents are covered under:

a. Any government program provided or required by Statute, or

b. Any plan covering individuals as a group and providing hospital and medical care benefits or service through group insurance or group prepayment arrangement, including student coverage obtained through an educational institution above the high school level, or

c. Any plan covering individuals and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

THE COMBINED BENEFITS FROM ALL PLANS WILL PAY UP TO, BUT NOT MORE THAN, 100% OF THE ACTUAL MEDICAL EXPENSES.

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan then adjusts its benefits so that the amount reimbursed will not exceed 100% of the actual medical expenses. Neither plan will pay more than it would in the absence of the "Coordination Provision". A plan without a coordination provision will always be the primary plan.

Rules to determine which plan is the primary carrier are as follows:

a. If the patient is the policyholder, then the policyholder's plan is primary;

b. If the dependent child is covered under both parents' plans, the father's plan is primary;

c. If neither (a) or (b) applies, the plan that has covered the insured the longer time is primary;

The rules for the order of benefit determination of claims for dependent children of divorced or separated parents are as follows:

1. The plan of the parent having custody of the child(ren) is primary, and

2. If the parent having custody has remarried, the plan of the stepparent is secondary, and the plan of the natural parent without custody is tertiary.

EXCEPTION: If a court decree has established financial responsibility for the dependent child(ren), then the plan of the parent with financial responsibility is always primary, the plan of the other natural parent is secondary, and the plan of the stepparent, if any is tertiary. For claims administration purposes, it will be assumed that financial responsibility has not been legally established, unless the claim file indicates otherwise.

Guidelines:

Champus provides benefits for retired military personnel and their dependents, as well as for dependents of active duty, deceased active duty, and deceased retired military personnel.

For dependents of active military personnel, the PEIA is always secondary carrier, since the Champus program does not contain a duplicate coverage provision for this classification of dependent.

When a retired military person is covered under the PEIA group plan provided through employment, the PEIA is primary carrier for the military person and any of the dependents enrolled in the group plan.

When a spouse of a retired military, deceased active duty or deceased retired military person is covered under a PEIA plan provided through employment, the PEIA is primary carrier for the spouse, however, it is secondary carrier for the retired military person and the other dependents or simply for the dependents (in the case of a deceased military person).

When both the spouse and the retired person are enrolled in group plans through their respective employment, the standard COB rules for determining order of payment are to be applied. Champus would always be third payer in this situation.

Medicare is usually the primary payor except in the case of an active employee age 65 or older.

HOW TO FILE A MAJOR MEDICAL CLAIM

All questions are to be answered completely, observing any special instructions required for "yes" answers.

1. The employee information on the claim form is to be completed by the policyholder.

2. Social Security Number of policyholder must be inserted on all claim forms.

3. Patient information is to be completed.

4. Other group insurance coverage information is to be completed if applicable. If applicable, Explanation of Benefits from the group insurance coverage is to be attached to the claim form.

5. Nature of injury or sickness.

6. Medicare information must be provided if applicable. Medicare Explanation of Benefits is to be attached to the claim form if Medicare is the primary carrier.

7. Policyholder must sign and date the claim form.

8. All itemized statements from a physician must include the following:

   a. patient's name
   b. nature of illness
   c. date of service (s)
   d. type of service (s)
   e. charges made for each service
   f. procedure code(s) and diagnosis code(s)
   g. federal tax identification number of the provider of service

   NOTE: Cash register receipts and cancelled checks are not acceptable proof of claim.

Reminder: Major medical claim forms are not acceptable when filing claims for prescription drugs purchased after July 31, 1989.

HOW TO FILE A PRESCRIPTION DRUG CLAIM

Effective August 1, 1989

1) The employee information on the claim form is to be completed by the policyholder.

2) Social security number of the policyholder must be inserted on all prescription drug claim forms.

3) Patient information is to be completed by the policyholder.

4) Policyholder and pharmacist must sign the completed PEIA claim form.

5) Other group insurance coverage information is to be completed, if applicable. If applicable, Explanation of Benefits from other group insurance coverage is to be attached to the claim form.

6) Pharmacist must fully complete the prescription data or a completed universal claim pharmacy form will be accepted.

7) Pharmacist must sign the PEIA prescription claim form, inserting his/her name, address, telephone and tax ID number.

The third-party claims administrator will accept the universal claim form to which all pharmacists have access, in lieu of the PEIA prescription drug claim form. A computer printout provided by a mail-order pharmacy with all required drug information, is also acceptable when attached to a PEIA prescription drug claim form.

Prescription drug claim forms can be submitted by the policyholder or by the pharmacy who accepts assignment. The participating pharmacy who accepts assignment will be paid directly by the Claims Administrator. The employee will pay only the deductible and/or the co-payment amount. Claims submitted without assignment will be paid directly to the policyholder.

Incomplete forms will be returned. It is suggested that drug claims be submitted on a monthly basis.

NOTE: Cash register receipts and cancelled checks are not acceptable proof of claim.

Confidential Nature of Claims Information:

All claims information submitted is confidential and is not to be released without proper authorization. The information is required by the Claims Administrator for claim processing purposes only and is not to be disclosed to any third party or his agent in correspondence, in telephone conversations, or in person without proper written authorization.

Where there is a non-duplication of benefits provision (COB) the plan gives the Claims Administrator the right to release claim information to another insurance company.

Special attention is to be given to the confidentiality of information contained in claims and received by the PEIA and/or Claims Administrator submitted by employees and elected officials under this plan. It is recognized that the claim file is handled or reviewed by more than one person. However, the information included in a claim is to be held in strict confidence of the personnel responsible for handling and/or processing the claim.

Appeals:

First level of appeal is to be made to the Claims Administrator in writing to determine whether or not a mistake in processing has been made. Second level of appeal is to be made to the PEIA.

Inquiries received from the employee or family member appealing the declination of a claim are to be answered based upon the policy information furnished in the Plan Document.

The policyholder may request a review of a declined payment of claim. The policyholder and/or authorized representative must make the request in writing within sixty (60) days of receipt of the disposition (declination) of said claim by the Claims Administrator.

Facts, issues, comments and all pertinent information regarding the declined claim and review are to be submitted in writing to:

Director
Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1025
Charleston, West Virginia 25305

Upon receipt of the review, the PEIA will have the entire case reconsidered, taking into account any additional materials which have been provided. A decision, in writing, explaining the basis for upholding or modifying the original disposition of the claim will be sent to the insured or authorized representative.

Claims Incurred Outside of U.S.A

All claims incurred outside of the United States are the initial responsibility of the insured and/or dependent for payment. The insured or dependent is responsible for obtaining all itemized billings, statements and receipts from hospitals, physicians, pharmacies, etc.

The medical expense charges incurred are to be submitted to the Claims Administrator along with a completed Medical Claim form and any additional information the Claims Administrator may need to process the claim.

The Claims Administrator will determine, through a local banking institution, the current currency exchange rate and reimburse the insured for incurred medical expenses.

SUBROGATION AND RIGHT OF RECOVERY

Subrogation:

To the extent of the value of benefits paid, the Public Employees Insurance Agency shall be subrogated and succeed to all rights of an insured to recover from any person or entity which may be liable for expenses incurred for covered services.

This right of subrogation shall constitute a lien against any settlement or judgment obtained by or on behalf of an insured for recovery of such expenses. An insured shall, upon request, execute and deliver to the PEIA such documents and information which the PEIA may require to define, verify or protect its right of subrogation. Benefits may be withheld pending receipt of necessary documents from the insured. In addition, the insured shall be responsible for making prompt reimbursement to the PEIA from any settlement or judgment obtained.

Failure by the insured to provide any requested documents or information, or to otherwise cooperate with the PEIA in protecting or securing its right, or to make prompt reimbursement from any settlement or judgment, shall not affect the PEIA's right of subrogation, but shall render the insured liable to the PEIA for any expenses, including reasonable attorney's fees, incurred in obtaining any such requested information, or any reimbursement to which it is entitled.

Right of Recovery:

The Public Employees Insurance Agency shall have the right to recover from any insured or other person or entity to whom benefits have been paid for payments subsequently determined to be excessive, for noncovered services, or otherwise improperly or incorrectly made. The insured shall cooperate fully with the PEIA to secure recovery of any such overpayments. The PEIA may, after making reasonable attempts to collect from the insured or other person or entity to whom such overpayment has been made, deduct the amount of the overpayment from other benefits which are or may become payable to or on behalf of the insured.

This provision shall not limit any other remedy provided by law.

RETIREE CLAIM PAYMENTS

Retired Employee and Eligible Dependent(s) Under Age 65:

All medical expense benefits as contained in the PEIA policy provisions shall continue to be paid as if the retiree is actively employed.

When the retired employee or dependent becomes eligible for Medicare prior to age 65, benefits under PEIA will be reduced by the amount of benefits payable under Medicare.

Retired Employee and Dependent(s) 65 or Over:

When the retired employee or dependent reaches age 65 and becomes eligible for Medicare, benefits under PEIA will be reduced by the amount of benefits payable under Medicare.

Medicare becomes the primary carrier and PEIA secondary which supplements Medicare.

Retirees who are receiving Medicare Benefits are not eligible for COBRA.

IMPORTANT: PEIA specifically advises retired employees and dependents approaching age 65 to enroll for Part A and Part B of Medicare. In administering claims it will be assumed that all insureds are enrolled for all Medicare Benefits, both Part A and Part B. Part A under Medicare includes coverage for inpatient hospital and skilled nursing care. Part B includes coverage for outpatient hospital, medical and surgical care. If an individual does not enroll for Parts A and B, then any expenses normally covered under Parts A and B will be the liability of the individual.

Monthly Costs:

The monthly contribution for the Benefits described above will vary depending on the employee's age and status and that of his/her dependents. Contact the PEIA for the exact contribution.

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Accounting

ADMINISTRATIVE EXPENSE FUND

The Public Employees Insurance Agency shall annually determine such sums as may be necessary to pay the administrative costs of the Plan.

Each participating division, board, commission, or department of the State shall pay to the Public Employees Insurance Agency the determined sum per year, per employee.

Agencies 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.

Contributions shall not be prorated in the event a member terminates or ceases to receive benefits before completion of a year of membership.

MONTHLY REPORT

A. Monthly Report Billing

Each participating agency receives a monthly report billing from the Public Employees Insurance Agency listing all eligible enrollees, based on data received, with the correct coverage code as of the date of the billing.

B. Updating the Monthly Report Billing

On receipt of monthly billing, the agency should verify that all listed employees are eligible and correct. If an employee should appear on the report for that month, but does not, the employee's name should be written on the billing along with the employee's effective date, social security number, coverage code, premium due (if any),optional life and dependent life coverages.

The agency should mark through a name which should not appear on that billing, such as a terminated or ineligible employee. For an employee who is changing from a single plan to a family plan or vice-versa, the agency need only change the coverage code (s) and amount due. Cards reflecting these changes, if not already forwarded, are to be sent immediately to PEIA.

If a name has been stricken from the billing, the agency must indicate on the side of the report whether the employee has been terminated, or transferred to another account. If terminated, the termination date should be noted.

When all changes have been made, the correct premium due should be recalculated.

C. Calculating Correct Premium Due

1. Employee Contribution:

To calculate the correct premium due, the agency should start with the total amount shown on the monthly billing and add or subtract any changes made manually on the report. When all changes have been made, the new total on Line 1 of the cover sheet should be used for that account number. Premiums for COBRA insureds must be included.

If the agency failed to deduct for an employee who is paying a premium, or collected the wrong amount, the employee's name should be indicated on the back of the cover sheet with the amount of overpayment or underpayment and the month to which it pertains.

The correct monthly premium due, shown on Line 1 of the cover sheet, and the adjustments on the back of the cover sheet, must balance with the amount remitted.

2. Agency Contribution:

The agency should follow the procedure outlined for calculating the employee contribution. Premiums due for retirees must be included.

3. Optional and Dependent Life Insurance:

The agency should follow the procedure outlined for calculating the employee contribution, if employees are billed for their premium.

The billing should be separated. The original should be submitted to PEIA, and the carbon copy should be retained by the agency. Checks and IGTs (if applicable) for the amount due must be remitted with the monthly report and cover sheet for each account.

Note:

1. The cover sheet for each account must reflect total amount due to include insureds under COBRA and retirees using earned extended insurance benefits.

2. Separate checks for each category (employee, agency, optional/dependent life) are not required. One check covering the total amount due is requested, if possible.

3. For those agencies who use Intra-governmental Transaction (IGT) to transfer premium, please ensure that premiums are transferred to the correct PEIA account. PEIA accounts are:

8265-05	Employee and agency health premium
8265-06	Administrative expense fee
8265-07	Optional and/or dependent life insurance

4. Any overpayment or underpayment must be reconciled on the monthly report the following month.

PREMIUM REQUIREMENTS

A. ACTIVE

Employee Contribution

Any employee who elects to participate in the insurance plan on or after July 1, 1988 will pay:

1st year	30% of total premium cost
2nd year	20% of total premium cost
3rd year and every year thereafter	10% of total premium cost not to exceed 1.5% of the employee's gross wage with the remainder of the total premium to be contributed by the State.

"...employees shall not be considered a new employee, for the purposes of these contribution limits, after returning from extended authorized leave on or after the first day of July, one thousand nine hundred eighty-eight." W.Va. Code 5-16-13

NOTE: There is a separate sheet and amount for COBRA insureds.

Agency Contribution

This amount must be remitted on all accounts.

NOTE: There is a separate sheet and amount for retirees.

Optional and/or Dependent Life Insurance,and Administrative Expense Fee

All employees who have elected to take the additional life and/or dependent life insurance will pay the full premium each month.

Administrative Expense Fee:

Agencies are billed annually on July 1 for each employee, and monthly as new employees are enrolled after July 1.

In addition to the administrative expense fee, new agencies enrolling in the PEIA plan will be assessed a one-time fee of $12.00 per enrollee on the first PEIA monthly billing.

Active Employees On Personal Leave:

The premium must be remitted to the payroll location each month so that it may be sent to PEIA with the correct monthly report.

The premium must be indicated on the report in the column under "Employee Contribution". This indicates that the employee is on leave and paying the full premium.

The agency contribution should be lined through since the employee is paying 100% of the premium. When calculating correct premium due, this amount should be deducted from the agency contribution. Failure to remit the premium due each month to the Public Employees Insurance Agency results in termination of insurance coverage.

B. RETIREE PREMIUM

Retirees will remain on the agency's account until the former employee has exhausted all earned extended insurance coverage for which he/she is eligible.

All agencies are responsible to remit to the Public Employees Insurance Agency the monthly premium for retired employees qualifying for earned extended insurance coverage for the time period in which the employee is eligible for earned extended insurance coverage.

> NOTE: ANY AGENCY wishing to charge general revenue funds for insurance benefits for retirees must provide documentation to the Director that such benefits cannot be paid for by any special revenue account or that the retiring employee has been paid solely with general revenue funds for TWELVE MONTHS PRIOR TO RETIREMENT. W.Va. Code 5-16-13

PREMIUM CREDIT

The following guidelines apply to employees who elected to participate in the Public Employees Insurance Plan **prior to July l, 1988**.

A. Single (AS) Contract to Family (AF) Contract

The Public Employees Insurance Agency allows a premium credit for the 30% employee contribution for any insured who changes from a single contract to a family contract under the Public Employees Insurance Program. This credit applies only to the 30% contribution made by an employee, and is based on applicable premiums during the credit period.

NOTE: The employee must pay 12 months from the effective date of the family coverage.

Example:

$28.80	Monthly single premium (previously paid)
66.00	Monthly family premium
$37.20	Monthly difference which employee must pay

66.00 x 12 months = $792.00 (one year family coverage premium)

$28.80 x 12 months = $345.60 (one year single coverage premium)
37.20 x 12 months = 446.40 (one year single premium credit)
$792.00 (same as one year family premium)

Family coverage:

$66.00	Employee monthly contribution
154.00	Agency monthly contribution
$220.00	Total monthly premium

THE PUBLIC EMPLOYEES INSURANCE AGENCY WILL COMPUTE THE NUMBER OF MONTHS IN WHICH AN EMPLOYEE IS ENTITLED TO RECEIVE A CREDIT.

When an employee changes from Single coverage to Family coverage and receives a credit for the 30% contribution made while the employee had Single coverage the agency's contribution will be increased proportionally by the amount credited in order that 100% of the required monthly premium is received by the Public Employees Insurance Agency for the employee.

Example:

If the employee is paying $37.20 per month, the agency contribution must be increased from $154.00 to $182.20 per month so the family premium of $220.00 per month is remitted to PEIA.

$ 37.20	Employee contribution
182.80	Agency contribution
$220.00	Total monthly premium remitted

B. Family (AF) Contract to Single (AS) Contract to Family (AF) Contract
(Effective November 1, 1989)

If an employee has paid 12 months on a family plan, and must revert to a single plan due to death or divorce of his/her spouse, or dependent becomes ineligible due to attainment of age 19 (or age 25 while maintaining full-time student status), he/she will not be required to contribute a percentage of the premium again upon changing back to a family plan.

C. Life Insurance Only (LA) Contract to Single (AS)/Family (AF) Contract

If an employee is currently enrolled for "Life Insurance Only" (LA) coverage (insured as a dependent under his/her spouse's PEIA coverage), and the one spouse's health coverage should terminate, the LA enrollee may enroll for the medical portion of the insurance program, and will not be required to contribute a percentage of the premium or be subject to the pre-existing condition limitations. In order to take advantage of this premium credit, the LA enrollee must make this election prior to or during the month following the termination date of the spouse's insurance coverage.

D. Life Insurance Only (LAD) Contract to Single (AS)/Family (AF) Contract

If an employee is currently enrolled for "Life Insurance Only" (LAD) coverage (not covered as a dependent under his/her spouse's coverage) and later wishes to enroll for the medical portion of the Insurance Program, that employee will be subject to the pre-existing condition limitations. In addition, the enrollee is required to pay 30% of the premium of the new contract (AS/AF) for a period of one year from the date of election on the new contract.

No premium credit is allowed for premiums paid on the LAD contract.

E. Dependent Status to Single (AS)/Family (AF) Contract
(Effective November 1, 1989)

An employee who meets the guidelines stated below will be allowed to enroll as the policyholder without having to contribute a percentage of the premium:

1) was covered as a dependent under his/her spouse's PEIA group health plan prior

to July 1, 1988, and has remained continuously covered as a dependent.

2) was employed prior to July 1, 1988, and remained continuously with PEIA participating State agency.

3) loses health coverage through spouse's termination of employment, death or divorce.

If the employee meets all three of the above guidelines, and enrolls in his/her plan during the month of loss of coverage or the following month, a percentage of the monthly premium will not apply.

Should he/she fail to enroll in the plan during the above period, premium guidelines in effect for new enrollees on or after July 1, 1988 will apply. In addition, new enrollees will be subject to the pre-existing condition limitations.

F. Premium Credit Exclusions

Premium credit does NOT apply if employee voluntarily resigns, has a lapse of coverage, and is later re-employed with a participating agency.

G. Involuntary Terminations

An employee who is involuntarily terminated or laid off from employment and returns to employment within one year from the date off the payroll will not be considered as a new enrollee for premium purposes. That employee will be reinstated in the insurance program with the same status as of the last day in the program.

H. Transfer (From one Participating Employer to Another)

Any participating employee (policyholder) who transfers from one participating agency to another and re-enrolls during the month of transfer or the immediate following month, will have continuous coverage.

No additional premium will be assessed if health and/or life insurance coverage is not changed or increased.

PREMIUM CREDIT (CONTINUED)

The following guidelines apply to employees who elect to participate in the PEIA plan **on or after July 1, 1988**.

A. Change of Coverage

There will be no premium credit allowed for previously paid premium, however, for those employees changing coverage codes, the following guidelines apply:

(1) Single (AS) Contract to Family (AF) Contract

Employee will have a new effective date for AF coverage and, for premium purposes, will begin paying premiums at 30% the first year, 20% the second year, and 10% the third year and every year thereafter.

(2) Family (AF) Contract to Single (AS) Contract

If an employee is paying 10% for family coverage, he/she will drop to 10% of the single coverage premium.

B. Involuntary Terminations

An employee who is involuntarily terminated or laid off from employment and returns to employment within one year from the date off the payroll will not be considered as a new enrollee for premium purposes. That employee will be reinstated in the insurance program with the same status as of the last day in the program.

C. Transfer (From one Participating Employer to Another)

Any participating employee (policyholder) who transfers from one participating agency to another and re-enrolls during the month of transfer or the immediate following month, will have continuous coverage.

No additional premium will be assessed if health and/or life insurance coverage is not changed or increased.

REFUNDS

A. Employees:

If an overpayment occurs on your monthly billing due to the wrong amount being deducted, or continuing deductions after an employee's insurance becomes free, a refund is due that person. If you cannot take credit on your report, complete a Request for Refund form, sign and date, with an authorized signature. Submit it to this office to be approved. If there is more than one month involved in the overage, do not request a refund until the deductions are correct and one refund form can cover all months for which a refund is due.

B. Agency:

When there is an overage on the agency contribution, you must take credit on your next monthly billing.

C. Administrative Expense Fee:

The same procedure indicated for Agency Contribution applies.

D. Optional & Dependent Life Insurance:

The same procedure indicated for Employee Contribution applies.

E. Refund Timeframes

1. Agency Error:

a. A refund due with incurred date within the current fiscal year shall be refunded during that current fiscal year from current fiscal year funds.

b. A refund due with 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 said immediately past fiscal year funds.

c. A refund due with incurred date in an immediate previous fiscal year and received after July 31 of the current fiscal year shall be submitted to the Court of Claims by the participating agency.

2. PEIA Error:

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

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COBRA

COBRA

Legal Requirements:

Federal law entitles the employee and covered dependents under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue medical coverage only in certain cases when coverage would otherwise terminate, provided the employee and/or dependent(s) pay the full group premiums. These circumstances and provisions are described in the COBRA Mandate Section.

COBRA Mandate:

I. Enrollment Guidelines

Active Employees

A covered active employee who would lose eligibility for coverage because of voluntary or involuntary termination (except for gross misconduct) or reduction in work hours to part-time status may elect to continue medical coverage for himself and his dependents at his own expense for up to 18 months from the date coverage would have terminated. It will be the responsibility of the employing agency to notify the Program of termination or reductions in hours within 60 days of date coverage would ordinarily have terminated under the Plan. The Program will then notify the employee within 14 days of his right to continue coverage. Coverage may be continued for up to 18 months, but will end earlier if he becomes covered under another group health plan, fails to pay the required premium, or becomes covered by Medicare.

Surviving Spouse and Dependents

Upon the death of a covered employee or retiree, the surviving legal spouse and dependents may elect to continue medical coverage at their own expense. For the surviving spouse, coverage may be continued for up to 36 months, unless they become covered under another group health plan. For surviving dependent children, coverage may continue for up to 36 months beyond the termination date for children as set forth in the Plan Document, but will end earlier if the child becomes covered in another group health plan. Either the agency or surviving spouse must notify the Program within 60 days of the death of the employee or retiree; the Program will then notify the spouse within 14 days of his or her right to continue coverage.

Divorced Spouse

In the event of divorce from a covered active or retired employee, the divorced spouse may elect to continue medical coverage at his or her own expense for up to 36 months from the date coverage would have terminated. Coverage will end earlier if the spouse remarries and becomes covered under another group plan or becomes covered by Medicare. It will be the responsibility of the divorced spouse to notify the Program of the divorce within 60 days from the date coverage would terminate, and the Program will notify the spouse of his or her option to continue coverage within 14 days. (Legal separation is treated the same as a divorce).

Dependent Children

A covered employee or retiree may elect to continue coverage on a dependent child, if the child no longer meets the definition of a covered dependent as defined in the Plan Document. Loss of eligibility may result from marriage, attainment of age 19 (or 25, if a full-time student), failure to maintain student status, etc. Coverage may be continued for up to 36 months following the date coverage would have terminated, but will end earlier if the dependent child becomes covered under another group health plan or becomes covered by Medicare. It will be the responsibility of the covered employee or retiree to notify the Program within 60 days of loss of the dependent's eligibility; the Program will then notify the employee within 14 days of his right to elect continued coverage on that dependent.

For All Plan Members:

The following provisions apply to all plan members for whom coverage is extended under the Program's new eligibility rules:

1. Continuation of coverage is optional on the part of the insured 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 class of coverage (single or family). There will be no contribution made from state or agency funds.

2. All premiums must be remitted to the enrolling agency. The PEIA is unable to accept payments from individuals.

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

4. After you have been notified by PEIA of your right to continue coverage, you must inform PEIA in writing within 60 days if you with to elect continuation coverage. You will then have an additional 45 days to pay the applicable premium, retroactive to the date coverage would otherwise have terminated.

5. During the 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 your extension, your coverage and cost will be affected accordingly.

6. If you elect continued coverage, new dependents may be added during your period of continuation.

7. The continuation option applies only to medical benefits; there are no extension provisions for employee or dependent life insurance.

8. If a covered person is enrolled in the PEIA program and is subject to the 12-month limitation for pre-existing conditions, this limitation will continue in effect under any continuation option until the expiration of the 12-month period.

9. If you are enrolled in an HMO, you will be given the same continuation options as those plan members covered by the PEIA health insurance plan. Additionally, if you have elected to continue coverage, you will retain your right to change your PEIA/ HMO enrollment during the regular annual re-enrollment period (July).

10. If you are enrolled in an HMO, you will be given the opportunity to convert to either the PEIA's or the HMO's plan.

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

Qualifying Events:

A qualifying event is an event which constitutes the loss of health coverage for a covered individual. Listed below are the qualifying events for employees, spouses, and dependent children.

1. Employee — Maximum Coverage Voluntary termination of employment; Involuntary termination of employment (except for gross misconduct) or Reduction in work hours to part-time status	18 Months
2. Spouse	36 Months
a. Death of your spouse **(Contact thePEIA Eligibility Section to determine if the PEIA Surviving Dependent Guidelines may be more beneficial to you); Divorce or legal separation; or Your spouse (the employee) elects Medicare as the primary carrier while an active employee.	
b. Voluntary termination of spouse's employment; Involuntary termination of spouse's employment (except for gross misconduct); or Reduction in spouse's work hours to part-time status.	18 Months
3. Dependent Children	36 Months
a. Death of parent **(Contact the PEIA Eligibility Section to determine if the PEIA Surviving Dependent Guidelines may be more beneficial to you); Parent's election of Medicare as the primary carrier while an active employee; Child no longer meets the eligibility requirements of a dependent child under the PEIA Eligibility Guidelines; If children do not remain covered by the employee, then their COBRA coverage will be under a family plan in the name of the parent who enrolled as a COBRA ENROLLEE due to the divorce or legal separation.	
b. Voluntary termination of parent's employment; Involuntary termination of parent's employment (except for gross misconduct); or Reduction in parent's work hours to part-time status.	

4. Surviving Dependent (Spouse or Child) - Dual Eligibility

A surviving dependent of a deceased insured employee is eligible to enroll under either the PEIA's Surviving Dependent program or the COBRA program. In most instances, the benefits offered by the PEIA's Surviving Dependent Program will exceed the benefits offered by COBRA. However, there will be cases where the Surviving Dependent Program benefits will be less than the benefits offered to a dependent who is eligible for COBRA.

An example of this would be an 18-year-old dependent child, not planning to be a full-time student after turning age 19, whose covered parent has died.

Under PEIA's Surviving Dependent guidelines, coverage for children terminates at the end of the month in which age 19 is attained. Under COBRA, the child would be eligible for up to 36 months of coverage as long as s/he was not covered under another group health plan.

If you are uncertain as to which program would offer the Dependent the greatest benefit, please contact the Eligibility Section of the PEIA.

II. Payment Guidelines

A. Timely Premium Payment

The total premium due for coverage (single or family) must be remitted to the enrolling agency on a timely basis each month. Failure to pay the insurance premium within 30 days of the date due will result in termination of coverage.

The PEIA will not accept premium payments from individuals, payments must be made through the enrolling agency. Advance payments and partial premium payments will not be accepted.

No contributions will be made from State or agency funds. Premium payment is the total responsibility of those individuals electing continued coverage.

III. Terminations

A. Reasons for Termination of Coverage

Terminated or reduced-hour employees may continue coverage for themselves and their eligible dependents for up to 18 months. All other eligible persons may continue coverage for up to three years. However, a person's right to continue coverage will end as soon as one of these events happen:

1. When the 18-month or three-year period described above ends.

2. When the employer ceases to provide any group health plan to an employee.

3. When coverage under the plan ends because premium wasn't paid.

4. When the person becomes covered as an employee under another group medical plan or becomes covered by Medicare.

5. In the case of a divorced spouse, when he/she remarries and becomes covered under another group health plan.

B. How to Terminate an Individual under COBRA

It is not necessary to submit a "Notice of Termination" card to remove qualified beneficiary who has elected COBRA benefits and continued for the full 18 months or 3 years. The insured will be removed from your account automatically at the end of the coverage period.

It is necessary to submit a "Notice of Termination" card to remove a qualified beneficiary who has elected COBRA benefits and has not continued for the full 18 months or 3 years.

Two (2) Notice of Termination cards must be completed. One card is to be retained for your agency file. The other card is to be remitted to the PEIA.

Conversions:

Conversion Privileges

When a person's eligibility for continued group coverage ends because he/she has continued coverage for 18 or 36 months, that person has the right to apply for the individual conversion coverage available under the PEIA plan.

HMO Conversion Options

If the insured is enrolled in a Health Maintenance Organization (HMO), the insured will be given the opportunity to convert to either the PEIA or the HMO conversion plan.

For further information on conversion privileges, contact the PEIA office at least thirty days prior to the end of continuation coverage.

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HMO

HEALTH MAINTENANCE ORGANIZATIONS

The Federal Health Maintenance Organization (HMO) Act of 1973 provides a system for delivering a broad scope of specified comprehensive health care services to its members for a fixed, pre-negotiated fee, 24 hours each day, 7 days each week. The HMO removes the barrier which usually causes individuals to wait until an illness becomes severe before seeking medical care and emphasizes outpatient and preventative care to reduce the need for hospitalization.

All HMO's must be certified by the Department of Health and Human Services and licensed by the West Virginia Insurance Commission.

The 1977 session of the West Virginia Legislature, passed a bill which granted Health Maintenance Organizations (HMO's) the right to operate in the State of West Virginia.

Solicitation by an HMO:

Any agency in a HMO service area and currently enrolled in the Public Employees Insurance Program may be solicited by an HMO. Employees are given the option of remaining with the PEIA or joining the HMO plan for a contract period of one year. Since the HMO's do not have life insurance coverage as provided by the PEIA, if an individual wishes to enroll for health coverage with an HMO, the life insurance coverage as well as the optional life insurance coverage would be continued with the PEIA

> NOTE: Open enrollment or solicitation by the HMO is done only once a year (in May and June), to be effective July 1.

Eligibility:

Eligibility for enrollment in an HMO is based on the same eligibility guidelines used for enrollment in the PEIA insurance program. Members must meet minimum eligibility requirements.

Enrollment Process:

When an employee or retiree wishes to convert health insurance benefits to an HMO, the life insurance benefits are retained through the PEIA. At the time of enrollment, the Payroll location completes two (2) CHANGE OF STATUS cards for each employee or retiree. It is important that each CHANGE OF STATUS card be signed and dated by the employee or retiree. One card is sent to the PEIA, and the other retained by the Payroll location.

The notation "HMO Conversion," the account number, and the new coverage code "M" must appear on each CHANGE OF STATUS card. A copy of the employee's HMO Conversion Application must accompany each CHANGE OF STATUS card.

The social security number on the CHANGE OF STATUS card is to be the same number showing on the monthly insurance report. All CHANGE OF STATUS cards and copies of the HMO Conversion Applications go to the Eligibility Division of the PEIA.

Continuation of Coverage During a Medical Leave of Absence:

Any employee who is on a medical leave of absence, approved by his employer, shall, subject to the following provisions of this paragraph, be entitled to continue his/her coverage until he/she returns to his/her employment, and such employee and employer shall continue to pay their proportionate share of premium costs as provided by this article: Provided, That the employer shall be obligated to pay its proportionate share of the premium cost only for a period of one year: Provided, however, That during the period of such leave of absence, the employee shall, at least once each month, submit to the employer the statement of a qualified physician certifying that the employee is unable to return to work. W.Va. Code 5-16-18

Continuation of Coverage During Personal Leave of Absence:

A person may be granted insurance coverage only while on a personal leave of absence for a period of 12 months with the approval of the agency where he/she is employed. The employee must remit 100% of the premium for each month he/she is on personal leave.

Retiring Employees:

Employees covered by an HMO who retire may remain with the HMO or be re-enrolled with the PEIA upon the effective date of retirement. This means that if an employee retires after being covered by an HMO for a period of six (6) months and wishes to convert back, the PEIA will provide health and life insurance coverage upon the effective date of retirement.

Moving Out of the HMO Service Area:

If an employee or retiree covered by an HMO moves or is transferred out of the service area, the employee or retiree will be re-enrolled with the PEIA with no lapse in coverage. For example, if an employee in the Department of Highways is covered by an HMO in the Wheeling, WV area and is transferred to the Department of Highways in Parkersburg, the employee will be re-enrolled in the PEIA since there is no HMO currently operating in the Parkersburg area.

Changes in Coverage:

When an employee or retiree enrolls in an HMO program and at the same time changes his/her contract information with the PEIA, a CHANGE OF STATUS card must be completed and submitted to the PEIA. The CHANGE OF STATUS card must reflect the HMO status. Examples would be, change of name, change of beneficiary, adding or deleting dependents to an existing Family contract, changing from AF to AS status, and addition of dependents within the eligibility period.

Termination of the HMO Contract by an Insured:

If, during the course of the contract period while covered by an HMO, an insured wishes to terminate his/her coverage, thirty (30) days' notice must be provided in writing to the insuring HMO. The insured will not be allowed to return to the PEIA until the end of the one year contract period. This means that it is entirely possible to cancel the HMO coverage at the end of two (2) months. However, it would be ten (10) months before health coverage would be available through the PEIA.

The employee or retiree, at the time of HMO termination, must sign a CHANGE OF STATUS card in the Benefits Coordinator's office. On the CHANGE OF STATUS card, it must be noted that the employee or retiree is transferring health insurance coverage from an HMO to the PEIA. The card also must show the coverage code, the account number and the date that this change is to take place.

When this has been completed, the Payroll location submits a copy of the HMO termination notice and the CHANGE OF STATUS card to the PEIA. Any delay in the employee or retiree signing the CHANGE OF STATUS card will result in automatic pre-existing condition limitations for the insured and all dependents. The transfer from HMO coverage to the PEIA must be performed at the time of the HMO termination.

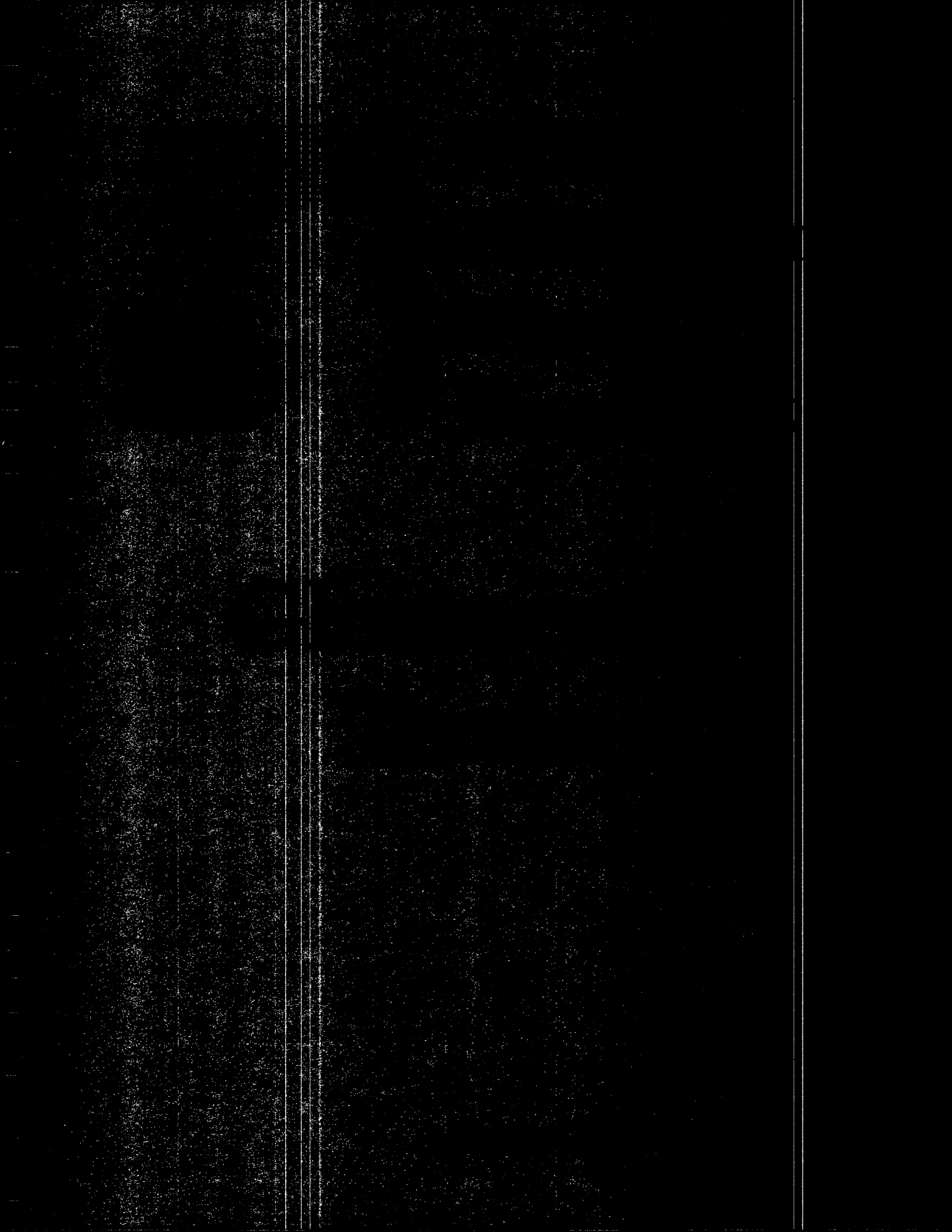
Death of an Insured While Covered Under an HMO:

If an employee or retiree passes away while covered by an HMO, the spouse will be given the option of converting to the HMO individual plan or returning to the PEIA as a surviving dependent or converting to a private policy with a contracted underwriter. Contact the PEIA for details regarding contribution to be remitted or forms for conversion.

Payment of Contribution

PEIA does not receive an appropriation to cover the matching contribution of employees. Therefore, agencies are directly responsible for the payment of monthly contributions to the HMO for health insurance coverage, and the remittance to PEIA for life insurance coverage.

If the HMO premium is higher than the PEIA rate, an additional "out-of-pocket" expense is to be deducted from the employee. The agency will not contribute more than the maximum premium established by PEIA for each type of coverage.



GLOSSARY OF TERMS

A

Accidental Injury:

Trauma or damage to some part of the body resulting from an unforeseen or unexpected occurrence or mishap.

Accommodation Charges:

Charges made by a hospital for room (not to exceed the allowance for a semi-private room), general nursing services, meals (including special diets), housekeeping services, minor medical and surgical supplies, medical and psychiatric social services and the use of equipment, facilities and/or services for which a separate charge is not customarily made by hospitals.

Administrator:

Director of PEIA who is empowered and authorized to establish group hospital and surgical insurance plan (s), a group major medical plan(s) and group life and accidental death plan (s) for employees made eligible.

Alcohol and Substance Abuse Treatment Facility

An Alcohol and Substance Abuse Treatment Facility is a licensed institution or a hospital established to provide medical treatment for patients who require inpatient care on account of alcoholism or substance abuse, which has permanent facilities for inpatient medical care on the premises, including 24-hour nursing service under the supervision of a full-time Registered Nurse (R.N.), and maintains daily medical records on all patients.

B

Benefit Period:

The period of time during which charges for covered services must be incurred in order to be eligible for payment by the Plan. A charge shall be considered incurred on the date the service or supply was provided to the insured. January through December of any given year.

Birthing Center:

A facility having staff to provide short stay, ambulatory health care for low risk birth away from a mother's usual residence, including prenatal and postpartum care for individuals with uncomplicated pregnancies, labor and vaginal birth and newborn care during the recovery period and which:

a) is fully licensed by the state in which it is located;

b) is supervised by a duly licensed physician; and

c) has available by telephone, 24 hours a day, a physician experienced and competent in the field of obstetrics.

C

Calendar Year:

January 1 through December 31 of each year.

Case Management:

For patients who have high-cost, long term and/or complicated discharge planning cases, this program will locate and assess medically appropriate alternative settings in which service can be provided. Case management also assists in managing patients' health care benefits as cost-effectively as possible. The program also may provide extra-contractual benefits when necessary.

Chiropractic:

A system of manipulative treatment which teaches that all diseases are caused by impingement on spinal nerves and can be corrected by spinal adjustments.

COBRA:

Consolidated Omnibus Budget Reconciliation Act

Copayment:

The percentage of expenses paid by an insured after satisfaction of the deductible.

Cosmetic Surgery:

Surgery intended solely to improve the appearance of the individual, but not to restore bodily function or correct deformity. Cosmetic surgery does not become "Reconstructive Surgery" because of psychological or psychiatric reasons.

Covered Service:

A service or supply which qualifies for payment by the PEIA under the terms of this program.

Custodial Care:

Expenses incurred for care comprised of accommodations (including room and other institutional services) and nursing services provided to an insured, because of age or other mental or physical condition, primarily to assist the insured in the activities of daily living, shall be deemed custodial care. Custodial care encompasses bathing, feeding, massage, turning/changing positions, primary setter, etc. The fact that the insured is concurrently receiving medical service which is merely maintenance care that cannot reasonably be expected to contribute substantially to the improvement of a medical condition shall not preclude the application of this limitation.

Current Procedural Terminology (CPT) Code:

A system of terminology and coding developed by the American Medical Association used for describing medical services and procedures.

D

Day:

For the purposes of this plan document, "Day" is defined as one 24-hour period.

Deductible:

A specified amount of charges for covered services, expressed in dollars, that must be incurred by a member during a benefit period, before the PEIA becomes liable for payment of remaining charges for covered services.

Dependent:

Eligible persons (spouse or child) other than the policyholder who are covered under the plan.

Discharge Planning:

The process of assessing a patient's need for medically appropriate treatment after hospitalization and effecting an appropriate and timely discharge.

Duplication of Benefits:

Overlapping or identical coverage of the same insured under two or more health plans, usually the result of contracts from different insurance carriers, service organizations or pre-payment plans; also known as multiple coverage.

E

Effective Date of Coverage:

The date on which coverage for an insured begins under this program.

Elective Surgery:

Surgery which may be medically necessary, but does not need to be performed on an emergency basis because reasonable delays will not adversely affect the outcome of the surgery.

Eligible Dependent:

Eligible dependent is as defined as:

a) The policyholder's spouse under a legally valid, existing marriage.

b) The unmarried children, including newborn children, stepchildren, children legally placed for adoption, legally adopted children of the policyholder or the policyholder's spouse, or any children fully dependent upon the policyholder for support and maintenance and residing in the household of the policyholder who are:

1) Under nineteen (19) years of age; or

2) nineteen (19) years of age or older provided that any such child in the sole judgment of the PEIA, is incapable of self-support by reason of physical handicap, developmental disability or mental retardation provided such child was eligible for coverage prior to attaining age nineteen (19). The PEIA may require proof of such disability from time to time; or

3) under twenty-five (25) years of age, who are enrolled as full-time students in an accredited educational institution which is recognized as such by the PEIA.

Employee:

An individual who meets the requirements of active employee as defined within this Plan Document who is eligible to enroll for coverage.

Exclusions:

Medical service, treatment or supplies not eligible for consideration under the PEIA program.

Explanation of Benefits:

A form sent to the insured person after a claim for payment has been evaluated or processed by the Third Party Administrator which explains the action taken on the claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, etc.

Extended Care Facility:

An Extended Care Facility is an institution that for a fee furnishes room, board and skilled nursing services for medical care; has one or more licensed nurses on duty at all times under the supervision of a doctor or Registered Nurse (R.N.) on a 24-hour basis. The Extended Care Facility must also have available at all times under an established agreement the services of a licensed physician. The institution must maintain daily medical records on all patients and comply with the legal requirements applicable to the operation of an Extended Care Facility.

F

Family Coverage:

Coverage for a policyholder and one or more eligible dependents.

Family Leave:

Leave provided because of the birth of a son or daughter of the employee, or because of placement of a son or daughter with the employee for adoption, or in order to care for the employee's son, daughter, spouse, parent or dependent who has a serious health problem.

Free Standing Facility (FSF):

An institution (other than a hospital) which is established, equipped, and operated primarily for the purpose of performing outpatient elective procedures of an uncomplicated nature. It does not provide beds for overnight confinement.

H

Handicap:

A mental or physical impairment which substantially limits one or more of a person's major life activities. The term "major life activities" includes functions such as care for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. "Substantially limits" means interferes with or affects over a substantial period of time. Minor, temporary ailments or injuries shall not be considered physical or mental impairments which substantially limit a person's major life activities. "Physical or mental impairment" includes such diseases and conditions as orthopedic, visual, speech and hearing impairments; cerebral palsy; epilepsy; muscular distrophy; autism; multiple sclerosis and diabetes. The term "handicap" does not include excessive use or abuse of alcohol, drugs or tobacco.

HMO (Health Maintenance Organization)

An organization that provides a wide range of comprehensive health care services for a specific group at a fixed periodic payment.

Home Health Care:

A provider which:

a) provides skilled nursing and other services on a visiting basis in the insured's home; and

b) is responsible for supervising the delivery of such services under a treatment plan approved in writing by the attending physician.

Hospice:

A medically directed program of services for terminally ill patients which stresses pain and symptom control. Services are provided by physicians, nurses, counselors, and therapists in the patient's home or hospice center. Patient must be given a prognosis of six months or less to live to be eligible for hospice benefits.

Hospital:

A provider that is a short-term, acute, general care facility which:

a) is a duly licensed institution;

b) for compensation from its patients is primarily engaged in providing inpatient diagnostic, surgical, and therapeutic services for the diagnosis, treatment and care of insured and sick persons by, or under the supervision of, a physician;

c) has organized departments of medicine and major surgery;

d) provides 24-hour nursing services by, or under the supervision of, registered graduate nurses (RNs).

e) is not, other than incidentally, a:

1) skilled nursing facility
2) nursing home;
3) custodial care home;
4) health resort;
5) spa or sanitarium;
6) place for rest;
7) place for the treatment of mental or emotional illness;
8) place for the treatment of alcoholism or drug abuse;
9) place for the provision of hospice care;
10) place for the provision of rehabilitation care;
11) place for the treatment of pulmonary tuberculosis.

I

Inpatient:

An insured who is admitted and treated as a registered bed patient with the reasonable expectation of remaining overnight in a hospital or other facility, and for whom an accommodation charge is made.

Insured:

A participating eligible employee, retiree, or surviving dependent or eligible dependent who is properly enrolled.

Intermittent Care:

To meet the requirement for "intermittent" skilled nursing care, an individual must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days.

L

Lifetime Maximum:

That amount of money which represents the maximum benefits payable by the PEIA, or on behalf of, an insured during the insured's lifetime.

M

Major Medical:

For the purposes of this Plan Document, Major Medical is that eligible portion of benefits which supplements the Hospital and Surgical benefits.

Maternity Care:

Prenatal, intrapartum and postpartum care rendered by a physician, hospital or other provider to a pregnant individual or newborn child during and following pregnancy and delivery.

Medical Emergency:

The sudden and unexpected onset of a condition or illness with severe symptoms requiring medical and/or surgical care as soon after the onset as possible, but in no event later than 24 hours after onset. This term may include, but is not limited to, such conditions or symptoms as: heart attacks, cardiovascular accidents, acute chest pains, acute appendicitis, convulsions, loss of consciousness and diabetic coma.

Medical Leave of Absence:

As used herein, refers to an approved absence from the employer due to medical reasons, which the employee can document by way of a statement of a qualified physician certifying that the employee is unable to work.

Medically Necessary:

Services or supplies provided by a hospital, physician or other provider which are required to identify or treat the patient's illness, condition or injury and which services or supplies, as determined by the Claims Administrator are:

a) consistent with the symptom or diagnosis and treatment of the insured's condition, disease, ailments or injuries;

b) appropriate with regard to standards of good medical practice;

c) not primarily cosmetic or for the convenience of an insured, physician, hospital or other provider; and

d) the most appropriate supply or level of service which can be safely provided to the insured. When applied to the care of an inpatient, it further means that the insured's medical symptoms or conditions require that the services or supplies cannot be provided to the insured as an outpatient in a physician's office or in a Free Standing Facility. Examples of other inappropriate levels of service include

hospital inpatient admissions or continued lengths of stay primarily for diagnostic services or custodial care.

The fact that a physician has prescribed, ordered, recommended or approved a service, treatment, hospitalization or supply does not, of itself, make such service, treatment, hospitalization or supply medically necessary, nor does it make the charge a covered service. The PEIA reserves the right to make the final determination of medical necessity on the basis of the final diagnosis and supporting medical data.

Mental or Emotional Illness:

A mental or emotional disorder characterized by an abnormal functioning of the mind or emotions in which psychological, intellectual, emotional or behavioral disturbances are the dominating feature, but excluding mental retardation.

Mental Hospital (Psychiatric Hospital)

A facility which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the active inpatient treatment of mental or emotional illness, with services provided by, or under the supervision of, a licensed psychiatrist and providing continuous nursing services under the supervision of registered graduate nurses. This term does not include facilities which are primarily custodial or schools for the mentally retarded.

Midwife:

The term "midwife" means a person educated in the discipline of nursing and midwifery, certified by examination with the American College of Nurse-Midwives, and licensed by state authority to engage in the practice of midwifery (CNM); or, a person trained in midwifery and licensed by the state authority to engage in the practice of midwifery.

O

Other Provider:

A person or entity other than a hospital or physician which is licensed, as required, to render covered services.

Outpatient:

A patient who receives services or supplies while not an inpatient.

P

Participant:

An eligible employee or eligible dependent who is properly enrolled in the PEIA program.

PEIA

The Public Employees Insurance Agency, as created by act of the West Virginia Legislature to provide health and/or life insurance coverage to all employees of the State of West Virginia, its political subdivisions, and other eligible individuals as outlined in the West Virginia Code.

Personal Leave of Absence:

As used herein, refers to an approved absence other than a medical leave of absence, which has been granted and approved by the employer. Total premium dollar must be received each month from the employee, otherwise insurance coverage terminates.

Physical Therapist

An individual licensed to practice physical therapy, or where there is no license involved, an individual certified by an appropriate professional body to practice physical therapy.

Physical Therapy

The treatment by physical means, including hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices, to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of body part.

Physician

A duly licensed Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Surgery, Doctor of Podiatry, or Doctor of Chiropractic..

Policyholder:

An eligible individual who has actually enrolled for coverage and authorized his/her payroll clerk to make proper payroll deductions.

PPO (Preferred Provider Organization):

An arrangement whereby a third party payor contracts with a group of medical care providers who furnish services at lower-than-usual fees in return for prompt payment and a certain volume of patients.

Pre-Admission Certification:

Prior approval of any hospital stay. PEIA requires the insured, dependent, designee or physician to contact the certification program representative for verification of medical necessity and determination of the length of stay for each admission.

Pre-admission certification does not assure payment, eligibility, or type of services covered under this benefit plan.

Pre-Authorization:

Verification from the Claims Administrator in advance that a service is covered by the Plan.

Pre-Certification (also Pre-Approval)

Advance approval by the certification program representative required for specific services covered by the Plan.

Pre-existing Condition:

Any injury, sickness or pregnancy or any condition relating to that injury, sickness, pregnancy, for which a participant receives treatment, incurs expenses or manifests symptoms within three months preceding the effective date of insurance coverage. No payment shall be made for expenses incurred for, or in connection with a pre-existing condition unless expenses are incurred after the expiration of a one year period after the effective date.

Primary Health Care Nursing:

Nursing care rendered by a non-salaried, duly licensed, registered professional nurse engaged in private nursing practice or partnership with other health care providers, acting within the lawful scope of his or her duties, provided such nurse, nurse-midwife or midwife is not related by blood or marriage to the insured, and not regularly residing in the household. "Midwife and nurse-midwife" shall be licensed as defined in the West Virginia Code 30-15-1.

Provider:

A hospital, physician or other provider, licensed where required and performing within the scope of the license.

R

Reasonable and Customary Fees (R & C)

As a basis for paying claims, determination of "reasonable and customary" fees for a particular service, supply or treatment shall be made by PEIA, and shall take into consideration the following factors:

1. The range of usual fees charged by most providers of similar training and experience located in the same geographic area for the same or comparable service, supply or treatment; and

2. Any unusual circumstances regarding the patient's condition which might require additional time, skill or experience on the provider's part to treat successfully; and

3. The rate of inflation using an accepted index.

Rehabilitation Hospital

A Rehabilitation Hospital is a facility which, for compensation, is primarily engaged in providing rehabilitation care services on an inpatient basis, for those disabled by disease or injury to be able to achieve the highest practicable level of functional ability. Such services are provided by, or under the supervision of, an organized staff of physicians with continuous nursing services provided under the supervision of a registered graduate nurse (RN).

S

Single Coverage

Coverage for the eligible employee, retiree, or surviving dependent only.

Special Care Units:

Areas of a hospital that are devoted to the care of specific medical conditions. Such units commonly include Intensive or Critical Care Units, Coronary Care Units, and Burn Units.

Speech Therapist

An individual licensed to practice speech therapy, or where there is no license involved, an individual certified by an appropriate professional body to practice speech therapy.

Speech Therapy

Treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies or previous therapeutic processes.

Subrogation:

The right to 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 the third party is, or may be, legally liable.

Surgery:

The treatment of disease, injury, or deformity by manual or instrumental operations performed by a licensed physician, such as the removal or repair of diseased parts or tissue by cutting. Surgery would include:

a) the performance of generally accepted operative and cutting procedures, including specialized instrumentations, and endoscopic examinations and other invasive procedures and injections into the bone or joint (but excluding injections or drugs, dyes or other substances);

b) the correction of fractures and dislocations;

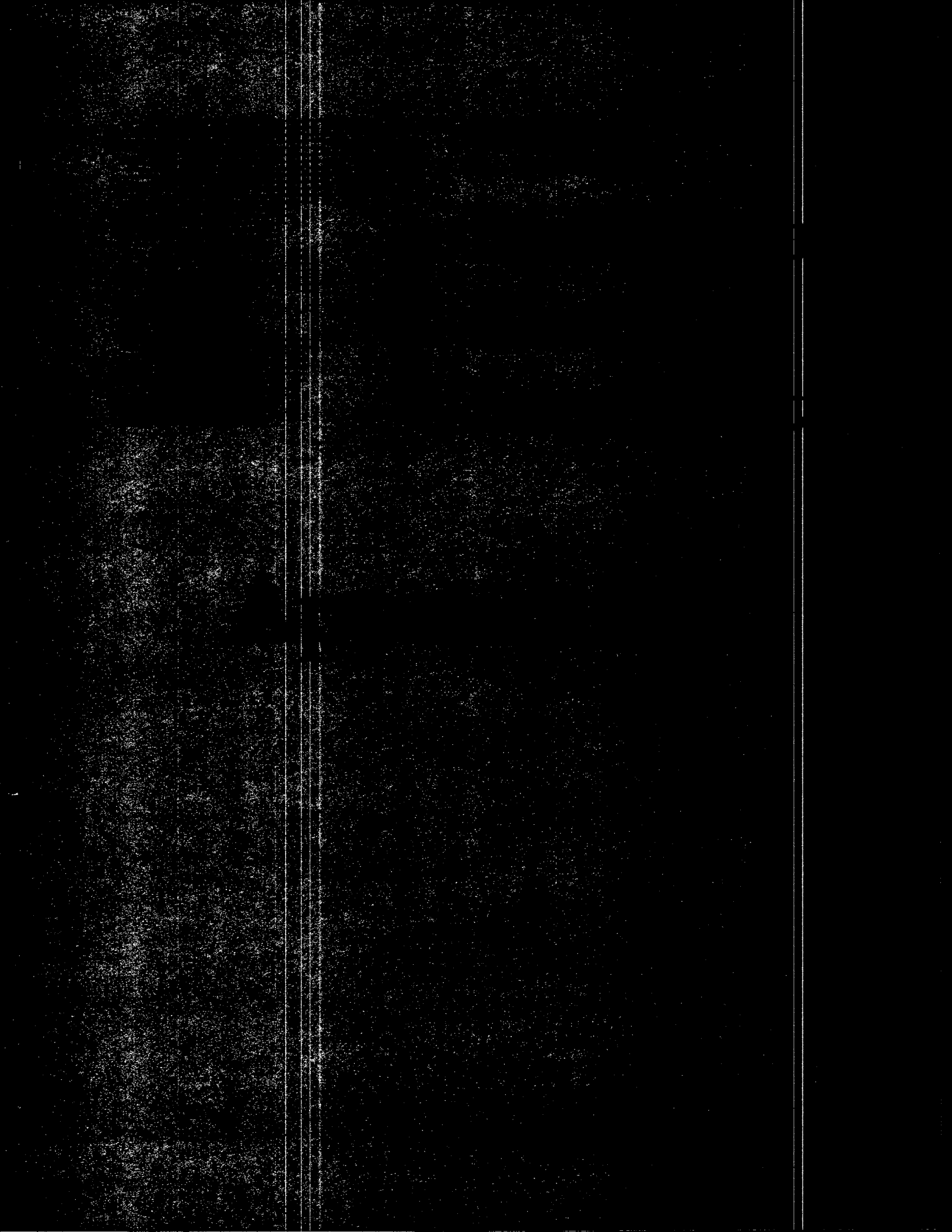
c) usual and related preoperative and postoperative care; and

d) other procedures as reasonably approved by PEIA.

T

Third-Party Claims Administrator:

For the purpose of this Plan Document, a company, corporation or organization contracted by PEIA to evaluate, determine and process all medical claims incurred by eligible insureds of the PEIA according to plan policy provisions and contract agreement.



APPENDIX A

OUTPATIENT SURGICAL AND DIAGNOSTIC PROCEDURES REQUIRING PRIOR APPROVAL

Cardiovascular

Cardiac catherization

Digestive

Branchial arch appendage excision
Colonoscopy without colonic polypectomy
Endoscopy (upper GI) with or without biopsy
Fistulectomy
Hemorrhoidectomy (external - single anatomic group)
Proctosigmoidoscopy
Sigmoidoscopy

Ear, Nose and Throat

Antral puncture
Adenoidectomy
Myringoplasty
Septum reconstruction
Septoplasty
Sinusotomy
Strabismus Surgery
Tonsillectomy

Eye

Canthoplasty
Cataract surgery with or without lens implantation
Iridectomy
Lacrimal duct probing or reconstruction
Pterygium (excision or transportation)

Genital - Female

Culdoscopy
Dilitation and curettage
Laparoscopy

Genital - Female - Obstetrics

Contraction stress test
Non-stress test
External version (with or without Tocolysis)

Miscellaneous

MRI (Magnetic Resonance Imaging procedure)

Musculoskeletal

Arthroplasty - small joint
Arthroscopy, surgical and diagnostic
Bunionectomy
Carpal tunnel release
Chemonuclealysis
Excision of bone cyst
Finger joint replacement - traumatic or arthritic lesion
Hammertoe repair with tenotomies and resection of bone
Osteotomy
Scar revision (accidental injury or disease only)
Superficial peripheral nerve decompression

Nervous

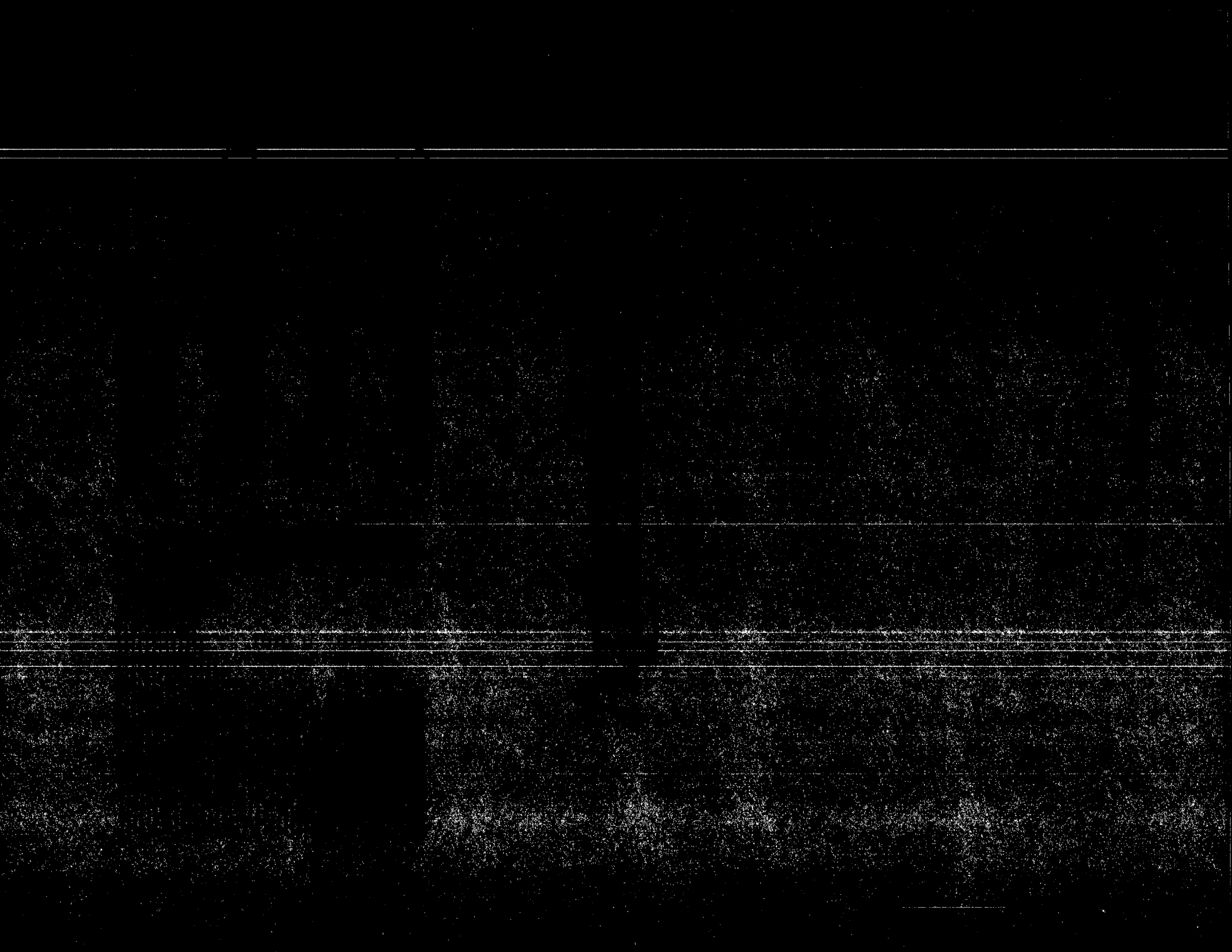
Myelogram

Respiratory

Bronchoscopy
Laryngoscopy

Urinary

Cystoscopy
Lithotripsy



APPENDIX B

Durable Medical Equipment

Item Description

Semi-Electric Bed with
rails and mattress

Alternating pressure pad mattress

Wheel chair with removable
arms and elevating legs

Walker (folding)

Oxygen Concentrator with backup
tank and all software

D-Tank

M-Tank

Liquid Oxygen

Portable Oxygen 240-400 liters

VP5 Port Ventilator

Suction Machine with all software

Accucheck II Kit

Nebulizers:
- Ultrasonic
- Pulmoaide

Apnea Monitor

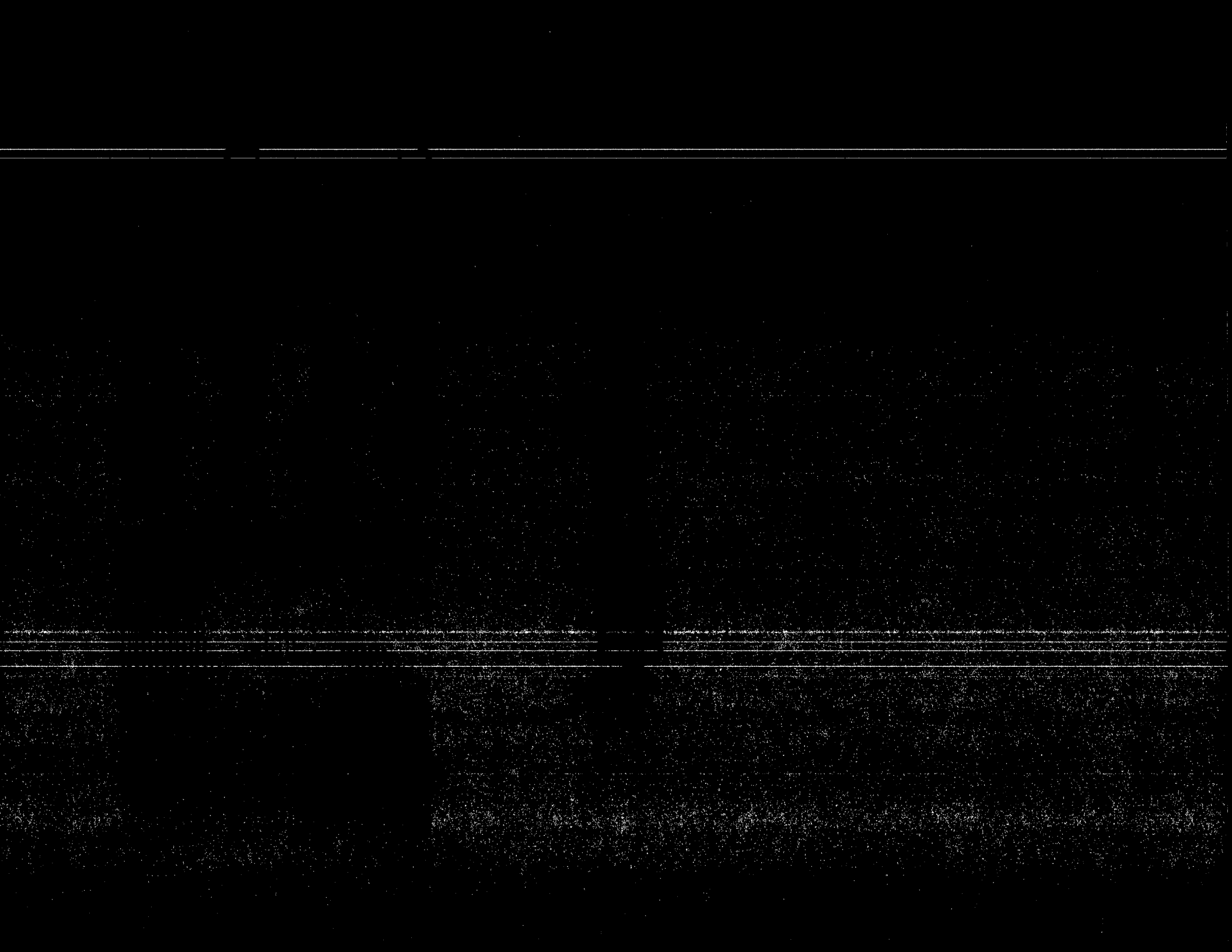
TENS Unit

IV Pole

Enteral Supply Kit

Feeding Kit (bag and tubing)

Food Pump Enteral w/wo Alarm



APPENDIX C
RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC CARE
from the American Academy of Pediatrics Committee on Practice and Ambulatory Care

These **Recommendations for Preventive Pediatric Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

A **prenatal visit** by the parents for anticipatory guidance and pertinent medical history is strongly recommended.

Health supervision should begin with medical care of the newborn in the hospital.

	INFANCY						EARLY CHILDHOOD					LATE CHILDHOOD				
Age[1]	By 1 mo.	2 mos.	4 mos.	6 mos.	9 mos.	12 mos.	15 mos.	18 mos.	24 mos.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	8 yrs.	10 yrs.	12 yrs.
History																
Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Measurements																
Height and weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head circumference	•	•	•	•	•	•										
Blood pressure										•	•	•	•	•	•	•
Sensory Screening																
Vision	S	S	S	S	S	S	S	S	S	S	O	O	O	O	S	O
Hearing	S	S	S	S	S	S	S	S	S	S	O	O	S[2]	S[2]	S[2]	O
Devel./Behav.[3] **Assessment**	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Physical Examination[4]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Procedures[5]																
Hered./metabolic screening[6]	•															
Immunization[7]		•	•	•			•	•	•			•				•
Tuberculin test[8]	—	—	—	—	—	•	—	—	•	—	—					
Hematocrit or hemaglobin[9]	—	—	—	—	•	—	—	—	•	—	—	—	—	•	—	—
Urinalysis[10]	—	—	—	•	—	—	—	—	•	—	—	—	—	•	—	—
Anticipatory Guidance[11]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Initial Dental Referral[12]										•						

Key: • = to be performed; S = subjective, by history; O = objective, by a standard testing method.

FOOTNOTES

These footnotes correspond with the numbers on the chart on the preceding page.

1. If a child comes under care for the first time at any point on the schedule, of if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

2. At these points, history may suffice: if problem suggested, a standard testing method should be used.

3. By history and appropriate physical examination: if suspicious, by specific objective developmental testing.

4. At each visit, a complete physical examination is essential, with infant totally unclothed, older children undressed and suitably draped.

5. These may be modified, depending upon entry point into schedule and individual need.

6. Metabolic screening (e.g. thyroid, PKU, galactosemia) should be done according to state law.

7. Recommended schedule for active immunization of normal infants and children:

Recommended age	Immunizations
2 months	DTP, OPV
4 months	DTP, OPV
6 months	DTP
15 months	MMR
18 months	DTP, OPV, PRP-D
4-6 years	DTP, OPV
12 years	MMR

DPT: Diptheria and tetanus toxoids with pertussis vaccine;
OPV: Oral poliovirus vaccine containing attenuated poliovirus types 1, 2, & 3;
MMR: live measles, mumps and rubella viruses in a combined vaccine;
PRP-D: haemophilus b diptheria toxoid conjugate vaccine.

8. For low risk groups, the Committee on Infectious Diseases recommends the following options: (1) no routine testing or (2) testing at three times -- infancy, preschool and adolescence. For high risk groups, annual TB skin testing is recommended.

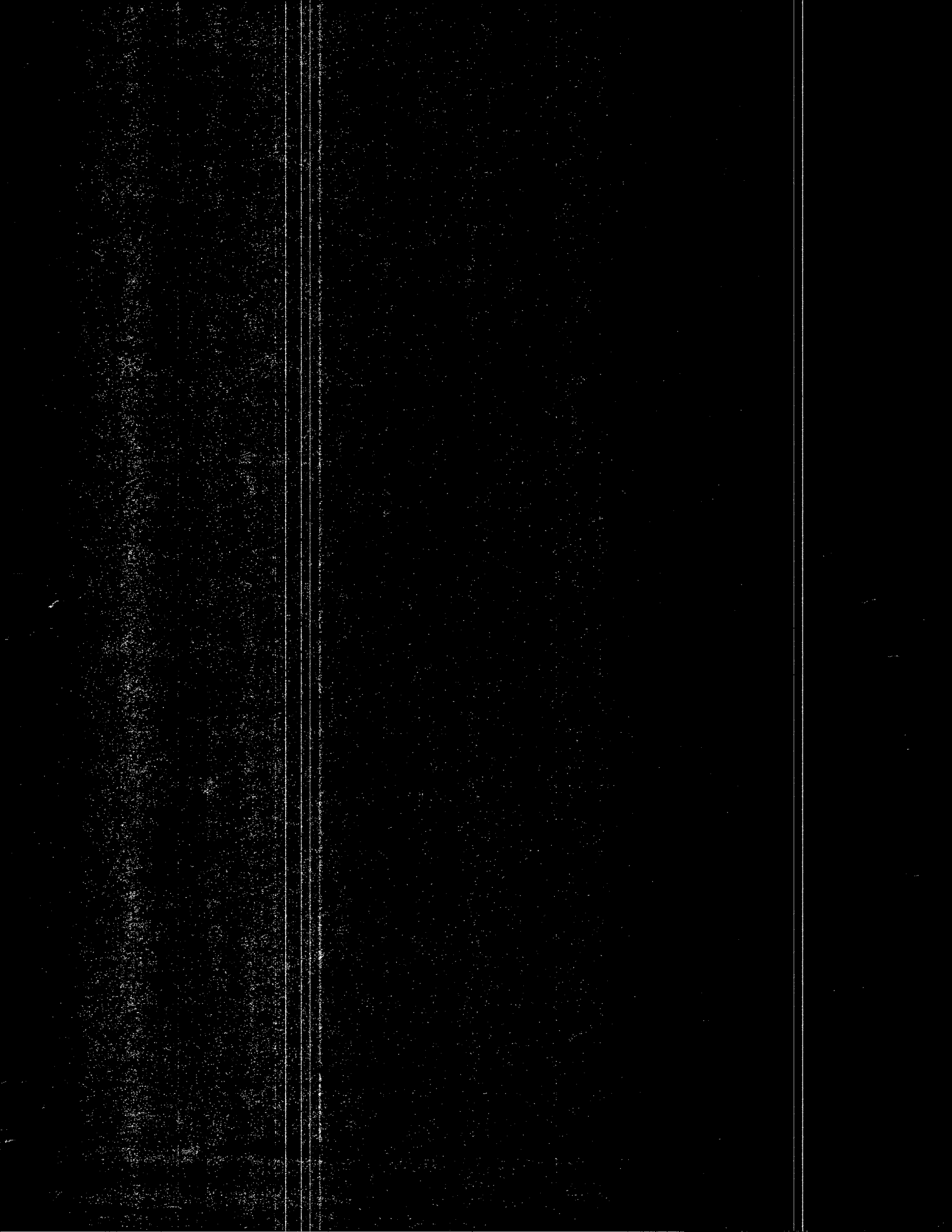
9. Present medical evidence suggests the need for reevaluation of the frequency and timing of hemaglobin or hematocrit tests. One determination is is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.

10. Present medical evidence suggests the need for reevaluation of the frequency and timing of urinalyses. One determination is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.

11. Appropriate discussion and counselling should be and integral part of each visit for care.

12. Subsequent examinations as prescribed by dentist.

N.B.: Special chemical, immunologic and endocrine testing are usually carried out upon specific indications. Testing other than newborn (e.g., inborn errors of metabolism, sickle disease, lead) are discretionary with the physician.



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Building 3, Capitol Complex
Charleston, WV 25305

Gaston Caperton
Governor

February 15, 1991

Honorable Ken Hechler
Secretary of State
State Capitol Building
Charleston, West Virginia 25305

Re: Omnibus Health Care Act - Amendment to Cooperative Plan

Dear Secretary Hechler:

As you will recall, the Department of Health and Human Resources, the Public Employees Insurance Agency and the Division of Rehabilitation Services filed a Cooperative Plan as an official record with your office on September 1, 1989. A copy of the enclosure letter is enclosed for your reference.

Enclosed is an amendment to Attachment B-1 of the Plan. Please file this amendment with the Plan as an official record of the Department of Health and Human Resources, the Public Employees Insurance Agency and the Division of Rehabilitation Services.

If your office desires further information regarding this amendment, please do not hesitate to call.

Very truly yours,

Taunja Willis Miller, Secretary
Department of Health and Human Resources

TWM/jah

Enclosures

cc: The Health Group

AMENDMENT TO ATTACHMENT B-1, PLAN FOR IMPLEMENTATION OF SENATE BILL NUMBER 576

Beginning in January, 1991, the PEIA will make weekly periodic interim payments to any West Virginia hospital which agrees to accept a 10% discount on all claims paid after January 1, 1991, and before July 1, 1991. The amount of the weekly payments will be established by determining an average of actual per week payments made by the PEIA to the hospital during the months of July through November, 1990, and reducing this average amount by 10%. Two reconciliations will occur, one in April and the second, a final reconciliation, in July, 1991. The PEIA will reconcile the total amount of weekly payments made to each hospital with the total amount of claims actually adjudicated for payment during this same period. The PEIA shall reimburse the hospital for any underpayments, or the hospital will reimburse the PEIA for any overpayments.

The principal terms of the hospital discount agreement were established by the PEIA Finance Board, created by the Legislature in August, 1990. The Finance Board authorized such agreements as an alternative to imposing an 18% discount on all services provided by a hospital after December 1, 1990. The 10% and 18% discounts are to be calculated from existing PEIA payment rates for each hospital, which have been frozen at April 1, 1989 levels.

The purpose of the discount agreements is to reduce total PEIA payments to hospitals, as part of the Finance Board's initial financial plan to balance PEIA costs and revenues for fiscal year 1990-91. The weekly payments will enable both the PEIA and participating hospitals to know the amount of weekly payments the agency will make during the contract period.

REVISED JANUARY 31, 1991.

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Building 6, Capitol Complex
Charleston, WV 25305

Gaston Caperton
Governor

September 1, 1989

FILED
1989 FEB 20 AM 8:51

The Honorable Ken Hechler
Secretary of State
State Capitol Building
Charleston, West Virginia 25305

Re: Omnibus Health Care Act - Cooperative Plan

Dear Secretary Hechler:

During the past legislative session, the Legislature adopted the Omnibus Health Care Act which had been codified at West Virginia Code §16-29-D-1 et seq. Subsection 3(c) of the Act requires the departments and divisions subject to the Act to "develop a plan or plans to ensure that a reasonable and appropriate level of health care is provided to the beneficiaries of the various programs including the Public Employees Insurance Agency and the Workers' Compensation Fund, the Division of Rehabilitation Services and, to the extent permissible, the State Medicaid Program. The Legislature made the Act effective from passage. However, various provisions of the Act do not become operational until the departments and divisions of State government adopt a plan or plans of cooperation. The Department of Health and Human Resources, the Divisions of Health, Human Services and Workers' Compensation within the Department, the Public Employees Insurance Agency and the Division of Rehabilitation Services have adopted on this date the attached plan of cooperation. Please file the plan as an official record of the Department of Health and Human Resources, the Public Employees Insurance Agency and the Division of Rehabilitation Services.

If your office desires further information regarding the Cooperative Plan, please do not hesitate to contact me at your convenience.

Very truly yours,

Taunja Willis Miller
Secretary

Attachment

Public Employees Insurance Agency

State Capitol Complex
Building 5, Room 1001
1900 Kanawha Blvd., E.
Charleston, WV
25305-0710
(304) 558-7850
Fax (304) 558-2516

Gaston Caperton
Governor

Sally K. Richardson
Director

May 25, 1993

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Rate Schedules Notebook a complete set of all current premium rate schedules for the PEIA.

Your assistance in filing these schedules is appreciated.

Sincerely,

Sally K. Richardson
Director

SKR:DPL:trs

Enclosures

cc: David P. Lambert
Dale Elswick

Public Employees Insurance Agency

State Capitol Complex
Building 5, Room 1001
1900 Kanawha Blvd., E.
Charleston, WV
25305-0710
(304) 558-7850
Fax (304) 558-2516

Gaston Caperton
Governor

Sally K. Richardson
Director

MEMORANDUM

TO: Insurance Coordinators/Payroll Clerks of County Commissions, Cities and Towns, and other Political Subdivisions

FROM: Sally K. Richardson SKR
Director

SUBJECT: Premium Rate Schedule for Active Employees/COBRA Insureds

DATE: December 22, 1992

==========

Enclosed is the premium rate schedule for active employees/COBRA insureds of local government employers to be effective February 1, 1993. This reflects a five percent reduction of premium in PEIA's health insurance. The life insurance premium remains the same.

Please note adjustments to the premium rates and make the proper payroll deductions for the February 1993 remittance.

Also, please note that the rates for health insurance for retired employees, whose premiums are being paid by accrued sick or annual leave, have not changed.

Thank you for your cooperation. If you have any questions, please contact the Premium Accounts Section at 558-7850.

Enclosure

SKR/DE/de
C:\NSRS93

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC INSURANCE RATE SCHEDULE FOR ACTIVE EMPLOYEES OF COUNTY COMMISSIONS, MUNICIPALITIES AND OTHER POLITICAL SUBDIVISIONS

EFFECTIVE DATE OF RATE SCHEDULE: 02/01/93	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	TOTAL PREMIUM
EMPLOYEE UNDER AGE 65: AMOUNT OF LIFE INSURANCE $10,000.00	ASN	SINGLE COVERAGE	$185.00
	AFN	FAMILY COVERAGE	$391.00
	LA	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL COVERAGE	$ 4.34
	LAD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 4.34
	MS	LIFE INSURANCE ONLY - HMO EMPLOYEE ONLY	$ 4.34
	MS C	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH CHILD(REN) ONLY	$ 4.34
	MF	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH SPOUSE AND CHILD(REN)	$ 4.34
	MF Y	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH SPOUSE	$ 4.34
EMPLOYEES AGES 65 THRU 69: AMOUNT OF LIFE INSURANCE $6,500.00	BSN	SINGLE COVERAGE	$184.00
	BFN	FAMILY COVERAGE	$390.00
	LB	LIFE INSURANCE ONLY - MUST BE COVERED AS A DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.82
	LBD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.82
	MA	LIFE INSURANCE ONLY - HMO EMPLOYEE ONLY	$ 2.82
	MA C	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH CHILD(REN) ONLY	$ 2.82
	MB	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH SPOUSE AND CHILD(REN)	$ 2.82
	MB Y	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH SPOUSE	$ 2.82

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC INSURANCE RATE SCHEDULE FOR ACTIVE EMPLOYEES OF COUNTY COMMISSIONS, MUNICIPALITIES AND OTHER POLITICAL SUBDIVISIONS

EFFECTIVE DATE OF RATE SCHEDULE: 02/01/93	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	TOTAL PREMIUM
EMPLOYEES AGES 70 AND OLDER: AMOUNT OF LIFE INSURANCE $5,000.00	CSN	SINGLE COVERAGE	$183.00
	CFN	FAMILY COVERAGE	$389.00
	LD	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.17
	LDD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.17
	MC	LIFE INSURANCE ONLY - HMO EMPLOYEE ONLY	$ 2.17
	MC C	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH CHILD(REN) ONLY	$ 2.17
	MD	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH SPOUSE AND CHILD(REN)	$ 2.17
	MD Y	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH SPOUSE	$ 2.17
COBRA	NES	COBRA EMPLOYEE - SINGLE COVERAGE	$189.00
	NEF	COBRA EMPLOYEE - FAMILY COVERAGE	$399.00
	NDS	COBRA DEPENDENT - SINGLE COVERAGE	$189.00
	NDF	COBRA DEPENDENT - FAMILY COVERAGE	$399.00
	NSD	COBRA EMPLOYEE - SINGLE DISABLED	$278.00
	NFD	COBRA EMPLOYEE - FAMILY DISABLED	$587.00
	NMO	COBRA - HEALTH MAINTENANCE ORGANIZATION	$000.00

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
RATE SCHEDULE FOR RETIREES/SURVIVING DEPENDENTS
NON-PARTICIPATING EMPLOYERS

Effective Date of
Rate Schedule: July 1, 1993

COVERAGE CODE	EXPLANATION OF COVERAGE CODE	PREMIUM
Under Age 65:		
NP A	Single Coverage	$ 168.00
NP B	Family Coverage with Dependent(s) Under Age 65	$ 428.00
NP C	Family Coverage with Dependent(s) Age 65 or Over, or on Medicare	$ 311.00
Age 65 or Over (or on Medicare):		
NP D	Single Coverage	$ 95.00
NP E	Family Coverage with Dependent(s) Age 65 or Over, or on Medicare	$ 204.00
NP F	Family Coverage with Dependent(s) Under Age 65	$ 298.00

C:\EPPREMS3

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/01	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
RETIREE UNDER AGE 65; AMOUNT OF LIFE INSURANCE $5,000.00	QSFN	SINGLE COVERAGE	$119.00
	QSAM1	SINGLE COVERAGE WITH MEDICARE	$ 42.00
	QSBFN*	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$117.00
	QSCM1*	SINGLE COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM	$ 40.00
	QFFN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$238.00
*AMOUNT OF LIFE INSURANCE $10,000.00	QFAM1	FAMILY COVERAGE WITH MEDICARE AND DEPENDENT(S) UNDER AGE 65	$164.00
	QFBFN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$236.00
	QFCM1*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
* GWM1	GWFN	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$151.00
	GWAM1	FAMILY COVERAGE WITH MEDICARE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 69.00
* GWBM1	GWBFN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$149.00
	GWCM1*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 67.00
	LQ	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LQB*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LQD	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$ 2.00
* Eff 1-1-92	LQE*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
RETIREE AGE 65 - 69 AMOUNT OF LIFE INSURANCE $5,000.00	HSM1	SINGLE COVERAGE	$ 42.00
	HSBM1	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 40.00
	HFM1	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 69.00
	HFBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUMS AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 67.00
HWM1	HFFN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$164.00
HWBM1	HFBFN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	LH	LIFE INSURANCE ONLY - MUST BE COVERED AS A DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LHB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LHD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LHE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
RETIREE AGE 67 OR OVER AMOUNT OF LIFE INSURANCE $2,500.00	ISM1	SINGLE COVERAGE	$ 41.00
	ISBM1	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 40.00
	IFM1	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 88.00
	IFBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 87.00
IWM1	IWPN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$182.00
IWBM1	IWBPN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$182.00
	LI	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 1.00
	LIB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LID	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 1.00
	LIE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
RETIREE ANY AGE HEALTH INSURANCE ONLY	SSPN	SINGLE COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$117.00
	SSAM1	SINGLE COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 40.00
	SFPN	FAMILY COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$238.00
	SFAM1	FAMILY COVERAGE - RETIREE MEDICARE AND DEPENDENT NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$182.00
	SWPN	FAMILY COVERAGE - RETIREE NON-MEDICARE AND DEPENDENT MEDICARE - NO LIFE INSURANCE BENEFITS	$148.00
	SWAM1	FAMILY COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 87.00
BASIC PLAN SURVIVING DEPENDENT RATE SCHEDULE	WS	SURVIVING SPOUSE UNDER AGE 65	$117.00
	WOM1	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$182.00
	WWM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$ 40.00
	WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$238.00
	WXM1	SURVIVING SPOUSE OVER AGE 65	$ 40.00
	WWM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$182.00
	YS	SURVIVING CHILD W/NO PARENTS	$117.00
	YF	SURVIVING CHILDREN W/NO PARENTS	$238.00

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
CATASTROPHIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTRO-PHIC PLAN
RETIREE UNDER AGE 65; AMOUNT OF LIFE INSURANCE $5,000.00	QSCN	SINGLE COVERAGE	$ 91.00
	QSAM2	SINGLE COVERAGE WITH MEDICARE	$ 30.00
	QSBCN*	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 89.00
	QSCM2*	SINGLE COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM	$ 28.00
	QFCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$176.00
*AMOUNT OF LIFE INSURANCE $10,000.00	QFAM2	FAMILY COVERAGE WITH MEDICARE AND DEPENDENT(S) UNDER AGE 65	$149.00
	QFBCN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$174.00
	QFCM2*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
* GWM2	~~QWCN~~	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$111.00
	QWAM2	FAMILY COVERAGE WITH MEDICARE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 49.00
* GWBM2	~~QWBCN~~*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$109.00
	QWCM2*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 47.00
	LQ	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNVER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LQB*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LQD	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$ 2.00
* Eff 1-192	LQE*	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
RETIREE AGE 65 - 66 AMOUNT OF LIFE INSURANCE $5,000.00	HSM2	SINGLE COVERAGE	$ 30.00
	HSBM2	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 28.00
	HFM2	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 49.00
	HFBM2	FAMILY COVERAGE WITH WAIVER OF PREMIUMS AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 47.00
	HWCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$149.00
	HWBCN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	LH	LIFE INSURANCE ONLY - MUST BE COVERED AS A DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LHB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LHD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LHE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
CATASTROPHIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTRO-PHIC PLAN
RETIREE AGE 67 OR OVER AMOUNT OF LIFE INSURANCE $2,500.00	ISM2	SINGLE COVERAGE	$ 29.00
	ISBM2	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 28.00
	IFM2	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 48.00
	IFBM2	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 47.00
	IWCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$148.00
	IWBCN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	LI	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 1.00
	LIB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LID	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 1.00
	LIE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
RETIREE ANY AGE HEALTH INSURANCE ONLY	ZSCN	SINGLE COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$ 89.00
	ZSAM2	SINGLE COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 28.00
	ZFCN	FAMILY COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$174.00
	ZFAM2	FAMILY COVERAGE - RETIREE MEDICARE AND DEPENDENT NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$147.00
	ZWCN	FAMILY COVERAGE - RETIREE NON-MEDICARE AND DEPENDENT MEDICARE - NO LIFE INSURANCE BENEFITS	$109.00
	ZWAM2	FAMILY COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 47.00
CATASTROPHIC SURVIVING DEPENDENT RATE SCHEDULE	WS	SURVIVING SPOUSE UNDER AGE 65	$117.00
	WOM2	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$147.00
	WWM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$ 28.00
	WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$236.00
	WXM2	SURVIVING SPOUSE OVER AGE 65	$ 28.00
	WMM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$147.00
	YS	SURVIVING CHILD W/NO PARENTS	$117.00
	YF	SURVIVING CHILDREN W/NO PARENTS	$236.00

West Virginia Public Employees Insurance Agency
Optional Life and Accidental Death & Dismemberment
(NO AD & D FOR RETIREES)
Rate Schedule

AGE	PLAN I	PLAN II	PLAN III	PLAN IV	PLAN V	PLAN VI
Under 65	$5,000.00	$10,000.00	$20,000.00	$30,000.00	$40,000.00	$50,000.00
65 - 69	$3,250.00	$ 6,500.00	$13,000.00	$19,500.00	$26,000.00	$32,500.00
70 & Over	$2,250.00	$ 4,500.00	$ 9,000.00	$13,500.00	$18,000.00	$22,500.00

SCHEDULE OF MONTHLY PREMIUM RATES FOR ACTIVE EMPLOYEES

Under 30	A1	$0.44	A2	$ 0.86	A3	$ 1.70	A4	$ 2.56	A5	$ 3.40	A6	$ 4.26
30 - 34	B1	$0.48	B2	$ 0.94	B3	$ 1.88	B4	$ 2.82	B5	$ 3.76	B6	$ 4.70
35 - 39	C1	$0.58	C2	$ 1.14	C3	$ 2.26	C4	$ 3.40	C5	$ 4.52	C6	$ 5.66
40 - 44	D1	$0.90	D2	$ 1.80	D3	$ 3.58	D4	$ 5.38	D5	$ 7.16	D6	$ 8.96
45 - 49	E1	$1.16	E2	$ 2.32	E3	$ 4.62	E4	$ 6.94	E5	$ 9.24	E6	$11.56
50 - 54	F1	$1.74	F2	$ 3.46	F3	$ 6.92	F4	$10.38	F5	$13.84	F6	$17.30
55 - 59	G1	$2.82	G2	$ 5.62	G3	$11.22	G4	$16.84	G5	$22.44	G6	$28.06
60 - 64	H1	$3.98	H2	$ 7.94	H3	$15.88	H4	$23.82	H5	$31.76	H6	$39.70
65 - 69	I1	$4.06	I2	$ 8.12	I3	$16.24	I4	$24.36	I5	$32.47	I6	$40.60
70 & Over	J1	$8.28	J2	$16.56	J3	$33.12	J4	$49.68	J5	$66.24	J6	$82.80

SCHEDULE OF MONTHLY PREMIUM RATES FOR RETIREES

Under 30	K1	$ .35	K2	$ .70	K3	$ 1.40	K4	$ 2.10	K5	$ 2.80	K6	$ 3.50
30 - 34	L1	$ .41	L2	$ .82	L3	$ 1.64	L4	$ 2.46	L5	$ 3.28	L6	$ 4.10
35 - 39	M1	$ .53	M2	$ 1.05	M3	$ 2.10	M4	$ 3.15	M5	$ 4.20	M6	$ 5.25
40 - 44	N1	$ .92	N2	$ 1.83	N3	$ 3.66	N4	$ 5.49	N5	$ 7.32	N6	$ 9.15
45 - 49	O1	$1.27	O2	$ 2.53	O3	$ 5.06	O4	$ 7.59	O5	$10.12	O6	$12.65
50 - 54	P1	$1.99	P2	$ 3.98	P3	$ 7.96	P4	$11.94	P5	$15.92	P6	$19.90
55 - 59	Q1	$3.34	Q2	$ 6.67	Q3	$13.34	Q4	$20.01	Q5	$26.68	Q6	$33.35
60 - 64	R1	$4.80	R2	$ 9.59	R3	$19.18	R4	$28.77	R5	$38.36	R6	$47.95
65 - 69	S1	$4.98	S2	$ 9.96	S3	$19.93	S4	$29.89	S5	$39.86	S6	$49.82
70 & Over	T1	$10.29	T2	$20.58	T3	$41.17	T4	$61.75	T5	$82.33	T6	$102.92

COMBINED DEPENDENT COVERAGE:

SPOUSE	EACH CHILD
$5,000.00	$2,000.00

$1.82

EFFECTIVE DATE OF REVISED RATE SCHEDULE: SEPTEMBER 1, 1990

A:\RATESOPT/th

Public Employees Insurance Agency

Gaston Caperton
Governor

Sally K. Richardson
Director

MEMORANDUM

TO: Finance Directors/Benefit Coordinators/Payroll Clerks of County Commissions, Cities and Towns, and Other Political Subdivisions

FROM: Sally K. Richardson SKR
Director

DATE: March 24, 1992

RE: Premium Rates For FY-93

To assist your agency in planning its budget for next year, I am writing to provide preliminary information about premium rates for Fiscal Year 1993.

The PEIA Finance Board had just received a very favorable claims experience report from its actuary. Based upon this report, the Finance Board believes it will not be necessary to increase non-State agency premium rates from FY-92 levels. The PEIA will forward the exact rate schedules to you as soon as they are developed.

You should also be made aware that the Legislature has enacted legislation which requires non-State agencies to contribute toward the cost of their retired employees who participate in the PEIA the same amount that State agencies contribute for their retired employees. Specifically, Senate Bill 536 added a new paragraph to W. Va. Code §5-16-22, which reads:

> Any employer, whether such employer participates in the public employees insurance agency insurance program as a group or not, which has retired employees, their dependents or surviving dependents of deceased retired employees who participate in the public employees insurance agency insurance program as authorized by this article, shall pay to the agency the same contribution toward the cost of coverage for its retired employees, their dependents or surviving dependents of deceased retired employees as the state of West Virginia, its boards, agencies, commissions, departments, institutions, spending units, or a county board of education pay for their retired employees, their dependents, and surviving dependents of deceased retired employees, as determined by the finance board. Each employer is hereby authorized and required to budget for and make such payments.

The Finance Board has not yet worked out the mechanics of how this contribution will be assessed. However, because of the PEIA's favorable claims experience, this assessment will not result in higher active premium rates for non-State agencies for Fiscal Year 1993. Depending upon whether the retiree contributions are pooled and assessed with active employee rates, or charged separately based upon the actual number of retirees participating by employer, an individual agency's total PEIA cost may or may not increase.

If you have any questions, please contact the Premium Accounts Section at 348-7850.

SKR:DPL:trs

Public Employees Insurance Agency

Intraoffice Memorandum

TO: All PEIA Staff

FROM: Dale Elswick DE

DATE: October 22, 1992

SUBJECT: Premium Rate Schedule for Retirees, State Agencies, Colleges and Universities, and County Boards of Education

Enclosed is a retyped copy of the PEIA rate schedule which became effective July 1, 1991.

It incorporates recent changes to certain Plan codes (e.g., PN to M1, CN to M2, etc.), but mostly it is being provided because the premium amounts on the original copy were difficult to read.

It is not being distributed outside the PEIA but will be used when replacement or additional copies are requested.

DE/bc
C:\WPDATA\PEIARATE.MEM

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC INSURANCE RATE SHCEDULE FOR ACITVE EMPLOYEES OF
STATE AGENCIES, COLLEGES AND UNIVERSITIES, AND
COUNTY BOARDS OF EDUCATION

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	AGENCY PREMIUM
EMPLOYEES AGES 65 THRU 69: AMOUNT OF LIFE INSURANCE $6,500.00	BS	EMPLOYEE ONLY	$176.00
	BSC	EMPLOYEE WITH CHILD(REN) ONLY	$278.00
	BF	EMPLOYEE WITH SPOUSE, AND CHILD(REN)	$380.00
	BFP	EMPLOYEE WITH EMPLOYEE SPOUSE, WITH CHILD(REN)	$380.00
	BFX	EMPLOYEE WITH EMPLOYEE SPOUSE, NO CHILD(REN)	$338.00
	BFY	EMPLOYEE WITH SPOUSE, NO CHILD(REN)	$338.00
	LB	LIFE INSURANCE ONLY - EMPLOYEE COVERED AS DEPENDENT UNDER SPOUSE'S BFX/BFP COVERAGE FOR MEDICAL BENEFITS	$ 2.82
	LBD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.82
	MA	LIFE INSURANCE ONLY - HMO EMPLOYEE ONLY	$ 2.82
	MA C	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH CHILD(REN) ONLY	$ 2.82
	MB	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH SPOUSE AND CHILD(REN)	$ 2.82
	MB Y	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH SPOUSE	$ 2.82

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC INSURANCE RATE SCHEDULE FOR ACTIVE EMPLOYEES OF
STATE AGENCIES, COLLEGES AND UNIVERSITIES, AND
COUNTY BOARDS OF EDUCATIONS

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	AGENCY PREMIUM
EMPLOYEES AGE 70 AND OLDER: AMOUNT OF LIFE INSURANCE $5,000.00	CS	EMPLOYEE ONLY	$175.00
	CSC	EMPLOYEE WITH CHILD(REN) ONLY	$277.00
	CF	EMPLOYEE WITH SPOUSE, AND CHILD(REN)	$379.00
	CFP	EMPLOYEE WITH EMPLOYEE SPOUSE, WITH CHILD(REN)	$379.00
	CFX	EMPLOYEE WITH EMPLOYEE SPOUSE, NO CHILD(REN)	$337.00
	CFY	EMPLOYEE WITH SPOUSE, NO CHILD(REN)	$337.00
	LD	LIFE INSURANCE ONLY - EMPLOYEE COVERED AS DEPENDENT UNDER SPOUSE'S CFX/CFP COVERAGE FOR MEDICAL BENEFITS	$ 2.17
	LDD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.17
	MC	LIFE INSURANCE ONLY - HMO EMPLOYEE ONLY	$ 2.17
	MC C	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH CHILD(REN) ONLY	$ 2.17
	MD	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH SPOUSE AND CHILD(REN)	$ 2.17
	MD Y	LIFE INSURANCE ONLY - HMO EMPLOYEE WITH SPOUSE	$ 2.17
	COD	HEALTH INSURANCE ONLY	-0-

WEST VIRGINIS PUBLIC EMPLOYEE INSURANCE AGENCY
RATE SCHEDULE FOR COBRA

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	MONTHLY PREMIUM
COBRA RATE SCHEDULE	CES	COBRA EMPLOYEE - SINGLE COVERAGE	$176.00
	CEC	COBRA EMPLOYEE - WITH CHILD(REN) ONLY	$300.00
	CEF	COBRA EMPLOYEE - FAMILY COVERAGE	$424.00
	CDS	COBRA DEPENDENT - SINGLE COVERAGE	$176.00
	CDC	COBRA DEPENDENT - WITH CHILD(REN) ONLY	$300.00
	CDF	COBRA DEPENDENT - FAMILY COVERAGE	$424.00
	CSD	COBRA EMPLOYEE - SINGLE DISABLED	$259.00
	CED	COBRA EMPLOYEE - DISABLED - WITH CHILD(REN) ONLY	$432.00
	CFD	COBRA EMPLOYEE - FAMILY DISABLED	$605.00
	CEY	COBRA EMPLOYEE - WITH SPOUSE, NO CHILD(REN)	$376.00
	CWY	COBRA DEPENDENT - WITH SPOUSE, NO CHILD(REN)	$376.00
	CDY	COBRA EMPLOYEE - DISABLED WITH SPOUSE - NO CHILD(REN)	$537.00

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
RETIREE UNDER AGE 65: AMOUNT OF LIFE INSURANCE $5,000.00	GSPN	SINGLE COVERAGE	$119.00
	GSAM1	SINGLE COVERAGE WITH MEDICARE	$ 42.00
	GSBPN*	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$117.00
	GSCM1*	SINGLE COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM	$ 40.00
	GFPN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$238.00
	GFAM1	FAMILY COVERAGE WITH MEDICARE AND DEPENDENT(S) UNDER AGE 65	$164.00
* AMOUNT OF LIFE INSURANCE $10,000.00	GFBPN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$236.00
	GFCM1*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	**GWM1	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$151.00
	GWAM1	FAMILY COVERAGE WITH MEDICARE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 69.00
	**GWBM1*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$149.00
	GWCM1*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 67.00
	LG	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LGB *	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LGD	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LGE *	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
**Effective 1-1-92			

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
RETIREE AGE 65 - 66 AMOUNT OF LIFE INSURANCE $5,000.00	HSM1	SINGLE COVERAGE	$ 42.00
	HSBM1	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 40.00
	HFM1	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 69.00
	HFBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUMS AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 67.00
	**HWM1	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$164.00
	**HWBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	LH	LIFE INSURANCE ONLY - MUST BE COVERED AS A DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LHB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
**Effective 1-1-92	LHD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LHE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
RETIREE AGE 67 OR OVER AMOUNT OF LIFE INSURANCE $2,500.00	ISM1	SINGLE COVERAGE	$ 41.00
	ISBM1	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 40.00
	IFM1	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 68.00
	IFBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 67.00
	**IWM1	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$163.00
	**IWBM1	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$162.00
	LI	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 1.00
	LIB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
**Effective 1-1-92	LID	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 1.00
	LIE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
BASIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	BASIC PLAN
RETIREE ANY AGE HEALTH INSURANCE ONLY	ZSPN	SINGLE COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$117.00
	ZSAM1	SINGLE COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 40.00
	ZFPN	FAMILY COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$236.00
	ZFAM1	FAMILY COVERAGE - RETIREE MEDICARE AND DEPENDENT NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$162.00
	ZWPN	FAMILY COVERAGE - RETIREE NON-MEDICARE AND DEPENDENT MEDICARE - NO LIFE INSURANCE BENEFITS	$149.00
	ZWAM1	FAMILY COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 67.00
BASIC PLAN SURVIVING DEPENDENT RATE SCHEDULE	WS	SURVIVING SPOUSE UNDER AGE 65	$117.00
	WOM1	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$162.00
	WWM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$ 40.00
	WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$236.00
	WXM1	SURVIVING SPOUSE OVER AGE 65	$ 40.00
	WMM1	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$162.00
	YS	SURVIVING CHILD W/NO PARENTS	$117.00
	YF	SURVIVING CHILDREN W/NO PARENTS	$236.00

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
CATASTROPHIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTROPHIC PLAN
RETIREE UNDER AGE 65: AMOUNT OF LIFE INSURANCE $5,000.00	GSCN	SINGLE COVERAGE	$ 91.00
	GSAM2	SINGLE COVERAGE WITH MEDICARE	$ 30.00
	GSBCN*	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 89.00
	GSCM2*	SINGLE COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM	$ 28.00
	GFCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$176.00
	GFAM2	FAMILY COVERAGE WITH MEDICARE AND DEPENDENT(S) UNDER AGE 65	$149.00
* AMOUNT OF LIFE INSURANCE $10,000.00	GFBCN*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$174.00
	GFCM2*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	**GWM2	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$111.00
	GWAM2	FAMILY COVERAGE WITH MEDICARE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 49.00
	**GWBM2*	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$109.00
	GWCM2*	FAMILY COVERAGE WITH MEDICARE AND WAIVER OF PREMIUM AND DEPENDENT(S) AGE 65 OR OVER,OR ON MEDICARE	$ 47.00
	LG	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LGB *	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LGD	LIFE INSURANCE COVERAGE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LGE *	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-
**EFFECTIVE 1-1-92			

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
CATASTROPHIC PLAN RATE SHCEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTRO-PHIC PLAN
RETIREE AGE 65 - 66 AMOUNT OF LIFE INSURANCE $5,000.00	HSM2	SINGLE COVERAGE	$ 30.00
	HSBM2	SINGLE COVERAGE WITH WAIVER OF PREMIUM	$ 28.00
	HFM2	FAMILY COVERAGE WITH DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 49.00
	HFBM2	FAMILY COVERAGE WITH WAIVER OF PREMIUMS AND DEPENDENT(S) AGE 65 OR OVER, OR ON MEDICARE	$ 47.00
	HWCN	FAMILY COVERAGE WITH DEPENDENT(S) UNDER AGE 65	$149.00
	HWBCN	FAMILY COVERAGE WITH WAIVER OF PREMIUM AND DEPENDENT(S) UNDER AGE 65	$147.00
	LH	LIFE INSURANCE ONLY - MUST BE COVERED AS A DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	$ 2.00
	LHB	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - MUST BE COVERED UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	-0-
	LHD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	$ 2.00
	LHE	LIFE INSURANCE ONLY - WAIVER OF PREMIUM - NO MEDICAL BENEFITS	-0-

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
CATASTROPHIC PLAN RATE SCHEDULE FOR RETIREES

EFFECTIVE DATE OF RATE SCHEDULE: 07/01/91	COVERAGE CODE	EXPLANATION OF COVERAGE CODE	CATASTROPHIC PLAN
RETIREE ANY AGE HEALTH INSURANCE ONLY	ZSCN	SINGLE COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$ 89.00
	ZSAM2	SINGLE COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 28.00
	ZFCN	FAMILY COVERAGE - NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$174.00
	ZFAM2	FAMILY COVERAGE - RETIREE MEDICARE AND DEPENDENT NON-MEDICARE - NO LIFE INSURANCE BENEFITS	$147.00
	ZWCN	FAMILY COVERAGE - RETIREE NON-MEDICARE AND DEPENDENT MEDICARE - NO LIFE INSURANCE BENEFITS	$109.00
	ZWAM2	FAMILY COVERAGE - MEDICARE - NO LIFE INSURANCE BENEFITS	$ 47.00
CATASTROPHIC SURVIVING DEPENDENT RATE SCHEDULE	WS	SURVIVING SPOUSE UNDER AGE 65	$117.00
	WOM2	SURVIVING SPOUSE OVER AGE 65 WITH DEPENDENT CHILD(REN)	$147.00
	WWM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE	$ 28.00
	WF	SURVIVING SPOUSE UNDER AGE 65 WITH DEPENDENT CHILD(REN)	$236.00
	WXM2	SURVIVING SPOUSE OVER AGE 65	$ 28.00
	WMM2	SURVIVING SPOUSE UNDER AGE 65 ON MEDICARE WITH DEPENDENT CHILD(REN)	$147.00
	YS	SURVIVING CHILD W/NO PARENTS	$117.00
	YF	SURVIVING CHILDREN W/NO PARENTS	$236.00

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850
FAX 304-348-2516

Gaston Caperton
Governor

Sally K. Richardson
Director

April 26, 1991

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Rate Schedule notebook a copy of the following document:

1. Memorandum to Presiding Official of County Commissions, Municipalities and Political Subdivisions, from Sally K. Richardson, dated April 18, 1991, entitled "Premium Rate Increase For FY 92."

This memorandum notifies non-State agencies of premium rate increases to become effective July 1, 1991.

As always, your cooperation and assistance are appreciated.

Sincerely,

Sally K. Richardson
Director

SKR:trs

Enclosure

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850
FAX 304-348-2516

Gaston Caperton
Governor

Sally K. Richardson
Director

MEMORANDUM

TO: Presiding Official
County Commissions, Municipalities and Political Subdivisions

FROM: Sally K. Richardson SKR (by mks)
Director

SUBJECT: Premium Rate Increase for FY-92

DATE: April 18, 1991

This memorandum is to serve as official notice that the PEIA Finance Board has approved a premium health insurance rate increase of 16.6 percent effective July 1, 1991. We regret having to increase rates, but this increase is necessary to fund the projected claims liability during the coming year for the insureds of your group.

The 16.6 percent figure includes two calculations: 14.6 percent reflects the actuary's projection of the non-State agencies' actual claims experience; the remaining 2 percent represents the projected costs of future incurred but not reported claims.

When the Finance Board developed its initial financial plan, implemented on January 1 of this year, it realized that non-State agency premiums should be increased to actual claims experience. However, recognizing the budgetary problems another premium increase in the current fiscal year would cause, the Finance Board delayed this 16.6 percent increase until July 1, 1991.

The premium rate amounts are as follows:

ACTIVE EMPLOYEES

Category	Coverage Code	Description	Amount
Employees Under Age 65--Amount of Life Insurance: $10,000	ASN	Single Coverage	$195.00
	AFN	Family Coverage	411.00
Employees Ages 65 through 69--Amount of Life Insurance: $ 6,500	BSN	Single Coverage	$194.00
	BFN	Family Coverage	410.00
Employees Age 70 and older--Amount of Life Insurance: $5,000	CSN	Single Coverage	$193.00
	CFN	Family Coverage	409.00

COBRA RATE SCHEDULE

Coverage Code	Explanation of Coverage Code	COBRA Premium
NES	COBRA Employee - Single Coverage	$195.00
NEF	COBRA Employee - Family Coverage	415.00
NDS	COBRA Dependent - Single Coverage	195.00
NDF	COBRA Dependent - Family Coverage	415.00
NSD	COBRA Employee - Single Disabled	289.00
NFD	COBRA Employee - Family Disabled	614.00
NMO	COBRA - Health Maintenance Organization	0.00

Please ensure that all COBRA insureds of your agency are informed of this increase and its effective date.

Please note the increase in the premium rate and adjust your payroll deductions accordingly for the July 1991 remittance.

Thank you for your cooperation. If you have any questions, please contact my office.

SKR/DE/de
E:\NSRI92

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850
FAX: 304-348-2516

Gaston Caperton
Governor

Sally K. Richardson
Director

September 5, 1991

The Honorable Ken Hechler
Secretary of State
State Capitol Building, Suite 157-K
Charleston, West Virginia 25305

Dear Secretary Hechler:

Enclosed please find for filing in the Public Employees Insurance Agency Rate Schedule notebook a copy of a Memorandum to All Insurance Coordinators from Sally K. Richardson, dated August 22, 1991, entitled "Premium Rate Schedule for FY-92." This memorandum notifies coordinators of changes in four enrollment codes.

Your cooperation and assistance in filing this document is, as always, appreciated.

Sincerely,

Sally K. Richardson /by DPL

Sally K. Richardson
Director

SKR:DPL:trs

Enclosure

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston
WV 25305
304-348-7850
FAX 304-348-2516

Gaston Caperton
Governor

Sally K. Richardson
Director

M E M O R A N D U M

TO: All Insurance Coordinators

FROM: Sally K. Richardson SKR
Director

DATE: August 22, 1991

SUBJECT: Premium Rate Schedule for FY-92

Please make the following corrections to the West Virginia Public Employees Insurance Agency Basic Plan Rate Schedule for Retirees for FY-92:

As reads	Change to read
HWPN	HWM1
HWBPN	HWBM1
IWPN	IWM1
IWBPN	IWBM1

Please ensure that the above new codes, if appropriate, are used when enrolling future retirees for coverage with this agency. Current retirees with the old codes are being corrected systematically.

If you have any questions, please call 348-7850.

Thank you for your continued support.

SKR/DE/de
E:\BPCODES

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston,
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

February 6, 1990

The Honorable Ken Hechler
Secretary of State
Building 1, Suite 157-K
Charleston, W. Va. 25305

Re: **Filing of Complete Public Employees Insurance Agency Rate Schedules**

Dear Secretary Hechler:

Last week, the Public Employees Insurance Agency filed with your office a set of our current insurance rate schedules, together with a memorandum notifying non-State agencies of an upcoming rate increase for non-State agencies.

Enclosed please find for filing a complete set of PEIA rate schedules, including a new schedule indicating the premium rate amounts for non-State agencies effective March 1, 1990.

Thank you for your cooperation and assistance with this matter.

Sincerely,

Sally K. Richardson
Director

SKR:DPL:trs

Enclosure

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees
of County Commissions, Municipalities and Other Political Subdivisions

	COVERAGE CODE	EXPLANATION OF COVERAGE CODES	TOTAL PREMIUM
EMPLOYEES UNDER AGE 65 AMOUNT OF LIFE INSURANCE $10,000.00	ASN	SINGLE COVERAGE	105.00
	AFN	FAMILY COVERAGE	242.00
	LA	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	3.38
	LAD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	3.38
	MS	LIFE INSURANCE ONLY - HMO SINGLE	3.38
	MF	LIFE INSURANCE ONLY - HMO FAMILY	3.38
EMPLOYEES AGES 65 THRU 69 AMOUNT OF LIFE INSURANCE $6,500.00	BSN	SINGLE COVERAGE	104.00
	BFN	FAMILY COVERAGE	241.00
	LB	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	2.20
	LBD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	2.20
	MA	LIFE INSURANCE ONLY - HMO SINGLE	2.20
	MB	LIFE INSURANCE ONLY - HMO FAMILY	2.20
EMPLOYEES AGES 70 OR OVER AMOUNT OF LIFE INSURANCE $5,000.00	CSN	SINGLE COVERAGE	103.00
	CFN	FAMILY COVERAGE	240.00
	LD	LIFE INSURANCE ONLY - MUST BE COVERED AS DEPENDENT UNDER SPOUSE'S PEIA COVERAGE FOR MEDICAL BENEFITS	1.69
	LDD	LIFE INSURANCE ONLY - NO MEDICAL BENEFITS	1.69
	MC	LIFE INSURANCE ONLY - HMO SINGLE	1.69
	MD	LIFE INSURANCE ONLY - HMO FAMILY	1.69

REVISED EFFECTIVE DATE OF RATE SCHEDULE: MARCH 1, 1990

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees for
State Agencies, Colleges and Universities, and
County Boards of Education

	Coverage Code	Explanation of Coverage Code	Year One 30% Employee	Year One 30% Agency	Year Two 20% Employee	Year Two 20% Agency	Year Three & Thereafter 10% Employee	Year Three & Thereafter 10% Agency	Total Premium
EMPLOYEES UNDER AGE OF 65: AMOUNT OF LIFE INSURANCE $10,000.00	AS	Single Coverage	$28.80	$67.20	$19.20	$76.80	$ 9.60	$86.40	$96.00
	AF	Family Coverage	66.00	154.00	44.00	176.00	22.00	198.00	220.00
	LA	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits.	1.02	2.36	.68	2.70	.34	3.04	3.38
	LAD	Life Insurance Only - no medical benefits	1.02	2.36	.68	2.70	.34	3.04	3.38
	MS	Life Insurance Only-HMO Single	1.02	2.36	.68	2.70	.34	3.04	3.38
	MF	Life Insurance Only-HMO Family	1.02	2.36	.68	2.70	.34	3.04	3.38
EMPLOYEES AGES 65 THRU 69 AMOUNT OF LIFE INSURANCE $6,500.00	BS	Single Coverage	28.50	66.50	19.00	76.00	9.50	85.50	95.00
	BF	Family Coverage	65.70	153.30	43.80	175.20	21.90	197.10	219.00
	LB	Life Insurance Only -must be covered as dependent under spouse's PEIA coverage for medical benefits	.66	1.54	.44	1.76	.22	1.98	2.20
	LBD	Life Insurance Only - no medical benefits	.66	1.54	.44	1.76	.22	1.98	2.20
	MA	Life Insurance Only-HMO Single	.66	1.54	.44	1.76	.22	1.98	2.20
	MB	Life Insurance Only-HMO Family	.66	1.54	.44	1.76	.22	1.98	2.20
EMPLOYEES AGES 70 AND OLDER AMOUNT OF LIFE INSURANCE $5,000.00	CS	Single Coverage	28.20	65.80	18.80	75.20	9.40	84.60	94.00
	CF	Family Coverage	65.40	152.60	43.60	174.40	21.80	196.20	218.00
	LD	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits.	.50	1.19	.34	1.35	.18	1.51	1.69
	LDD	Life Insurance Only - no medical benefits	.50	1.19	.34	1.35	.18	1.51	1.69
	MC	Life Insurance Only-HMO Single	.50	1.19	.34	1.35	.18	1.51	1.69
	MD	Life Insurance Only-HMO Family	.50	1.19	.34	1.35	.18	1.51	1.69

Basic Rate Schedule for Retirees

	Coverage Code	Explanation of Coverage Code	Total Premium
RETIREE UNDER AGE 65 AMOUNT OF LIFE INSURANCE $5,000.00	GS	Single Coverage	$66.00
	GSA	Single Coverage with Medicare	27.00
	GSB*	Single Coverage with Waiver of Premium	64.00
	GSC*	Single Coverage with Medicare and Waiver of Premium	25.00
***AMOUNT OF LIFE INSURANCE $10,000.00**	GF	Family Coverage with dependent(s) under age 65	135.00
	GFA	Family Coverage with Medicare and dependent(s) under age 65	99.00
	GFB*	Family Coverage with Waiver of Premium and dependent(s) under age 65	133.00
	GFC*	Family Coverage with Medicare and Waiver of Premium and dependent(s) under age 65	97.00
	GW	Family Coverage with dependent(s) age 65 or over, or on Medicare	84.00
	GWA	Family Coverage with Medicare with dependent(s) age 65 or over, or on Medicare	45.00
	GWB*	Family Coverage with Waiver of Premium and dependent(s) age 65 or over, or on Medicare	82.00
	GWC*	Family Coverage with Medicare and Waiver of Premium and dependent(s) age 65 or over, or on Medicare	43.00
	LG	Life Insurance Only - Must be covered as dependent under spouse's PEIA coverage for medical benefits	1.56
	LGB*	Life Insurance only - Waiver of Premium - must be covered under spouse's PEIA coverage for medical benefits	----
	LGD	Life Insurance Only - No Medical Benefits	1.56
	LGE*	Life Insurance Only - Waiver of Premium - No Medical Benefits	----

EFFECTIVE DATE OF REVISED RATE SCHEDULE: JULY 1, 1989

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees

Basic Rate Schedule for Retirees

	Coverage Code	Explanation of Coverage Code	Total Premium
RETIREE AGE 65-66 AMOUNT OF LIFE INSURANCE $5,000.00	HS	Single Coverage	$27.00
	HSB	Single Coverage with Waiver of Primium	25.00
	HF	Family Coverage with dependent(s) age 65 or over, or on Medicare	45.00
	HFB	Family Coverage with Waiver of Premium and dependent(s) age 65 or over, or on Medicare	43.00
	HW	Family Coverage with dependent(s) under age 65	101.00
	HWB	Family Coverage with Waiver of Premium and dependent(s) under age 65	99.00
	LH	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits	1.56
	LHD	Life Insurance Only - no medical benefits	1.56
	LHB	Life Insurance Only - Waiver of Premium and must be covered as dependent under spouse's PEIA coverage for medical benefits	0.00
	LHE	Life Insurance Only - Waiver of Premium and No Medical Benefits	0.00
RETIREE AGE 67 OR OVER AMOUNT OF LIFE INSURANCE $2,500.00	IS	Single Coverage	27.00
	ISB	Single Coverage with Waiver of premium	26.00
	IF	Family Coverage with dependent(s) age 65 or over, or on Medicare	45.00
	IFB	Family Coverage with waiver of premium and dependent(s) age 65 or over, or on Medicare	44.00
	IW	Family Coverage with dependent(s) under age 65	101.00
	IWB	Family Coverage with waiver of premium and dependent(s) under age 65	100.00
	LI	LIfe Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits	.78
	LID	Life Insurance Only - no medical benefits	.78
	LIB	Life Insurance Only - waiver of premium , must be covered as dependent under spouse's PEIA Coverage for medical benefits	0.00
	LIE	Life Insurance Only - waiver of premium and no medical benefits	0.00
RETIREE ANY AGE HEALTH INSURANCE ONLY	ZS	Single Coverage - Non-Medicare - no life insurance benefits	64.00
	ZSA	Single Coverage - Medicare - no life insurance benefits	25.00
	ZF	Family Coverage - Non-Medicare - no life insurance benefits	133.00
	ZFA	Family Coverage - Retiree Medicare and dependent non-Medicare - no life insurance benefits	97.00
	ZW	Family Coverage - Retiree non-Medicare and dependent Medicare, no life insurance benefits	82.00
	ZWA	Family Coverage - Medicare - no life insurance benefits	43.00

SURVIVING DEPENDENT RATE SCHEDULE

WS	Surviving Spouse under age 65	93.00
WO	Surviving spouse over age 65 with dependent child(ren)	135.00
WW	Surviving Spouse under age 65 on Medicare	31.00
WF	Surviving Spouse under age 65 with dependent child(ren)	217.00
WX	Surviving spouse over age 65	31.00
WM	Surviving Spouse under age 65 on Medicare with dependent child(ren)	135.00
YS	Surviving child/No parent	93.00
YF	Surviving children/No parent	217.00

COBRA RATE SCHEDULE

		Coverage effective prior to January 1, 1990	Coverage effective on or after January 1, 1990
CES	COBRA Employee - Single Coverage	$ 93.00	$ 95.00
CEF	COBRA Employee - Family Coverage	217.00	221.00
CDS	COBRA Dependent - Single Coverage	93.00	95.00
CDF	COBRA Dependent - Family Coverage	217.00	221.00
CMO	COBRA - Health Maintenance Organization	0.00	0.00

EFFECTIVE DATE OF REVISED RATE SCHEDULE: JANUARY 1, 1990

OPTIONAL LIFE AND ACCIDENTAL\DEATH & DISMEMBERMENT PLAN (NO AD&D FOR RETIREES)

AGE	PLAN I	PLAN II	PLAN III	PLAN IV	PLAN V	PLAN IV
Under 65	$5,000	$10,000	$20,000	$30,000	$40,000	$50,000
65 - 69	$3,250	$ 6,500	$13,000	$19,500	$26,000	$32,500
70 & Over	$2,250	$ 4,500	$9,000	$13,500	$18,000	$22,500

SCHEDULE OF MONTHLY PREMIUM RATES FOR ACTIVE EMPLOYEES

UNDER 30	A1 $ .44	A2 $ .86	A3 $ 1.70	A4 $ 2.56	A5 $ 3.40	A6 $ 4.26
30 - 34	B1 $ .48	B2 $ .94	B3 $ 1.88	B4 $ 2.82	B5 $ 3.76	B6 $ 4.70
35 - 39	C1 $ .58	C2 $ 1.14	C3 $ 2.26	C4 $ 3.30	C5 $ 4.52	C6 $ 5.66
40 - 44	D1 $ .90	D2 $ 1.80	D3 $ 3.58	D4 $ 5.38	D5 $ 7.16	D6 $ 8.96
45 - 49	E1 $ 1.16	E2 $ 2.32	E3 $ 4.62	E4 $ 6.94	E5 $ 9.24	E6 $ 11.56
50 - 54	F1 $ 1.74	F2 $ 3.46	F3 $ 6.92	F4 $ 10.38	F5 $ 13.84	F6 $ 17.30
55 - 59	G1 $ 2.82	G2 $ 5.62	G3 $ 11.22	G4 $ 16.84	G5 $ 22.44	G6 $ 28.06
60 - 64	H1 $ 3.98	H2 $ 7.94	H3 $ 15.88	H4 $ 23.82	H5 $ 31.76	H6 $ 39.70
65 - 69	I1 $ 4.06	I2 $ 8.12	I3 $ 16.24	I4 $ 24.36	I5 $ 32.48	I6 $ 40.60
70 & OVER	J1 $ 8.28	J2 $16.56	J3 $ 33.12	J4 $ 49.68	J5 $ 66.24	J6 $ 82.80

SCHEDULE OF MONTHLY PREMIUM RATES FOR RETIREES

UNDER 30	K1 $ .30	K2 $ .60	K3 $ 1.20	K4 $ 1.80	K5 $ 2.40	K6 $ 3.00
30 - 34	L1 $ .36	L2 $ .70	L3 $ 1.40	L4 $ 2.10	L5 $ 2.80	L6 $ 3.50
35 - 39	M1 $ .46	M2 $ .90	M3 $ 1.80	M4 $ 2.70	M5 $ 3.60	M6 $ 4.50
40 - 44	N1 $ .78	N2 $ 1.56	N3 $ 3.12	N4 $ 4.68	N5 $ 6.24	N6 $ 7.80
45 - 49	O1 $ 1.08	O2 $ 2.16	O3 $ 4.32	O4 $ 6.48	O5 $ 8.64	O6 $ 10.80
50 - 54	P1 $ 1.70	P2 $ 3.40	P3 $ 6.80	P4 $ 10.20	P5 $ 13.60	P6 $ 17.00
55 - 59	Q1 $ 2.86	Q2 $ 5.70	Q3 $ 11.40	Q4 $ 17.10	Q5 $ 22.80	Q6 $ 28.50
60 - 64	R1 $ 4.10	R2 $ 8.20	R3 $ 16.40	R4 $ 24.60	R6 $ 32.80	R6 $ 41.00
65 - 69	S1 $ 4.26	S2 $ 8.52	S3 $ 17.06	S4 $ 25.56	S5 $ 34.10	S6 $ 42.62
70 & OVER	T1 $ 8.80	T2 $17.60	T3 $ 35.20	T4 $ 52.80	T5 $ 70.40	T6 $ 88.00

COMBINED DEPENDENT COVERAGE:

SPOUSE	EACH CHILD	
$5,000.00	$2,000.00	$ 1.82

Public Employees Insurance Agency

Capitol Complex
Building 5
Tenth Floor
Charleston.
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

January 31, 1990

The Honorable Ken Hechler
Secretary of State
Building 1, Suite 157-K
Charleston, W. Va. 25305

Re: **Filing of Public Employees Insurance Agency Benefit Plan Document and Insurance Rate Schedules**

Dear Secretary Hechler:

Enclosed please find for filing copies of the following documents: (1) a new Public Employees Insurance Agency Plan Document, to be effective March 1, 1990; (2) a January 31, 1990, memorandum to Non-State Agency Payroll Clerks/Benefit Coordinators, notifying them of a premium rate increase, effective March 1, 1990; and (3) the PEIA's current premium rate schedules, effective July 1, 1989.

As you may know, rules and regulations of the Public Employees Insurance Agency generally are exempt from the rule-making provisions of the State Administrative Procedures Act. See W. Va. Code §5-16-18. Only a rule which would impose a premium assessment on State employees and employees of county boards of education must be promulgated in accordance with W. Va. Code §29A-1-1 et seq. See W. Va. Code §5-16-13a(c).

Even though the PEIA is not required by law to file its Plan Document or rate schedules with your Office, we are committed to the principles of public notice and of having these documents on file in a central location. For this reason, I am requesting that the Plan Document and rate schedules be filed in your Office together with the existing rules and regulations of the PEIA.

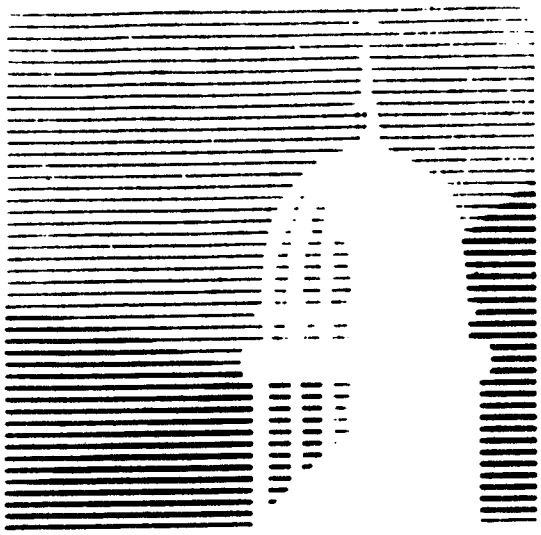
Thank you very much for your cooperation and assistance.

Sincerely,

Sally K. Richardson
Director

SKR:trs

Enclosures



State of West Virginia

Department of Administration

Public Employees Insurance Agency

Rate Schedules

Public Employees Insurance Agency

MEMORANDUM

Capitol Complex
Building 5
Tenth Floor
Charleston.
WV 25305
304-348-7850

Gaston Caperton
Governor

Sally K. Richardson
Director

TO: Non-State Agency Payroll Clerks/Benefit Coordinators

FROM: Sally K. Richardson
Director

DATE: January 31, 1990

SUBJECT: Premium Rate Increase

This memorandum will serve as offical notice that as of March 1, 1990, PEIA will be increasing your health insurance premium rate by 10%. The increase is necessary because the funds received from non-State agencies have not been sufficient to cover the cost of paying claims for the insureds for which your group is responsible. To avoid any backlog in payment of medical claims for your group, an immediate rate increase is essential.

PEIA has developed new health insurance coverage codes for non-State agency insureds. We have merely added an 'N' to the former codes, which will denote non-State agency. Please pay particular attention to the new codes. The codes and corresponding premium rate amounts are shown below:

Category	Coverage Code	Description	Amount
Employees Under Age 65--Amount of Life Insurance: $10,000	ASN	Single Coverage	$105.00
	AFN	Family Coverage	242.00
Employees Ages 65 through 69--Amount of Life Insurance: $6,500	BSN	Single Coverage	$104.00
	BFN	Family Coverage	241.00
Employees Ages 70 and older--Amount of Life Insurance: $5,000	CSN	Single Coverage	$103.00
	CFN	Family Coverage	240.00

Please note the increase in the premium rate and adjust your payroll deductions accordingly for the March 1990 remittance.

Thank you for your cooperation. If you have any questions, please contact my office.

SKR/CM/JEL

West Virginia
PEIA Public Employees Insurance Agency

Gaston Caperton
Governor

Sally K. Richardson
Director

M E M O R A N D U M

To: All Benefit Coordinators/Payroll Locations

FROM: Raymond Shingler, Manager
Audit and Fiscal Affairs

DATE: May 11, 1989

RE: **NEW PREMIUM RATES**

Enclosed is the new premium rate schedule which is effective July 1, 1989.

RS:trs

Enclosure

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees

	Coverage Code	Explanation of Coverage Code	Year One 30% Employee	Year One 30% Agency	Year Two 20% Employee	Year Two 20% Agency	Year Three & Thereafter 10% Employee	Year Three & Thereafter 10% Agency	Total Premium
EMPLOYEES UNDER AGE OF 65: AMOUNT OF LIFE INSURANCE $10,000.00	AS	Single Coverage	$28.80	$67.20	$19.20	$76.80	$ 9.60	$86.40	$96.0
	AF	Family Coverage	66.00	154.00	44.00	176.00	22.00	198.00	220 0
	LA	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits.	1.02	2.36	.68	2.70	.34	3.04	3.3
	LAD	Life Insurance Only - no medical benefits	1.02	2.36	.68	2.70	.34	3.04	3.3
	MS	Life Insurance Only-HMO Single	1.02	2.36	.68	2.70	.34	3.04	3.3
	MF	Life Insurance Only-HMO Family	1.02	2.36	.68	2.70	.34	3.04	3.3
EMPLOYEES AGES 65 THRU 69 AMOUNT OF LIFE INSURANCE $6,500.00	BS	Single Coverage	28.50	66.50	19.00	76.00	9.50	85.50	95.0
	BF	Family Coverage	65.70	153.30	43.80	175.20	21.90	197.10	219.0
	LB	Life Insurance Only -must be covered as dependent under spouse's PEIA coverage for medical benefits	.66	1.54	.44	1.76	.22	1.98	2.2
	LBD	Life Insurance Only - no medical benefits	.66	1.54	.44	1.76	.22	1.98	2.2
	MA	Life Insurance Only-HMO Single	.66	1.54	.44	1.76	.22	1.98	2.2
	MB	Life Insurance Only-HMO Family	.66	1.54	.44	1.76	.22	1.98	2.2
EMPLOYEES AGES 70 AND OLDER AMOUUNT OF LIFE INSURANCE [illegible]000.00	CS	Single Coverage	28.20	65.80	18.80	75.20	9.40	84.60	94.0
	CF	Family Coverage	65.40	152.60	43.60	174.40	21.80	196.20	218.0
	LD	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits.	.50	1.19	.34	1.35	.18	1.51	1.6
	LDD	Life Insurance Only - no medical benefits	.50	1.19	.34	1.35	.18	1.51	1.6
	MC	Life Insurance Only-HMO Single	.50	1.19	.34	1.35	.18	1.51	1.6
	MD	Life Insurance Only-HMO Family	.50	1.19	.34	1.35	.18	1.51	1.6

Basic Rate Schedule for Retirees

	Coverage Code	Explanation of Coverage Code	Total Premium
RETIREE UNDER AGE 65 AMOUNT OF LIFE INSURANCE $5,000.00	GS	Single Coverage	$66.00
	GSA	Single Coverage with Medicare	27.00
	GSB*	Single Coverage with Waiver of Premium	64.00
	GSC*	Single Coverage with Medicare and Waiver of Premium	25.00
*AMOUNT OF LIFE INSURANCE $10,000.00	GF	Family Coverage with dependent(s) under age 65	135.00
	GFA	Family Coverage with Medicare and dependent(s) under age 65	99.00
	GFB*	Family Coverage with Waiver of Premium and dependent(s) under age 65	133.00
	GFC*	Family Coverage with Medicare and Waiver of Premium and dependent(s) under age 65	97.00
	GW	Family Coverage with dependent(s) age 65 or over, or on Medicare	84.00
	GWA	Family Coverage with Medicare with dependent(s) age 65 or over, or on Medicare	45.00
	GWB*	Family Coverage with Waiver of Premium and dependent(s) age 65 or over, or on Medicare	82.00
	GWC*	Family Coverage with Medicare and Waiver of Premium and dependent(s) age 65 or over, or on Medicare	43.00
	LG	Life Insurance Only - Must be covered as dependent under spouse's PEIA coverage for medical benefits	1.56
	LGB*	Life Insurance only - Waiver of Premium - must be covered under spouse's PEIA coverage for medical benefits	---
	LGD	Life Insurance Only - No Medical Benefits	1.56
	LGE*	Life Insurance Only - Waiver of Premium - No Medical Benefits	---

EFFECTIVE DATE OF REVISED RATE SCHEDULE: JULY 1, 1989

West Virginia Public Employees Insurance Agency
Basic Insurance Rate Schedule for Active Employees

Basic Rate Schedule for Retirees

	Coverage Code	Explanation of Coverage Code	Total Premium
RETIREE AGE 65-66	HS	Single Coverage	$27.00
AMOUNT OF LIFE	HSB	Single Coverage with Waiver of Primium	25.00
INSURANCE $5,000.00	HF	Family Coverage with dependent(s) age 65 or over, or on Medicare	45.00
	HFB	Family Coverage with Waiver of Premium and dependent(s) age 65 or over, or on Medicare	43.00
	HW	Family Coverage with dependent(s) under age 65	101.00
	HWB	Family Coverage with Waiver of Premium and dependent(s) under age 65	99.00
	LH	Life Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits	1.56
	LHD	Life Insurance Only - no medical benefits	1.56
	LHB	Life Insurance Only - Waiver of Premium and must be covered as dependent under spouse's PEIA coverage for medical benefits	0.00
	LHE	Life Insurance Only - Waiver of Premium and No Medical Benefits	0.00
RETIREE AGE 67 OR OVER	IS	Single Coverage	27.00
AMOUNT OF LIFE INSURANCE	ISB	Single Coverage with Waiver of premium	26.00
$2,500.00	IF	Family Coverage with dependent(s) age 65 or over, or on Medicare	45.00
	IFB	Family Coverage with waiver of premium and dependent(s) age 65 or over, or on Medicare	44.00
	IW	Family Coverage with dependent(s) under age 65	101.00
	IWB	Family Coverage with waiver of premium and dependent(s) under age 65	100.00
	LI	LIfe Insurance Only - must be covered as dependent under spouse's PEIA coverage for medical benefits	.78
	LID	Life Insurance Only - no medical benefits	.78
	LIB	Life Insurance Only - waiver of premium , must be covered as dependent under spouse's PEIA Coverage for medical benefits	0.00
	LIE	Life Insurance Only - waiver of premium and no medical benefits	0.00
RETIREE ANY AGE	ZS	Single Coverage - Non-Medicare - no life insurance benefits	64.00
HEALTH INSURANCE ONLY	ZSA	Single Coverage - Medicare - no life insurance benefits	25.00
	ZF	Family Coverage - Non-Medicare - no life insurance benefits	133.00
	ZFA	Family Coverage - Retiree Medicare and dependent non-Medicare - no life insurance benefits	97.00
	ZW	Family Coverage - Retiree non-Medicare and dependent Medicare, no life insurance benefits	82.00
	ZWA	Family Coverage - Medicare - no life insurance benefits	43.00

SURVIVING DEPENDENT RATE SCHEDULE

WS	Surviving Spouse under age 65	93.00
WO	Surviving spouse over age 65 with dependent child(ren)	135.00
WW	Surviving Spouse under age 65 on Medicare	31.00
WF	Surviving Spouse under age 65 with dependent child(ren)	217.00
WX	Surviving spouse over age 65	31.00
WM	Surviving Spouse under age 65 on Medicare with dependent child(ren)	135.00
YS	Surviving child/No parent	93.00
YF	Surviving children/No parent	217.00

COBRA RATE SCHEDULE

CES	COBRA Employee - Single Coverage	93.00
CEF	COBRA Employee - Family Coverage	217.00
CDS	COBRA Dependent - Single Coverage	93.00
CDF	COBRA Dependent - Family Coverage	217.00
CMO	COBRA - Health Maintenance Organization	0.00

EFFECTIVE DATE OF REVISED RATE SCHEDULE: JULY 1, 1989

OPTIONAL LIFE AND ACCIDENTAL\DEATH & DISMEMBERMENT PLAN (NO AD&D FOR RETIREES)

AGE	PLAN I	PLAN II	PLAN III	PLAN IV	PLAN V	PLAN IV
Under 65	$5,000	$10,000	$20,000	$30,000	$40,000	$50,000
65 - 69	$3,250	$ 6,500	$13,000	$19,500	$26,000	$32,500
70 & Over	$2,250	$ 4,500	$9,000	$13,500	$18,000	$22,500

SCHEDULE OF MONTHLY PREMIUM RATES FOR ACTIVE EMPLOYEES

UNDER 30	A1 $ .44	A2 $ .86	A3 $ 1.70	A4 $ 2.56	A5 $ 3.40	A6 $ 4.26
30 - 34	B1 $ .48	B2 $ .94	B3 $ 1.88	B4 $ 2.82	B5 $ 3.76	B6 $ 4.70
35 - 39	C1 $ .58	C2 $ 1.14	C3 $ 2.26	C4 $ 3.30	C5 $ 4.52	C6 $ 5.66
40 - 44	D1 $ .90	D2 $ 1.80	D3 $ 3.58	D4 $ 5.38	D5 $ 7.16	D6 $ 8.96
45 - 49	E1 $ 1.16	E2 $ 2.32	E3 $ 4.62	E4 $ 6.94	E5 $ 9.24	E6 $ 11.56
50 - 54	F1 $ 1.74	F2 $ 3.46	F3 $ 6.92	F4 $ 10.38	F5 $ 13.84	F6 $ 17.30
55 - 59	G1 $ 2.82	G2 $ 5.62	G3 $ 11.22	G4 $ 16.84	G5 $ 22.44	G6 $ 28.06
60 - 64	H1 $ 3.98	H2 $ 7.94	H3 $ 15.88	H4 $ 23.82	H5 $ 31.76	H6 $ 39.70
65 - 69	I1 $ 4.06	I2 $ 8.12	I3 $ 16.24	I4 $ 24.36	I5 $ 32.48	I6 $ 40.60
70 & OVER	J1 $ 8.28	J2 $16.56	J3 $ 33.12	J4 $ 49.68	J5 $ 66.24	J6 $ 82.80

SCHEDULE OF MONTHLY PREMIUM RATES FOR RETIREES

UNDER 30	K1 $ .30	K2 $ .60	K3 $ 1.20	K4 $ 1.80	K5 $ 2.40	K6 $ 3.00
30 - 34	L1 $ .36	L2 $ .70	L3 $ 1.40	L4 $ 2.10	L5 $ 2.80	L6 $ 3.50
35 - 39	M1 $ .46	M2 $ .90	M3 $ 1.80	M4 $ 2.70	M5 $ 3.60	M6 $ 4.50
40 - 44	N1 $ .78	N2 $ 1.56	N3 $ 3.12	N4 $ 4.68	N5 $ 6.24	N6 $ 7.80
45 - 49	O1 $ 1.08	O2 $ 2.16	O3 $ 4.32	O4 $ 6.48	O5 $ 8.64	O6 $ 10.80
50 - 54	P1 $ 1.70	P2 $ 3.40	P3 $ 6.80	P4 $ 10.20	P5 $ 13.60	P6 $ 17.00
55 - 59	Q1 $ 2.86	Q2 $ 5.70	Q3 $ 11.40	Q4 $ 17.10	Q5 $ 22.80	Q6 $ 28.50
60 - 64	R1 $ 4.10	R2 $ 8.20	R3 $ 16.40	R4 $ 24.60	R6 $ 32.80	R6 $ 41.00
65 - 69	S1 $ 4.26	S2 $ 8.52	S3 $ 17.06	S4 $ 25.56	S5 $ 34.10	S6 $ 42.62
70 & OVER	T1 $ 8.80	T2 $17.60	T3 $ 35.20	T4 $ 52.80	T5 $ 70.40	T6 $ 88.00

COMBINED DEPENDENT COVERAGE:

SPOUSE	EACH CHILD	
$5,000.00	$2,000.00	$ 1.82