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November 15, 2005

The Honorable Betty Ireland
Secretary of State
1900 Kanawha Boulevard, East
State Capitol, Suite 157-K
Charleston, West Virginia 25305

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OFFICE WEST VIRGINIA
SECRETARY OF STATE

Re: West Virginia PEIA
Summary Plan Description (SPD)
For Fiscal Year 2006

Dear Ms. Ireland:

Enclosed, for filing, please find the West Virginia Public Employees Insurance Agency's Summary Plan Description (SPD) for Plan Year 2006, which became effective July 1, 2005. Also enclosed, for electronic use, is a CD that contains the SPD. This version of the SPD will remain in affect until amended or replaced.

Thank you very much for your attention to this matter.

Sincerely,

B. Keith Huffman
General Counsel and Acting Co-Director

BKH/pb

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WEST VIRGINIA PEIA

SUMMARY PLAN DESCRIPTION

BENEFITS FOR PLAN YEAR 2005-2006



JULY 1, 2005 TO JUNE 30, 2006



Notice to PEIA Enrollees Concerning Election for Plan Exemption From Certain Federal Requirements

Under a 1996 Federal law, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is self-funded by the employer, rather than provided through a health insurance policy. The Public Employees Insurance Agency (PEIA) has elected to exempt the PEIA PPB Plan from item number three (3) of the following requirements:

1. Limitations on pre-existing condition exclusion periods.
2. Special enrollment periods.
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status.
4. Standards relating to benefits for mothers and newborns.
5. Parity in the application of certain limits to mental health benefits.
6. Required coverage for reconstructive surgery following mastectomies.

The PEIA PPB Plan complies with all of the other listed Federal requirements. The exemption from the Federal requirement will be in effect for the plan year beginning July 1, 2005 and ending June 30, 2006. The election may be renewed for subsequent plan years.

The only practical effect to PEIA members of this election is that the PEIA PPB Plan will make a thirty dollar reduction for family coverage and a fifteen dollar reduction for single coverage in premiums per month for members who certify that they and their covered dependents do not use tobacco.

The Federal law also requires the Plan to provide covered employees and dependents with a certificate of creditable coverage when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

If you have questions about this election, please call Customer Service at (304) 558-7850 or, toll-free, at 1-888-680-7342.

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Introduction

Welcome to your PEIA Summary Plan Description. This booklet describes the benefits provided for PEIA insureds for Plan Year 2006 (July 1, 2005 - June 30, 2006). It includes important information for all public employees who have ANY coverage through PEIA.

Managed Care Members

For those who are enrolled in managed care plans, this booklet provides all of the eligibility and enrollment information regarding your benefits. If you need or want to change your benefits, please refer to the information in the beginning of this booklet for details of your rights, responsibilities, and the time frames for making eligibility changes. Information in this booklet regarding managed care plan guidelines is limited. Therefore, you should refer to your managed care Evidence of Coverage for benefit details if you are covered by one of the managed care plans offered by PEIA.

PPB Plan Participants

For those enrolled in the PEIA PPB Plan A or B, this booklet includes many details of the Preferred Provider Benefit (PPB) Plan. It is important to review this information closely so that you may familiarize yourself with all aspects of PEIA's PPB Plans. Please keep this booklet close at hand and refer to it often if you have questions about your PEIA PPB Plan benefits.

This *Summary Plan Description* (SPD) provides PEIA PPB Plan participants with an easy-to-read description of benefits available through the PEIA Plan and instructions on how to use these benefits. The SPD is a summarized version of a portion of PEIA's Plan Document. The Plan Document describes, in detail, all aspects of the operations of the Agency, and is on file with the Secretary of State.

The PEIA PPB Plan contracts with third party administrators (TPAs) to process health, drug and fringe benefit claims. If you have a question about a specific claim or benefit, the fastest way to obtain information is to contact the TPA directly at one of the numbers listed on the next page.

PEIA now offers the PEIA PPB Plan B to all active employees. Plan B is similar to the standard PPB Plan A, but offers lower premiums with higher deductibles, higher out-of-pocket maximums, and higher copayments for prescription drugs. The medical coverage is the same as in PPB Plan A. The differences in deductibles, out-of-pocket maximums and drug copayments are noted in the benefit tables in the Medical Benefits section and the Prescription Drug Benefits section of this book.

Life Insurance Only

For employees who carry only life insurance with the PEIA, your eligibility and enrollment details are in this booklet. Details of the life insurance coverage are in the *Life Insurance Booklet*.

Subject to Change

The benefit information in this *Summary Plan Description* is subject to change during the plan year, if circumstances arise which require adjustment. Plan changes will be communicated to participants through the PEIA News. The changes will be included in PEIA's Plan Document, which is on file with the Secretary of State, and will be incorporated into the next edition of the *Summary Plan Description*.

Who to Call with Questions

Health Claims, Benefits, Preauthorizations and Prior Approvals for Out-of-State Care

Acordia National 1-304-353-7820 or 1-888-440-7342 (toll-free)
..... or on the web at www.acordianational.com

Precertification and Utilization Management

Acordia National 1-304-353-7820 or 1-888-440-7342 (toll-free)
..... or on the web at www.acordianational.com

Prescription Drug Benefits and Claims

Express Scripts 1-877-256-4680 (toll-free) or on the web at www.express-scripts.com

Common Specialty Medications

Curascript 1-866-413-4135 (toll-free)

Subrogation and Recovery

Beacon Recovery Group 1-800-874-0500 (toll-free)

PEIA

Answers to questions about eligibility, life insurance and third-level claim appeals

WV Public Employees Insurance Agency 1-304-558-7850 or 1-888-680-7342 (toll-free)
..... or on the web at www.wvpeia.com

Mountaineer Flexible Benefits

Dental, vision, and disability insurance and flexible spending accounts

Fringe Benefits Management Company 1-800-342-8017 (toll-free)
..... or on the web at www.fbm-benefits.com

Managed Care Plans

Carelink 1-800-348-2922 (toll-free) or on the web at www.cvtty.com
The Health Plan 1-800-624-6961 (toll-free) • 1-740-695-3585
..... or on the web at www.healthplan.org

Terms & Definitions

Acordia National: The third party administrator that handles medical claim processing, customer service, precertification, case management, preauthorization and prior approval for out-of-network services for the PEIA PPB Plan.

Allowed Amounts: For each PEIA-covered service, the allowed amount is the lesser of the actual charge amount or the maximum fee for that service as set by the PEIA.

Alternate Facility: A facility other than an acute care hospital.

Annual Deductible: The amount you must pay each plan year before the plan pays its portion of the cost. Under the PPB Plan, office visits are not subject to the deductible. Only the Allowed Amounts for covered expenses will be applied to your deductible. The family deductible is divided up among the family members. No one member of the family will pay more than the individual deductible.

Beacon Recovery Group: The subrogation and recovery vendor for PEIA. Beacon pursues recovery of money paid for claims that were not the responsibility of the PEIA PPB Plan. For more information, read the "Recovery of Incorrect Payments" section.

Beneficiary: The person who receives the proceeds of your PEIA life insurance policy.

Claims Administrator: Acordia National.

Common Specialty Medications: Specialty medications are high-cost injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of the patient's drug therapy. Specialty drugs have the following key characteristics:

- Need frequent dosage adjustments
- Cause more severe side effects than traditional drugs
- Need special storage, handling and/or administration
- Have a narrow therapeutic range
- Require periodic laboratory or diagnostic testing
- Cost in excess of \$1,300 per 30-day supply

Under the PEIA PPB Plan, Common Specialty Medications are available only via mail order through Curascript, are subject to a \$50 copay for up to a 34-day supply, and may not be purchased in 90-day supplies.

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

Coinurance: The percentage of eligible expenses that you are required to pay after the deductible has been met. This is the amount applied to your out-of-pocket maximum. You are responsible for paying the coinsurance and deductible amounts directly to the provider of services.

Copayment: This is the set dollar amount that you pay when you use the services—like the flat dollar amount you pay for an office visit in the PEIA PPB Plan. Copayments do not count toward your annual out-of-pocket maximum or your annual deductible.

Curascript: The exclusive specialty pharmacy vendor for the PEIA PPB Plan. Curascript provides mail order delivery of the Common Specialty Medications detailed in the Prescription Drug Benefits section of this Summary Plan Description.

Deductible: The amount of eligible expenses you are required to pay before the plan begins to pay benefits. The deductible does not apply to charges for office visits. See Annual Deductible above.

Dependent: An eligible person, under PEIA guidelines, who the policyholder has properly enrolled for coverage under the Plan.

Durable Medical Equipment: Medical equipment that is prescribed by a physician which can withstand repeated use, is not disposable, is used for a medical purpose, and is generally not useful to a person who is not sick or injured.

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

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

Employers: PEIA offers its benefits through these West Virginia employers:

- State government and its agencies;
- State-related colleges and universities;
- County boards of education;
- County and municipal governments; and
- Other employers as specified in W. Va. Code §5-16-2.

Under West Virginia law, different types of employers may offer their employees different benefits. Therefore, the benefits for which you are eligible may vary. If you have any questions about the benefits available to you, contact the benefit coordinator at your payroll location or call the PEIA.

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

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

Explanation of Benefits (EOB): A form sent to the person filing the claim after a claim for payment has been evaluated or processed by the Claims Administrator which explains the action taken on the claim. This explanation might include the amount paid, benefits available, reasons for denying payment, etc.

Handicap: A medical 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 oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or 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 dystrophy; autism; multiple sclerosis and diabetes. The term "handicap" does not include excessive use or abuse of alcohol, tobacco or drugs.

HMO (Health Maintenance Organization): A managed care organization that provides a wide range of comprehensive health care services for a fixed periodic payment. PEIA contracts with HMOs to provide health coverage for policyholders and their dependents who choose this coverage. HMO participants receive general information about the plans in PEIA's Shopper's Guide, and specific information in the Evidence of Coverage (EOC) provided by their HMO.

Inpatient: Someone admitted to the hospital as a bed patient for medical services.

Insured: Someone who is eligible for and enrolled in the PEIA PPB Plan, a managed care plan or life insurance only. Insured refers to anyone who has coverage under any plan offered by PEIA.

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

Medicare: The federal program of health benefits for retirees and other qualified individuals as established by Title XVII of the Social Security Act of 1965, as amended. Medicare consists of four parts, A, B, C and D. Parts A and B provide medical coverage to Medicare Beneficiaries. Retired qualified Medicare Beneficiaries covered by PEIA are REQUIRED to enroll for both Medicare Part A and Part B. Medicare Part C is not offered under PEIA. Medicare Part D (drug coverage), which will become effective on January 1, 2006, IS NOT required for members of the PEIA Plans.

Medicare Beneficiary: Individual eligible for Medicare as established by Title XVII of the Social Security Act of 1965, as amended.

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

Notification: The required process of reporting an inpatient stay to PEIA's utilization management vendor, Acordia National. This process is performed to screen for care planning, discharge planning, follow-up care and ancillary service requirements.

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

Participant: A policyholder or dependent enrolled in the PEIA PPB Plan A or B.

PEIA PPB Plan A: The standard PEIA PPB Plan offered to all eligible employees.

PEIA PPB Plan B: The lower-cost PEIA PPB Plan offered to all eligible active employees. Plan B offers lower premiums with higher deductibles, higher out-of-pocket maximums, and higher copayments for prescription drugs. The medical coverage is the same as in Plan A. The differences in deductibles, out-of-pocket maximums and drug copayments are noted in the benefit tables in the "Medical Benefits" section and the "Prescription Drug Benefit" section of this book.

PEIA PPO: The PEIA PPO is the network of providers from whom PEIA PPB Plan participants can receive care to get the highest level of benefit. This network consists of all WV providers who provide health care services or supplies to any PEIA participant. For services provided outside of the State, several networks are available. Contact Acordia National with questions about out-of-state providers.

Plan: The plan of benefits offered by the Public Employees Insurance Agency, including the PEIA PPB Plans, managed care plans and life insurance coverages.

Plan Year: A 12-month period beginning July 1 and ending June 30.

Policyholder: The employee, retired employee, surviving dependent or COBRA participant in whose name the PEIA provides any health or life insurance coverage.

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

Precertification: The required process of reporting any inpatient stay and certain outpatient procedures in advance to obtain approval for the admission or service. Acordia National handles precertification.

Pre-existing Condition: A physical or mental condition that had been diagnosed or treated, or for which the patient incurred expenses in the three months prior to becoming covered by the Plan.

Preferred Provider Organization (PPO): A plan that uses a network of providers to provide benefits at the highest benefit level. PPO plans also offer out-of-network benefits with higher member cost-sharing.

Premium: The payment required to keep coverage in force.

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

Prior Authorization: The required process of obtaining authorization from the Rational Drug Therapy Program for coverage for some prescription medications under the PEIA PPB Plan.

Provider Discount: A previously determined percentage that is deducted from a provider's charge or payment amount and is not billable to the insured when PEIA is the primary payer and the service is provided in West Virginia or by a PPO network provider.

Rational Drug Therapy Program (RDT): The Rational Drug Therapy Program of the WVU School of Pharmacy provides clinical review of requests for drugs that require prior authorization under the PEIA PPB Plan.

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

Secondary Payer: The plan or coverage whose benefits are determined after the primary plan has paid. Order of payment is determined by rules described under "Which Plan Pays First" on page 60.

Third Party Administrator (TPA): A company with which PEIA has contracted to provide services such as customer service, utilization management and claims processing to PEIA PPB Plan participants.

Utilization Management: A process by which PEIA controls health care costs. Components of utilization management include pre-admission and concurrent review of all inpatient stays, known as precertification; prior review of certain outpatient surgeries and services; and medical case management. Utilization management is handled by Acordia National.

Waiver of Premium: If you become disabled before age 60, and while insured, your basic life insurance coverage will continue as long as you are disabled without further payment of premium. To be considered disabled, you must be unable to do any work for pay or profit. Application for a waiver of premium must be provided to PEIA's life insurance carrier within 12 months of your last day worked. Contact your benefit coordinator or PEIA to obtain an application.

What PEIA Offers

Health Coverage

PEIA offers the PEIA PPB Plans A and B to all active employees. Plan A is the standard plan. Plan B is similar to Plan A, but offers lower premiums with higher deductibles, higher out-of-pocket maximums, and higher copayments for prescription drugs. The medical coverage is identical in PPB Plans A and B. The differences in deductibles, out-of-pocket maximums and drug copayments are noted in the benefit tables in the *Medical Benefits* section and the *Prescription Drug Benefits* section of this book.

If you live in an area where PEIA offers a managed care plan, you may be eligible to enroll in a managed care plan or in the PEIA PPB Plan. You must live in the managed care plan's enrollment area to be eligible to enroll in a plan. Please consult your Shopper's Guide or contact your benefit coordinator to determine what managed care plans are offered in your area.

The PEIA PPB Plans use a coordination of benefits provision that determines how they will pay if you have other health insurance available to you. See page 59 for a complete description of this provision. The PEIA PPB Plans may be of little or no value to you as secondary insurance.

Life Insurance

As an active employee under age 65, you are eligible for a basic \$10,000 decreasing term life insurance policy with accidental death and dismemberment (AD&D) benefits. If you choose not to enroll for health benefits, you may still choose to enroll for basic life insurance. You must enroll for basic life insurance before you elect any of the optional life insurance coverages. Eligibility and enrollment details for the life insurance plans are included in this booklet. For a complete description of the life insurance benefits, please see the *Life Insurance Booklet*.

Mountaineer Flexible Benefits

Mountaineer Flexible Benefits is a "cafeteria plan" which offers additional optional benefits. This plan is available to active employees of all State agencies, colleges, universities, and those county boards of education and non-State agencies which elect to participate. If you're not sure whether you're eligible, contact your benefit coordinator.

The Mountaineer Flexible Benefits Plan enables employees to choose from among several options for dental, vision and short- and long-term disability insurance, as well as medical care and dependent care flexible spending accounts, and to pay for these benefits on a pre-tax basis. A Legal Plan is also available as a post-tax benefit option.

Open Enrollment for Mountaineer Flexible Benefits is held each Spring, usually during April and May. The current information about these benefits is included in the enrollment materials mailed prior to the annual Open Enrollment.

If you have questions about Mountaineer Flexible Benefits, contact Fringe Benefits Management Company at 1-800-342-8017.

The Mountaineer Flexible Benefits Plan offers dental and vision coverage for retired employees on a post-tax basis. Enrollment materials were mailed to all eligible retired employees during the enrollment period. If you have questions about these benefits, contact Fringe Benefits Management Company at 1-800-342-8017.

Mountaineer Flexible Benefits At-A-Glance	
Benefit	Options
Dental Benefits ¹	Coverage for routine dental care. Deductibles, copayments and benefits vary.
Vision Benefits ¹	Coverage for vision exams and corrective lenses.
Disability Insurance	Replacement of a portion of your pay if you are disabled.
Medical Flexible Spending Account	Deposit up to \$3,000 for tax-free reimbursement of eligible medical expenses.
Dependent Care Flexible Spending Account	Deposit up to \$5,000 for tax-free reimbursement of eligible expenses.
*Legal Plan	Coverage for legal matters.

¹ These benefits are available to retirees on a post-tax basis.
* This is a post-tax benefit

Eligibility and Enrollment for Active Employees

Who Is Eligible

As a public employee, you are eligible to be covered under the plans offered by your employer if you are:

- a full-time employee (working regularly at least 20 hours per week);
- an elected official who works full-time in the elected position;
- a member of the West Virginia Legislature (must pay 100% of the premium);
- an elected member of a county board of education; or
- a school service employee eligible under W. Va. Code, Chapter 18A.

Temporary and part-time employees are not eligible.

Dependents

If you elect PEIA coverage, you may also enroll the following dependents:

- your legal spouse;
- your biological or adopted children under age 19;
- stepchildren who live with you and are under age 19;
- children under age 19 who are members of your household and fully dependent upon you for support and maintenance (a notarized statement from the member affirming the member's 100% financial responsibility for the dependent is required); and
- children or stepchildren over age 19 who live with you and are incapacitated and cannot support themselves due to a physical or mental disability which began before age 19 (or age 25 if a full-time student).

Coverage for dependent children may be extended to the end of the month in which they reach age 25 if they are full-time students. See page 17, "Full-time Students Age 19 and Over" for details.

Married children are not eligible for coverage.

How to Enroll

You may enroll for PEIA health and life benefits by completing enrollment forms at your place of employment. On these forms you will select the types of coverage you want and enroll the eligible dependents you wish to cover.

Participation in PEIA benefit plans is not automatic; you must complete the proper enrollment forms. Enrollment will authorize your employer to deduct the premiums for the coverages you select from your salary.

There are restrictions on how and when you may enroll and make changes in your coverage. Please read all parts of the "Eligibility" section of this booklet carefully before you enroll so that you will fully understand your options and responsibilities.

New Employees

You may enroll for health coverage, basic life insurance, dependent life insurance, and up to \$500,000 of optional life insurance coverage during the calendar month you are hired and the following two calendar months. This is your "initial enrollment period."

If you enroll for basic life insurance, then you may enroll for optional life insurance, as well. No medical information form is required for up to \$100,000 of optional life insurance elected during this initial enrollment period. A medical information form is always required for optional life insurance in excess of \$100,000.

Health and life insurance coverage will become effective the first day of the calendar month following the date of enrollment. If you enroll and begin work on the first day of a month, your coverage will not be effective until the first day of the following calendar month. If you enroll before you actually start work, coverage will begin the first day of the month following your first day of active employment.

If you choose not to enroll for life insurance during this initial enrollment period, but want life coverage later (basic, optional or dependent optional) for you or your dependents, you will have to submit a medical information form and be approved by PEIA's life insurance carrier. Coverage will become effective the first day of the calendar month following approval.

If you choose not to enroll for health coverage as a new employee, you may do so later in accordance with guidelines in effect at the time you choose to enroll.

Health Coverage

For health coverage to be effective, you must be actively at work. To be considered "actively at work," you must:

- perform the normal tasks for your job on a full-time basis on the day your coverage is to begin; and
- perform such tasks at one of your normal places of business or at a location to which you must travel to do your job; and
- not be absent from work because of leave of absence or temporary layoff.

If you do not meet these requirements, coverage for you and your dependents will begin on the next day on which you do meet these requirements.

Pre-existing Medical Conditions

A pre-existing medical condition is one that has been diagnosed or treated, or for which you or your dependents have incurred expenses within the three months immediately before the effective date of the PEIA PPB Plan coverage.

Any employee and/or dependent enrolling in the PEIA PPB Plan will be subject to pre-existing condition limitations.

Expenses for a pre-existing condition will not be covered by the PEIA PPB Plan for the first twelve months your coverage is in effect. This limitation is waived if you had creditable coverage for at least 90 days under another similar health plan that terminated no more than 62 days prior to the effective date of the PEIA PPB Plan coverage, and if you submit your certificate of creditable coverage from your former insurer with your Health Insurance Enrollment Form.

The pre-existing condition limitation does not apply to pregnancy, to any condition meeting the definition of handicap, or to newborn or adopted children who are enrolled in the benefit plan within the calendar month of, or the two calendar months following the date of birth, adoption or placement in the home.

Managed care plans do not apply pre-existing condition limitations on their members.

Life Insurance Coverage

For life insurance coverage (or an increase in the amount of optional life insurance) to go into effect, you must meet the following requirements on the effective date of coverage:

- a) have completed a full day of active work on that date; and
- b) have completed a full day of active work on your last regularly scheduled work day and be able to work on the date you become eligible.

If you do not meet the requirements of a) and b) above, the coverage will become effective on the date you return to active work.

Active work and actively at work mean performing regular duties for a full work day for the policyholder.

Medicare for Active Employees

For PEIA PPB Plan active employees who are age 65 or older and eligible for Medicare, as long as you are an active employee, PEIA will be your primary insurer, except in a few rare cases. As long as you are an active employee, you do not need to sign up for Medicare Part B and pay the premium. When you prepare to retire, you must enroll for Medicare Part B. If you do not enroll in Medicare Part B, PEIA will process your claims as if you did have the Part B coverage. In other words, PEIA will pay only the amount we would have paid if Medicare had processed your claim and made a payment.

For PEIA PPB Plan active employees who are also eligible for Medicare, and Medicare is the primary payor, PEIA will use the traditional method of coordinating benefits.

If you become eligible for Medicare prior to age 65, please send a copy of your Medicare card to PEIA. This notification will make the claims payment process go much more smoothly.

Existing Employees

Existing employees may make changes in their coverage as follows:

Health Coverage

Existing employees who choose not to take PEIA health coverage at the time of employment may add health coverage through the PEIA PPB Plan at any time by completing a Health Insurance Enrollment Form. Coverage will be effective on the first day of the month following enrollment. Pre-existing condition limitations may apply. Please see the information about pre-existing condition limitations on the preceding page.

Existing employees who choose not to take PEIA health coverage at the time of employment are not eligible to enroll in a managed care plan unless they experience one of the following qualifying events:

- commencement or termination of employment of the employee's spouse;
- a significant change in the health coverage of the employee's spouse attributable to the spouse's employment; or
- employment change due to strike or lock-out.

If you transfer from one participating State agency to another in the middle of a plan year without a lapse in coverage, that transfer does not give you the right to change health plans. You can only change plans if the transfer moves you out of the enrollment area of a plan so that accessing care is unreasonable. Since the PEIA PPB Plan has an unlimited enrollment area, you will not be permitted to transfer out of it during the plan year, even if you move.

When an employee transfers from one participating State agency to another, PEIA will collect updated salary information, and the premium at the new agency will be based on the salary at the new agency, whether it is a salary increase or a decrease. Transfer from a State agency to a non-State agency may permit a change in coverage based on financial hardship.

Life Insurance

Existing employees may add or increase the amount of life insurance at any time by completing an Optional Life Insurance Enrollment Form, submitting a medical information form, and being approved by PEIA's life insurance carrier. Coverage will become effective on the first day of the month following approval by the life insurance carrier.

Newly Eligible Active Employees

Employees who become eligible to enroll for health coverage due to loss of other coverage may enroll for coverage during the calendar month that the previous coverage was lost or the two following calendar months. Newly eligible employees may enroll in the PEIA PPB Plan or a managed care plan. They may make another plan selection during the next open enrollment period.

Dependents

If you enroll your dependents when you enroll, their coverage begins the same day as yours. If you enroll them at a later date, their coverage will become effective the first day of the month following enrollment. If you are adding a dependent to your existing dependent life insurance policy at a date later than the calendar month following an enrollment event, coverage will not become effective until a medical information form has been submitted to, and approved by, PEIA's life insurance carrier.

Additional Dependents

If you wish to add new dependents, such as a new spouse, your biological newborn or adopted child, you must complete enrollment forms to add them to your coverage. Coverage is not automatic.

PEIA PPB Plan

For the PPB Plan, you should enroll new dependents during the calendar month of or the two calendar months following the date they become eligible (i.e., date of marriage, date of birth or adoption) even if you already have family coverage. If you do not complete the proper enrollment forms to have your new dependent(s) added to your coverage within this time frame, the new dependent(s) will be subject to pre-existing condition limitations.

Managed Care Plans

If you are a member of one of the managed care plans offered by PEIA, you must enroll new dependents during the calendar month of or the two calendar months following the date they become eligible (i.e., date of marriage, date of birth or adoption) even if you already have family coverage. If you fail to complete the proper enrollment forms within this timeframe, new dependents cannot be added to your coverage until the next open enrollment period.

Life Insurance

You may add new dependents to your existing dependent life insurance policy during the month of or the two calendar months following the date they become eligible (i.e., date of marriage, date of birth or adoption), and no medical information will be required. Otherwise, you will have to submit a medical information form and be approved to obtain dependent life insurance coverage.

Special Rules for Newborn or Adopted Children

PEIA PPB Plan

Newborn Child

For the PPB Plan, if you enroll your biological newborn child during the calendar month of birth or the two following calendar months, coverage will be made effective retroactive to the date of birth. Otherwise, coverage will be effective on the first day of the month following the date of enrollment and the child may be subject to pre-existing condition limitations. You do not need a Social Security Number to enroll your newborn, but when you get the baby a Social Security Number, please provide it to your benefit coordinator.

Adopted Child

If you enroll an adopted child during the calendar month the child is placed in your home or the two following calendar months, coverage under the PPB Plan can be made effective retroactive to the date of placement. Otherwise, coverage will be effective on the first day of the month following the date of enrollment and the child may be subject to pre-existing condition limitations. However, coverage for an adopted infant will become effective the day the adoptive parents are legally and financially responsible for the medical expenses if bona fide legal documentation is presented to PEIA.

Managed Care Plans

Newborn Child

If you participate in one of the managed care plans, you must enroll your biological newborn child within the calendar month of or the two calendar months following the birth and the coverage will be made effective retroactive to the date of birth. If you do not complete the proper enrollment forms to add your newborn to your coverage within this time frame, you cannot add the newborn child until the next open enrollment period.

Adopted Child

If you enroll an adopted child into your managed care plan during the calendar month the child is placed in your home or the two following calendar months, coverage can be made effective retroactive to the date of placement. If you fail to complete the proper enrollment forms within this timeframe, the adopted child cannot be added to your coverage until the next open enrollment period.

Newborns or adopted children must be enrolled into a managed care plan in either the calendar month of or the two calendar months following an eligibility event or within the open enrollment period. They are not subject to pre-existing condition limitations. Newborns and adopted children cannot be enrolled in your managed care plan at any other time.

Life Insurance

Newborn Child

You should add a biological newborn child to your existing dependent life insurance policy during the calendar month of or the two calendar months following the date of birth. Otherwise, you will have to submit a medical information form and be approved to obtain dependent life insurance coverage for your child.

Adopted Child

You should add an adopted child to your existing dependent life insurance policy during the calendar month of or the two calendar months following the date of placement in your home. Otherwise, you will have to submit a medical information form and be approved to obtain dependent life insurance coverage for your adopted child.

Eligibility and Enrollment for Retired Employees

Who Is Eligible

If you are a retired public employee, you are eligible for PEIA health and life benefits, provided you meet the minimum eligibility requirements of the applicable State retirement system and if your last employer immediately prior to retirement is a participating employer under the State retirement system. Members of the Teacher's Defined Contribution Retirement plan must have 12 or more years of credited service or be age 60 with 5 years of service to qualify to continue PEIA insurance benefits upon retirement. Members who participate in a non-State retirement system must, in the case of education employees (such as TIAA-CREF or similar plans), meet the minimum eligibility requirements of the State Teachers Retirement System, and in other cases, meet the minimum eligibility requirements of the Public Employees Retirement System. If you have questions about your retirement, contact the Consolidated Public Retirement Board (CPRB) toll-free at 1-800-654-4406.

If you have PEIA coverage as an active employee, you may continue coverage into retirement without interruption. To do so, you must complete Retired Employee Enrollment Forms during the calendar month of retirement or the two following calendar months.

Continuous coverage and employment are necessary if you wish to use your accrued sick and/or annual leave for extended employer-paid PEIA coverage. You cannot defer your sick and/or annual leave.

If you were not covered under a PEIA Plan as an active employee or if you allow your coverage to lapse, you may choose to enroll for health coverage at the time of your retirement if your last employer immediately prior to retirement is a participating employer under the State retirement system and as long as you meet the minimum qualifications. Coverage will be effective on the first day of the month following enrollment.

Please Note: If you retire, then return to active employment with a participating agency, you will lose your right to use your sick and/or annual leave for extended employer-paid PEIA coverage. When you return to active employment and have PEIA benefits as an active employee, your new effective date of coverage in the PEIA plan will be after July 1, 2001, and therefore you will be ineligible for the sick/annual leave benefit.

Deferred Retirement

If you defer your retirement from a participating employer under the State retirement plan, you may not re-enroll in PEIA if you have other (private sector) employment just prior to retirement. To be eligible to enroll in PEIA, your last employer prior to retirement must have been a public entity that participates in the State retirement system.

Employees with 20 or more years of service, but who have not retired, may defer enrollment in PEIA health benefits for up to two (2) years following separation. If and when these employees choose to enroll for health coverage, they will be required to pay 105% of the total premium for the coverage they choose. Enrollees in this category will not be eligible for PEIA's premium assistance program or retiree premium subsidy.

Disability Retirement

A member who is granted disability retirement by a state retirement system is eligible to continue coverage in the PEIA Plan as a retired employee. Members in this category pay the same premiums as those with 25 or more years of service.

Medicare

As a retired employee, when you become an eligible beneficiary of Medicare, you must enroll in Medicare Part A **and** Medicare Part B. Part A is an entitlement program and is available without payment of a premium to most individuals. Part B is the supplementary medical insurance program that covers physician services, outpatient laboratory and x-ray tests, durable medical equipment and outpatient hospital care. Part B is a voluntary program that requires payment of a monthly premium.

If you do not enroll in Medicare Part B, PEIA will process your claims as if you did have the Part B coverage. In other words, PEIA will pay only the amount we would have paid if Medicare had processed your claim and made a payment. If you are Medicare eligible but still an active employee, PEIA will pay as the primary plan, Medicare will be secondary, and it is not necessary for the active employee to enroll in Medicare Part B.

If you become eligible for Medicare prior to age 65, please send a copy of your Medicare card to PEIA. This notification may allow PEIA to reduce your premiums, and will make the claims payment process go much more smoothly.

Beginning January 1, 2006, Medicare will offer a new program, Medicare Part D (prescription drug coverage). Please be aware that you DO NOT have to purchase Medicare Part D (prescription drug coverage) when it becomes available on January 1, 2006. PEIA will continue to provide prescription drug coverage to our Medicare members, and Medicare Part D will be of little or no use to you.

Dependents

If you elect PEIA coverage, you may also enroll the following dependents:

- your legal spouse;
- your biological or adopted children under age 19;
- stepchildren who live with you and are under age 19;
- children under age 19 who are members of your household and fully dependent upon you for support and maintenance (a notarized statement from the member affirming the member's 100% financial responsibility for the dependent is required); and
- children or stepchildren over age 19 who live with you and are incapacitated and cannot support themselves due to a physical or mental disability which began before age 19 (or age 25 if a full-time student).

Coverage for dependent children may be extended to the end of the month in which they reach age 25 if they are full-time students. See page 17, "Full-time Students Age 19 and Over" for details.

Married children are not eligible for coverage.

How to Enroll

You may enroll for PEIA health and life benefits by completing enrollment forms through your retirement system. On these forms, you will select the types of coverage you want and enroll the eligible dependents you wish to cover.

Participation in PEIA benefit plans is not automatic; you must complete the proper enrollment forms. Enrollment will authorize your retirement system to deduct the premiums for the coverages you select from your annuity.

There are restrictions on how and when you may enroll and make changes in your coverage. Please read all parts of the "Eligibility" section of this booklet carefully before you enroll, so that you will fully understand your options and responsibilities.

PEIA PPB Plan

You may enroll in the PEIA PPB Plan regardless of age or Medicare status. The PEIA PPB Plan coordinates benefits with Medicare, so when you are retired and eligible for Medicare, the PEIA PPB Plan will generally cover what Medicare does not. For more details, see the "Coordination of Benefits" section of this book.

Managed Care Plans

As a retired employee, you may enroll in a managed care plan if you are not yet eligible for Medicare. If you or any enrolled dependents have Medicare as your primary health coverage (or will at any time during the plan year) you may not join an HMO. Your only option for PEIA-sponsored Medicare supplement coverage is the PEIA PPB Plan. If either you or your enrolled dependents become Medicare-primary while enrolled in a managed care plan, you must notify PEIA and transfer to the PEIA PPB Plan. Generally, Medicare is primary when the policyholder is retired. If you have more questions about when Medicare is primary, call PEIA's Customer Service Unit at 1-888-680-7342.

Life Insurance

If you wish to elect new or increased optional life insurance as a retired employee, you must enroll and submit a medical information form during the calendar month of retirement or the two following calendar months. Coverage will be effective pending the approval of PEIA's life insurance carrier. You may not elect or increase optional life insurance after this period.

You may continue dependent life insurance after retirement by completing the Retired Employee Optional Life Insurance Enrollment Form during the calendar month of retirement or the two following calendar months.

Plan Year 2006

Dependents

If you enroll your dependents when you enroll, their coverage begins the same day as yours. If you enroll them at a later date, their coverage will become effective the first day of the month following enrollment. If you are adding a dependent to your existing dependent life insurance policy at a date later than the calendar month following an enrollment event, coverage will not become effective until a medical information form has been submitted to, and approved by, PEIA's life insurance carrier.

Additional Dependents

If you wish to add new dependents, such as a new spouse, your biological newborn or adopted child, you must complete enrollment forms to add them to your coverage. Coverage is not automatic.

PEIA PPB Plan

For the PPB Plan, you should enroll new dependents during the calendar month of or the two calendar months following the date they become eligible (i.e., date of marriage, date of birth or adoption) even if you already have family coverage. If you do not complete the proper enrollment forms to have your new dependent(s) added to your coverage within this timeframe, the new dependent(s) will be subject to pre-existing condition limitations.

Managed Care Plan

If you are a member of one of the managed care plans offered by PEIA, you must enroll new dependents during the calendar month of or the two calendar months following the date they become eligible (i.e., date of marriage, date of birth or adoption) even if you already have family coverage. If you fail to complete the proper enrollment forms within this timeframe, new dependents cannot be added to your coverage until the next open enrollment period. Additional dependents cannot be enrolled in your managed care plan at any other time.

Life Insurance

Add new dependents to your existing dependent life insurance policy during the calendar month of or the two calendar months following the date they become eligible (i.e., date of marriage, date of birth or adoption). Otherwise, you will have to submit a medical information form and be approved to obtain dependent life insurance coverage.

Special Rules for Newborn or Adopted Children

PEIA PPB Plan

Newborn Child

For the PPB Plan, if you enroll your biological newborn child during the calendar month of birth or the two following calendar months, coverage will be made effective retroactive to the date of birth. Otherwise, coverage will be effective on the first day of the month following the date of enrollment and the child may be subject to pre-existing condition limitations. You do not need a Social Security Number to enroll your newborn, but when you get the baby a Social Security Number, please provide it to your benefit coordinator.

Adopted Child

If you enroll an adopted child during the calendar month the child is placed in your home or the two following calendar months, coverage under the PPB Plan can be made effective retroactive to the date of placement. Otherwise, coverage will be effective on the first day of the month following the date of enrollment and the child may be subject to pre-existing condition limitations. However, coverage for an adopted infant will become effective the day the adoptive parents are legally and financially responsible for the medical expenses if bona fide legal documentation is presented to PEIA.

Managed Care Plans

Newborn Child

If you participate in one of the managed care plans, you must enroll your biological newborn child within the calendar month of or the two calendar months following the birth and the coverage will be made effective retroactive to the date of birth. If you do not

complete the proper enrollment forms to add your newborn to your coverage within this time frame, you cannot add the newborn child until the next open enrollment period.

Adopted Child

If you enroll an adopted child into your managed care plan during the calendar month the child is placed in your home or the two following calendar months, coverage can be made effective retroactive to the date of placement. If you fail to complete the proper enrollment forms within this timeframe, the adopted child cannot be added to your coverage until the next open enrollment period.

Newborns or adopted children must be enrolled into a managed care plan in either the calendar month of or the two calendar months following an eligibility event or within the open enrollment period. They are not subject to pre-existing condition limitations. Newborns and adopted children cannot be enrolled in your managed care plan at any other time.

Life Insurance

Newborn Child

You should add a biological newborn child to your existing dependent life insurance policy during the calendar month of or the two calendar months following the date of birth. Otherwise, you will have to submit a medical information form and be approved to obtain dependent life insurance coverage for your child.

Adopted Child

You should add an adopted child to your existing dependent life insurance policy during the calendar month of or the two calendar months following the date of placement in your home. Otherwise, you will have to submit a medical information form and be approved to obtain dependent life insurance coverage for your adopted child.

Eligibility and Enrollment for Surviving Dependents

Who Is Eligible

If you are a surviving dependent of an active or retired public employee, and you were insured by PEIA (either in the PEIA PPB Plan or in a managed care plan) at the time of the employee's death, you may elect to continue coverage under your health plan. Surviving dependents are not eligible for life insurance coverage. **Eligibility of a surviving spouse for PEIA coverage terminates upon remarriage.** If a divorce occurs after the remarriage, re-enrollment as a surviving dependent is not allowed.

Dependents

If you elect PEIA coverage, you may also enroll the following dependents who were covered at the time of the policyholder's death:

- your biological or adopted children under age 19;
- stepchildren who live with you and are under age 19;
- children under age 19 who are members of your household and fully dependent upon you for support and maintenance (a notarized statement from the member affirming the member's 100% financial responsibility for the dependent is required); and
- children or stepchildren over age 19 who live with you and are incapacitated and cannot support themselves due to a physical or mental disability which began before age 19 (or age 25 if a full-time student).

Coverage for dependent children may be extended to the end of the month in which they reach age 25 if they are full-time students. See page 17, "Full-time Students Age 19 and Over—Student Verification," for details.

Married children are not eligible for coverage.

How to Enroll

To continue coverage without interruption, surviving dependents must complete enrollment forms in the calendar month death occurs or the two following calendar months. Surviving dependents must enroll in the same plan in which they were covered at the time of the policyholder's death. During open enrollment, you may select any plan for which you are eligible.

Surviving dependents are not eligible for life insurance.

Special Eligibility Situations

If You And Your Spouse Are Both Public Employees

Two public employees who are married to each other, but who are both eligible for benefits under PEIA may elect to enroll as follows: 1) as Family with Employee Spouse in any plan; 2) as "Employee Only" and "Employee and Child(ren)" in two different plans; 3) as "Employee Only" and "Employee and Child(ren)" in the PPB Plan (remember you'll have two deductibles and two out-of-pocket maximums this way); or 4) as "Employee Only" and "Employee and Child(ren)" in the same managed care plan. All children must be enrolled under the same policyholder. If no children are to be covered, you may enroll as "Family with Employee Spouse" or as separate "Employee Only" plans.

Both employees are eligible to enroll for the basic life policy, as well as optional and dependent life insurance.

Since both spouses, as policyholders, are eligible to make independent benefit elections, both spouses receive the Shopper's Guide, Tobacco Affidavit/Transfer Form, Summary Plan Description, and other relevant benefit information.

Transfer from One Participating Agency to Another

If you transfer from one participating State agency to another in the middle of a plan year without a lapse in coverage, you may continue your PEIA coverage uninterrupted. Such a transfer does not create an initial enrollment period, and does not give you the right to change health plans. You can only change plans if the transfer moves you out of the enrollment area of a plan so that accessing care is unreasonable. Since the PEIA PPB Plan has an unlimited enrollment area, you will not be permitted to transfer out of it during the plan year, even if you move.

When an employee transfers from one participating State agency to another, PEIA will collect updated salary information, and the premium at the new agency will be based on the salary at the new agency, whether it is a salary increase or a decrease. Transfer from a State agency to a non-State agency may permit a change in coverage based on financial hardship.

Full-time Students Age 19 and Over

Student Verification

Coverage for a dependent child ceases at the end of the month in which the child reaches age 19; however, coverage may be extended (on a year-to-year basis) to age 25 if the child is unmarried, enrolled as a full-time student, and dependent on you for support and maintenance.

"Enrolled as a full-time student" means the child attends courses full-time (as determined by the institution) in a graduate or undergraduate college or university (other than a U.S. Military academy when the academy considers the student to be on active duty) or attends a trade or professional school as the child's full-time occupation.

Student verification is a two-step process:

1. Verification of full-time student status will be requested by PEIA when your child turns age 19.
2. In the fall of each subsequent year, you must verify your child's full-time student status by providing a completed student verification form or letter from the school's registrar.

Annual Student Verification Process

Each August PEIA mails Student Verification Letters to policyholders who have dependent children over age 19. It is your responsibility to complete the student verification process by the deadline given in that letter. Because school terms vary, PEIA will accept pre-registrations, but the policyholder will be required to notify PEIA once the school term has begun if the child chooses not to attend, withdraws from school, or does not maintain full time student status at the institution in which he or she is enrolled.

Once you have verified full-time student status, your eligible student will be covered through the following August 31 as long as he or she remains a full-time student throughout the regular school year. If a student is not returning to full-time status in the fall, COBRA dependent coverage may be elected, and it will be effective September 1 of that same year.

If you do not complete the annual student verification process by the deadline in the Student Verification Letter, PEIA will assume that the dependent is no longer a full-time student and will terminate coverage for that student effective August 31. To have coverage reinstated, you will have to provide verification of student status and complete a Change-in-Status form from your benefit

coordinator to add the child back to your coverage. In this case, there will be a lapse in coverage, and any claims incurred while coverage is not in force will be the responsibility of the policyholder. Also, when the student is reinstated after the lapse in coverage, he or she may be subject to pre-existing condition limitations as a new enrollee.

Withdrawal for Medical Necessity

If it becomes medically necessary for your child to cut back to part-time status or withdraw temporarily from school, he or she may continue to be covered under the PEIA plan for one year under an approved medical leave. You will be asked to provide documentation from your child's physician verifying that the illness or injury prevents the student from attending classes full-time, and the date your child may be expected to return to full-time status. If the medical leave extends beyond one year, you may apply to cover that child as a disabled child. Approval will be granted at the discretion of PEIA's medical director.

Loss of Full-time Student Status

If your child loses eligibility because he or she is no longer a full-time student, you should notify your benefit coordinator promptly. Continued coverage under COBRA will be available if the loss of eligibility is reported promptly. If you fail to notify your benefit coordinator promptly, your employing agency may look to you for reimbursement of premiums your employer paid in error.

Return to Full-time Status

If your child (age 19 or over) voluntarily withdraws from school, has a lapse in coverage, and later re-enrolls as a full-time student, he or she may be reinstated for PEIA coverage. You must complete a Change-in-Status form and add this child to your list of dependents again to reinstate this coverage. This child may be subject to pre-existing condition limitations.

Working Families Tax Relief Act (WFTRA) of 2004

As a result of the Working Families Tax Relief Act (WFTRA) of 2004, the federal IRS has changed the way it treats children under the tax code. This change may affect you if you pay your health and life insurance premiums pre-tax through a Section 125 premium conversion plan.

The IRS has developed a new definition for "qualified child" and "qualified relative." If you have dependents, they must meet one of these definitions to qualify for you to pay your premiums on a pre-tax basis. In nearly all circumstances, if your dependent meets PEIA eligibility criteria, they will also meet one of these federal definitions. The new definitions are as follows:

A "qualifying child" (QC) is a child who:

- has a specific, family-type relationship to the employee-taxpayer.
- resides with the employee in his/her household for more than half of the tax year (with certain exceptions such as "temporary absences" if a full-time student).
- is under age 19 and not a full-time student (under age 24 if a full-time student) as of the end of the calendar year in which the employee's taxable year begins. There is no age requirement if a child is permanently and totally disabled.
- has not provided more than half of his/her own support. The employee-taxpayer no longer has to provide over half of the dependent-child's support for the tax year, unless s/he is a full-time student.

A "qualifying relative" (QR) is a "too old" child or other individual who:

- has a specific, family-type relationship to the employee-taxpayer, or is someone (other than a spouse) who resides with the employee in his/her household for the employee's taxable year. A person will not be a member of the employee's household if at any time during the taxable year the relationship between the employee and the person violates local law.
- receives over half of his/her own support from the employee-taxpayer.
- is not anyone's "qualifying child"

This change from the IRS *does not* change PEIA's eligibility rules. It does not create any new category of eligible dependents, or make people who were previously ineligible for coverage now eligible. It simply redefines the way the IRS treats dependent children age 24 and over for tax purposes. We are required to provide this information in the Summary Plan Description.

Disabled Child

Your dependent child may be covered after reaching age 19 if he or she is incapable of self-support because of mental or physical disability.

To be eligible:

- the disabling condition must have begun before age 19, or before age 25 if a full-time student; and
- the child must be incapable of self-sustaining employment and chiefly dependent on you for support and maintenance.

To continue this coverage, contact PEIA for an application. You will be asked to provide documentation when the child reaches age 19 and periodically thereafter.

Court-Ordered Dependent (COD)

If a PEIA-insured employee and his or her spouse divorce, and the employee is not the custodial parent for the dependent child(ren), the employee may continue to provide medical benefits for the child(ren) through the PEIA plan. If the non-custodial parent is ordered by the court to provide medical benefits for the child(ren), the custodial parent may submit medical claims for the court-ordered dependent(s), and benefits may be paid directly to the custodial parent. Special claim forms are required. The custodial parent will also receive Explanations of Benefits (EOBs) for the CODs as claims are processed. Contact PEIA to discuss this benefit.

Medicare and Active Employees

If an active employee becomes eligible for Medicare, the PEIA PPB Plan remains the primary insurer for that employee, except if the employee attains Medicare eligibility due to End Stage Renal Disease (ESRD). As long as you are an active employee, you do not need to sign up for Medicare Part B and pay the premium. When you prepare to retire, you must enroll for Medicare Part B. If you do not enroll in Medicare Part B, PEIA will process your claims as if you did have the Part B coverage. In other words, PEIA will pay only the amount we would have paid if Medicare had processed your claim and made a payment.

For PEIA PPB Plan active employees who are also eligible for Medicare, and Medicare is the primary payor (as in the case of ESRD), PEIA will use the traditional method of coordinating benefits.

If you become eligible for Medicare prior to age 65, please send a copy of your Medicare card to PEIA. This notification will make the claims payment process go much more smoothly.

If the spouse or dependent of an active employee becomes eligible for Medicare, the PEIA PPB Plan remains the primary insurer for that spouse or dependent as long as the policyholder remains an active employee. When the policyholder retires, PEIA becomes the secondary insurer for any spouse or dependent(s) on Medicare.

Leaves of Absence

It is the employer's responsibility to make the determination regarding an employee's eligibility for a leave of absence. It is important to note that a leave of absence is intended for an employee who is expected to return to work and for whom the employer maintains an open position. It is not intended to extend medical benefits for individuals who are not eligible to retire and not able to return to work, or for whom a position is not being held open. Such a person is not an employee and it is improper to continue his or her health coverage as if he or she were still an employee. Employers are reminded that under State law it is a felony to misrepresent any material fact to obtain PEIA benefits to which a person is not entitled (W. Va. Code §5-16-12).

Return from a leave of absence does not constitute a qualifying event which would allow the member to change plans during the plan year.

Medical Leave (Non-Workers' Compensation)

Any employee who is on a medical leave of absence due to an injury or illness that is not covered by Workers' Compensation is eligible to continue coverage subject to the following:

- the medical leave must be approved by the employer;
- the employee and employer must continue to pay their respective proportionate shares of the premium cost. If the employee fails to pay his or her premium, the employer may terminate coverage;
- the employer is obligated to pay its share only for a period of one year, after which the employee may be required to pay the full cost of coverage. If the employee fails to pay his or her premium, the employer may terminate coverage; and
- each month the employee must submit to the employer a physician's statement certifying that the employee is unable to return to work. The employer must retain these statements in the employee's personnel file.

Medical Leave (Workers' Compensation)

Any employee who is on a leave of absence and is receiving temporary total disability benefits from Workers' Compensation is entitled to continue PEIA coverage until he or she returns to work. The employer and employee must continue to pay their respective proportionate shares of the premium cost for as long as the employee receives temporary total disability benefits. If the employee fails to pay his or her premium, the employer may terminate coverage.

Personal Leave

An employee may continue insurance coverage while on a personal leave of absence approved by the employer. The monthly premium will be paid according to the policy or agreement established by your employer. If the employee fails to pay his or her premium, the employer may terminate coverage.

Family Leave

An employee may continue insurance coverage during an approved family leave. If the employee fails to pay his or her premium, the employer may terminate coverage. Contact your benefit coordinator for further details regarding the federal Family and Medical Leave Act (FMLA).

Military Leave

For an employee on military leave with pay, health and life insurance benefits will generally continue without interruption, as long as the employee is on the payroll.

An employee who is on an approved military leave of absence without pay, due to an active call of duty from the President, is entitled to continue health and life benefit coverage for as long as premium payments are made. The employee is responsible for paying their employee share of the premium costs for each month during the military leave of absence, and Governor Wise's Executive Order No. 19-01 requires the employer to pay its share. Upon return from a military leave, if there has been a lapse in coverage, the employee may generally reinstate the same health and/or life insurance benefits without penalty.

Leaves of Absence for Teachers and Service Personnel

Any teacher or school service employee who is returning from an approved leave of absence of one year or less shall be restored to the same benefits which he or she had at the time of the approved leave of absence.

Other Eligibility Details

Annual Open Enrollment

Each Spring PEIA holds an open enrollment period for health coverage during which PEIA insureds may choose from among managed care plans and the PEIA PPB Plan. The period is typically the first Monday in April through the first Friday in May. During Open Enrollment, participants may move between plans without penalty and no pre-existing condition limitations will be applied. Choices made during the open enrollment period are effective on July 1 of that year.

During Open Enrollment, eligible policyholders who have not taken advantage of any health coverage from PEIA also have the opportunity to enroll in the PEIA PPB Plan or any managed care plan, subject to the deadlines and rules in force for that enrollment period. Pre-existing condition limitations will not apply when eligible active or retired individuals enroll in a managed care plan during open enrollment. Pre-existing condition limitations do apply to new enrollees in the PPB Plan. See *How to Enroll* on page 7 for details about life insurance in this case.

Selections made during Open Enrollment are effective on July 1 of that year, and remain in effect for a full plan year unless the member moves outside the service area of his or her managed care plan. A physician's withdrawal from a managed care plan does not qualify a member to change plans in the middle of a plan year.

In advance of Open Enrollment PEIA allows members the opportunity to sign up for online enrollment. If a member chooses online enrollment, he or she commits to completing the open enrollment on PEIA's secure website. If a member does not choose online enrollment, then active employees and non-Medicare retirees are mailed a Tobacco Affidavit and Transfer Form; Medicare retirees receive a Retiree Tobacco Affidavit.

At the beginning of Open Enrollment, PEIA mails a *Shopper's Guide* to all active and non-Medicare retiree policyholders. The *Shopper's Guide* provides a side-by-side comparison of the general attributes of all plans offered. It is intended as a general guide to the available plans. Members requiring further information about a specific plan should contact that plan directly.

Following Open Enrollment, all plan members are mailed a confirmation letter showing their chosen plan, type of coverage and tobacco status for the next plan year. These letters are mailed in early June.

Medical Identification Cards

Each plan mails ID cards to its members. Managed care plans issue ID cards each year. PEIA issues cards upon enrollment in the plan, and subsequently when there are changes in the plan that warrant it.

Your PEIA PPB Plan ID card verifies that you have medical and prescription drug coverage through PEIA. On the back we've listed important phone numbers you may need. One card will be issued for individual coverage, and two cards will be issued for family coverage. The policyholder's name and identification number will be printed on all cards. If you want additional cards for children not residing with you, or if you need to replace a lost card, please contact Express Scripts at 1-877-256-4680.

If you enroll in a managed care plan, you will receive an identification card from that plan, not from PEIA. For additional or replacement cards, call your plan.

Your Responsibility To Make Changes

It is your responsibility to keep your PEIA enrollment records up to date. You must notify your benefit coordinator immediately of any changes in your family situation, and complete the appropriate change forms to keep your PEIA coverage up to date. Examples of such changes include a change of address, a change in your marital status, or a dependent child no longer qualifying for coverage.

You should do this whether you belong to the PEIA PPB Plan, a managed care plan or if you've elected only life insurance coverage. If you fail to notify your benefit coordinator promptly of changes in your family status, your employing agency may look to you for reimbursement of premiums your employer paid in error.

When Coverage Ends

In most cases when your employment ends you have the option to extend health coverage under the federal COBRA law, or convert your life insurance benefits into a private policy. All of these options are at your expense and require you to act within a specified time. Please see the section on "Options After Termination of Coverage" beginning on page 24.

Voluntary Termination

PEIA coverage for an active policyholder and any covered dependents terminates at the end of the month in which the employee voluntarily ceases employment, or goes off the payroll.

Involuntary Termination

A policyholder who is terminated from employment involuntarily or through a reduction of work force may continue coverage for three additional months after the end of the month in which employment ends. The policyholder will be responsible for paying the employee's share of the premium during these three months.

Retired/Retiring Employees

Coverage for an employee who has already retired will terminate at the end of the calendar month in which the retiree elects no longer to participate.

For retiring employees, coverage will terminate at the end of the month in which the employee goes off the payroll, unless forms have been completed to continue coverage through their retirement system. If you are not yet eligible for Medicare, then your retirement does not qualify you to change health care plans. If you are enrolled in a managed care plan as an active employee, then you must remain in that managed care plan upon retirement until the next open enrollment, when you may choose any plan for which you are eligible. If Medicare becomes the primary coverage for you or your dependents while enrolled in a managed care plan, you must transfer to the PEIA PPB plan.

Dependents/Surviving Dependents

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

- policyholder (active or retired) terminates or loses coverage;
- dependent spouse is divorced from employee;
- dependent child reaches 19th birthday;
- dependent child marries;
- dependent child who has extended coverage beyond age 19 as a full-time student reaches his/her 25th birthday or ceases full-time student status;
- surviving spouse remarries;
- disabled dependent no longer meets disability guidelines; or
- policyholder voluntarily removes dependent from coverage.

Failure To Pay Premium

Your coverage as an active or retired policyholder, and coverage of your dependents, will be terminated if you fail to pay your premium contributions when due. Premiums are due by the fifth day of the month following the month for which the premium was invoiced. Example: May premium is due June 5. If payment is not received by PEIA within 15 days following the due date, all medical

claims will be pended. Additionally, the PEIA drug card will be suspended. If payment is not received within 30 days following the due date, coverage will be cancelled, and all claims incurred will be your personal responsibility.

Non-State Agency Employer Withdrawal From The Plan

By its agreement to participate in the PEIA plan, a non-State entity is required by PEIA to stay in the plan for a minimum of three years. If a participating county or municipal government or other employer withdraws or is terminated from the PEIA plan, coverage for all affected insureds ends on the effective date of that employer's withdrawal/termination.

Retirees eligible to participate in the Consolidated Public Retirement System (CPRS) may continue participation in PEIA. The withdrawn agency is billed a subsidy premium for these retirees. Retirees not eligible to participate in CPRS must look to their former employer for retiree coverage.

Certificate of Creditable Coverage

A Certificate of Creditable Coverage will be generated automatically upon termination of health coverage. You will need this certificate to verify your coverage under PEIA and avoid pre-existing condition limitations if you are enrolling in another benefit plan. If additional certificates are needed, contact PEIA's Customer Service Unit.

Options After Termination of Coverage

If your PEIA coverage terminates, you may have a right to continue health and life coverage. Your options are explained below.

Continuing Health Coverage under COBRA

You and your enrolled dependents may have the right to continue your current health coverage for a limited time under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). PEIA's COBRA program is administered by Acordia National, and all COBRA eligibility is maintained by Acordia National. New enrollees in any PEIA-sponsored health plan will receive a detailed notice of their COBRA rights from Acordia National.

You and/or your dependents may elect to continue coverage for up to 18 months due to termination of your employment (other than by reason of gross misconduct) or reduction in work hours.

Your dependents are eligible to continue coverage in their own right for a maximum of 36 months under COBRA in the case of:

- divorce or legal separation;
- loss of eligibility of dependent children; or
- death of employee.

An election to continue coverage under COBRA must be made within 60 days of the end of the coverage. If you elect to continue coverage under COBRA, you will be responsible for paying the full premium plus a 2% administrative fee. Please note that COBRA premiums are billed directly to you.

To enroll for COBRA benefits, contact Acordia National at 1-888-440-7342.

If 18 months of COBRA coverage is provided due to termination or reduction in hours of employment, and if any COBRA beneficiary is determined to be disabled under the Social Security Act at any time during the first 60 days of this COBRA coverage, then the 18-month continuation period may be extended to 29 months for all individuals who are qualified beneficiaries. The disabled person can be a covered employee or a dependent. The disability determination must be reported to PEIA within 60 days of the determination and before the end of the original 18-month coverage period.

Under COBRA, PEIA will charge 150% of the applicable premium for coverage during the 11-month disability extension. If a second qualifying event occurs during the 11-month extension, entitling a qualified beneficiary to 36 months of coverage (an additional 7 months of coverage), then PEIA will charge 150% of the applicable premium until the end of the 36-month continuation coverage period.

Coverage under COBRA will cease under these circumstances ("you" refers to the person who elected COBRA):

- you become covered under another group plan (unless it contains a pre-existing condition exclusion that reduces your benefits);
- you become entitled to Medicare;
- you fail to pay the premium;
- the policyholder's former employer withdraws or is terminated from the PEIA plan; or
- the PEIA PPB Plan ends.

If you are covered by another health plan or Medicare before the COBRA election is made, you may make a COBRA election. In other words, your employer may end the right to COBRA continuation coverage based upon other group health plan coverage or entitlement to Medicare benefits only if the qualified beneficiary first becomes covered under the other group health plan coverage or entitled to (covered for) the Medicare benefits after the date of the COBRA election.

When coverage under COBRA ends, you have the option to convert your coverage to an individual policy.

Converting Health Coverage to an Individual Policy

If you have been covered by PEIA (either under the PEIA PPB Plan or through one of the managed care plans) and your coverage ends, you may apply for individual health coverage. Your covered dependents may also have this right.

Please call PEIA at 1-304-558-7850 or toll-free at 1-888-680-7342 to discuss your options. Benefits under an individual policy are determined by the insurer, and may differ substantially from the PEIA plan. Premiums for individual policies are generally higher than rates for a group plan like the PEIA PPB Plan.

If your coverage has been continued under COBRA, then you may apply for an individual policy when your COBRA coverage ends.

Converting Life Insurance to an Individual Policy

When employment ends, you may convert all or part of the life insurance coverage into an individual policy. Dependents who lose eligibility for life insurance coverage may convert optional dependent life insurance to an individual policy. This provision does not apply to retired employees or their dependents.

You must submit an application and remit the first premium within 31 days after the termination of the life insurance coverage. Coverage under the individual policy will become effective the day after the group life insurance coverage ends.

To obtain a Life Insurance Conversion Application Form, call PEIA at 1-304-558-7850 or toll-free at 1-888-680-7342. The individual life insurance policy is issued by PEIA's life insurance carrier, not PEIA. Once you have completed the application form, mail it to the address printed on the application form. Premiums for individual policies are generally higher than rates for a group plan.

Paying For Benefits

Each year the PEIA Finance Board sets premium rates for the PEIA PPB Plan. PPB Plan premiums are set at a level that ensures that the premiums collected from employers and employees will pay the anticipated claims for that year. Managed care plan premiums are also set annually prior to Open Enrollment.

Your coverage as an active or retired policyholder, and coverage of your dependents, will be terminated if you fail to pay your premium contributions when due.

Tobacco-free Discount

PEIA's PPB Plan premiums and optional life insurance premiums are based on the tobacco-use status of insureds. Tobacco-free insureds will receive the preferred monthly premium rate. Plan insureds must have been tobacco-free for 6 months prior to the beginning of the Plan Year to qualify for the discount for the entire plan year. Members who become tobacco-free during a plan year may apply for the discount when they have been tobacco-free for at least six months. Newly hired PPB Plan insureds must have been tobacco-free for 6 months prior to their effective date of coverage to qualify for the discount.

Tobacco-free insureds must sign an affidavit each year and return it during Open Enrollment to receive the reduced premium rate for the following full plan year. For family coverage, all enrolled family members must be tobacco-free to qualify the family for the reduced rate. PEIA reserves the right to review medical records to check for tobacco use. PEIA offers a tobacco cessation benefit. See page 51 for details.

If the tobacco affidavit is not submitted by the insured during Open Enrollment, the insured will not receive the tobacco-free discount until a completed tobacco affidavit is submitted. PEIA has sixty days from receipt of the tobacco affidavit to process the request and implement the discount. The tobacco-free discount will apply only for the remainder of the plan year, and WILL NOT be applied retroactively. No refunds will be granted to members who submit tobacco affidavits after open enrollment.

Active Employees

If you are an active employee of a State agency, college, university or county board of education, most of your health insurance premium is paid by your employer. The amount of your contribution is determined by your salary, the type of coverage you choose, and your tobacco-use status.

If you are an active employee of a local government agency, your employer will set your health insurance premium contribution level. You may pay anywhere from 0% to 100% of the premium that PEIA charges to your employer.

Retired Employees

Premiums for most retired employees are deducted from their annuity on a monthly basis. Some retired employees pay premiums directly to the PEIA each month, and for them, premiums are due by the fifth of the month following the month for which the premium was invoiced. Example: May premium is due June 5. If premium payment is not received by PEIA within 15 days following the due date, all medical claims will be pended. Additionally, the PEIA drug card will be suspended. If payment is not received within 30 days following the due date, coverage will be cancelled, and all claims incurred will be the policyholder's personal responsibility. PEIA offers a direct draft option for premium payment. Call PEIA for details.

Retired Employees Who Retired Before July 1, 1997

Retired employees who retired prior to July 1, 1997, pay premiums based on the plan they choose, their tobacco-use status and eligibility for Medicare. Generally, retired employees' contributions pay for about 30% of the cost of their claims. The remaining 70% of the cost is paid by employers. Eligible retired employees may use sick and/or annual leave to extend employer-paid health coverage.

Employees Who Retire On or After July 1, 1997

Employees who retire on or after July 1, 1997, pay premiums for their health coverage based on the plan they choose, their eligibility for Medicare, their tobacco-use status, and their credited years of service as reported by the Consolidated Public Retirement Board (CPRB), or for those in the Teachers Defined Contribution Plan or a non-State retirement plan, the years of service reported by the employing agency or the non-State plan. These premiums may be adjusted annually for medical inflation. Employees with 25 or more years of service will be charged the same premium as those who retired before July 1, 1997. Those with fewer than 25 years of service will pay higher premiums. If you are using accrued sick and/or annual leave or years of service to extend your employer-paid insurance, all, or a portion of this increased premium will be covered by your accrued leave. Disability retiree premiums are assessed on twenty-five (25) years of service.

Deputy Sheriffs

Deputy sheriffs who retire prior to attaining age 55 have two benefit plan options available to them. Those considering early retirement should call PEIA for details of their plans and premium requirements.

Surviving Dependents

Surviving dependents of public employees pay premiums for their health coverage based on the plan they choose, their eligibility for Medicare and their tobacco-use status. These premiums may be adjusted annually for medical inflation. Surviving dependents are considered to have 25 or more years of service, and will be charged the same premium as those who retired before July 1, 1997.

Premiums for some surviving dependents are deducted from their annuity on a monthly basis. Some surviving dependents pay premiums directly to the PEIA each month, and their premiums are due by the fifth of the month following the month for which the premium was invoiced. Example: May premium is due June 5. If payment is not received by PEIA within 15 days following the due date, all medical claims will be pended. Additionally, the PEIA drug card will be suspended. If payment is not received within 30 days following the due date, coverage will be cancelled, and all claims incurred will be the policyholder's personal responsibility. PEIA offers a direct draft option for premium payment.

Extending Employer-Paid Insurance Upon Retirement

You may be eligible to extend your employer-paid insurance upon retirement, but how you do that is determined by your employer. To take advantage of this benefit, you must move directly from active public employment into your respective retirement system. If you choose to defer your retirement, you cannot defer your sick and annual leave for use later. Elected public officials are not eligible for this benefit. This benefit terminates when the policyholder dies; it cannot be used by surviving dependents, who may continue coverage by paying the monthly premium.

You may also have the option to use your accrued leave to increase your retirement benefits from your retirement system. You must choose between additional retirement benefits and extended employer-paid insurance coverage. You may not use some of your accrued leave to increase your retirement benefit and the rest to extend your employer-paid insurance coverage. Once this election is made, you may not revoke the selection.

Using Accrued Sick and Annual Leave to Extend Coverage

If you are an employee of a State agency or a county board of education (or an eligible employee of a local agency) with coverage through a PEIA plan and have accrued sick and/or annual leave when you retire, you may use that accrued leave to extend your employer-paid insurance coverage. You must be enrolled in a PEIA plan or a PEIA-sponsored managed care plan or a group life insurance plan offered by PEIA prior to your retirement to qualify. This extended coverage must be for full months. Employees hired on or after July 1, 2001, are not eligible for this benefit.

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

If you and your spouse are both public employees eligible for extended employer-paid insurance coverage, you may combine your accrued leave to extend your family coverage provided each of your respective employers agrees. Certain restrictions apply. See your benefit coordinator for details.

The amount of this benefit depends on when you came into the PEIA plan as follows:

Before July 1, 1988:

If you are an employee who has been continuously covered by PEIA since before July 1, 1988, then your additional coverage is calculated as follows:

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

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

Between July 1, 1988 and June 30, 2001:

If you were hired after July 1, 1988 and before July 1, 2001, or if you had a lapse in coverage during this period then your additional coverage is calculated as follows:

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

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

On or after July 1, 2001:

If you were hired on or after July 1, 2001, or if you had a lapse in coverage during this period, you are not eligible for extended employer-paid insurance upon retirement.

Extending Coverage for Higher Education Faculty

If you are a full-time faculty member employed on an annual contract basis for a period other than 12 months, you may extend your employer-paid insurance coverage based on your years of teaching service. Your benefit is calculated as follows:

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

5 years of teaching service = 1 year of family coverage

Retired Employee Premium Assistance Program

Retired employees whose total annual income is less than 250% of the current federal poverty level may receive assistance in paying a portion of their PEIA monthly health premium based on years of active service, through a grant provided by the PEIA. Applicants must be enrolled in the PEIA PPB Plan. Managed care plan members are not eligible for this program. Retired employees using accrued sick and/or annual leave to pay their premiums are not eligible for this program until their accrued leave is exhausted. Applications are mailed to all eligible retired employees each spring. Those who qualify for Premium Assistance also qualify for Prescription Drug Copay Assistance. See the "Prescription Drug Benefit" section starting on page 65 for details.

Years of Service

The amount of assistance for which you are eligible is based on years of active service. For surviving dependents, it will be based on years of service earned by the deceased policyholder. Disabled retirees are considered to have twenty (20) years of service.

Retirees with twenty (20) or more years of service are eligible for 100% of the base assistance amount. Retirees with 10-14 years are eligible for only 60% of the base assistance amount. These figures will be verified by the appropriate State retirement system. Following is a chart with the percentages of assistance available based on years of active service. Remember that even at the 100% level, this assistance pays only a portion of the total health insurance premium.

Years of active service	Percentage of assistance available
20 or more years	100
15-19 years	80
10-14 years	60
5-9 years	30
Fewer than 5 years	0

Life Insurance Premiums

Life insurance premiums for all participants are set by PEIA's life insurance carrier. For active employees of State agencies, colleges, universities and county boards of education, basic life insurance premiums are paid by your employer. For active employees of a local government agency, your employer will determine what, if any, portion of the life insurance premium will be paid for you. Retired employees must pay the basic life insurance premium to keep coverage in force. Optional life insurance premiums are paid by the employee and are based on age and amount of coverage. See your Life Insurance Booklet for further details of the options available to you.

Life Insurance Waiver of Premium

If you are an active employee with basic life insurance, and you become totally disabled before you reach age 60, your basic life insurance may be continued at no cost to you while you remain totally disabled. To qualify for this waiver of premium, you must furnish proof of total disability within one year after the date of disability. The date of disability is considered the last day you were actively at work. You must furnish proof of total disability after you have been disabled for nine (9) months, but not later than twelve (12) months after your last day of active work. To qualify for the waiver of premium, you must have been covered under basic life insurance when your disability began.

"Total Disability" exists when you are completely unable, due to sickness or injury or both, to engage in any gainful occupation for which you are reasonably fitted by education, training or experience. You will not be considered totally disabled while working at any gainful occupation.

To apply for a disability waiver of premium, contact your benefit coordinator. Proof of continuing disability will be required three months before each anniversary of the initial date of disability. You may be asked by PEIA's life insurance carrier to submit periodic medical exams. AD&D coverage does not continue under the waiver of premium.

If your waiver of premium is approved, your basic life insurance will remain at \$10,000 at no premium cost to you. At age 65, your basic life coverage decreases to \$5,000, and further reduces to \$2,500 at age 67. This coverage will end at the earliest of these events:

- the end of disability;
- the failure to provide proof of continued disability; or
- the failure to submit to a physical examination when required by PEIA's life insurance carrier.

See your Life Insurance Booklet for more details.

Managed Care Plan Premiums

If you enroll in a managed care plan offered by the PEIA for your health coverage, your premium contribution is set by the managed care plan. Premiums are published in the Shopper's Guide each year prior to Open Enrollment. The published premiums are set for one year. In most cases, your employer will contribute up to the same amount toward your coverage as if you were enrolled in the PEIA PPB Plan. If the managed care plan's premium is higher than this amount, you will be responsible for the difference. Local government agencies will determine their contribution for managed care plans. To find the amount of your premium contribution, check the Shopper's Guide for the current plan year or contact your benefit coordinator.

The managed care plans being offered by your employer are part of the PEIA benefits package and you may enroll for any plan in which you meet the eligibility guidelines. Your plan choice is binding for one year unless you move outside the service area of the plan you have chosen. Your physician's withdrawal from a plan does not qualify you to change plans.

Premium Conversion

Paying Premiums With Pre-Tax Dollars

The PEIA premium conversion plan is an IRS Section 125 plan which allows active, participating employees to save tax dollars when paying health and life insurance premiums. Your participation in the premium conversion plan is automatic if you are an active employee of one of the following:

- State government and its agencies;
- State-related colleges and universities; or
- a participating county board of education.

Federal law does not allow retired employees to participate in premium conversion.

With premium conversion, your premiums are deducted from your salary before federal, State and Social Security taxes are calculated. This reduces the amount of your income subject to tax. You must agree to pay the premiums through this plan for a full plan year, unless you have a change in family status that allows you to change your benefits. The example below demonstrates how premium conversion can reduce your taxes and increase your take-home pay. This example does not include State income tax, and assumes a 15% federal income tax bracket.

Without Premium Conversion Plan		With Premium Conversion Plan	
Amount	Description	Amount	Description
\$1,500	Monthly Income (Taxable Income)	\$1,500	Monthly Income
-\$340	Taxes	-\$121	Insurance Premium
\$1,160	After-tax Salary	\$1,379	Taxable Income
-\$121	Insurance Premium	-\$313	Taxes
\$1,039	Take-home Pay	\$1,066	Take-home Pay
		\$27	Additional Take-home Income

How to Participate

If your employer offers the premium conversion plan, your premiums automatically will be deducted on a pre-tax basis. If you do not wish to participate in the premium conversion plan, you must indicate this in writing to your benefit coordinator.

Decisions regarding premium conversion must be made when you initially enroll for PEIA coverage or during the annual open enrollment period each spring.

Limits on Benefit Changes

The premium conversion plan does not change your PEIA coverage, but it does limit your ability to make changes in your plan. Under the IRS rules, you must pay the same amount of premium each month during the year, unless you have a qualifying change in family status.

Qualifying changes in family status are:

- marriage or divorce of the employee;
- death of the employee's spouse or dependent;
- birth or adoption of the employee's child;
- commencement or termination of employment of the employee's spouse or dependent;
- a change from full-time to part-time employment status, or vice versa, by the employee or his or her spouse;
- an unpaid leave of absence taken by the employee or spouse;
- a significant change in the health coverage of the employee or spouse attributable to the spouse's employment;
- annulment;

- change in the residence or work site of the employer, spouse, or dependent;
- a dependent loses eligibility due to age or student status; or
- employment change due to strike or lock-out.

You may make a change in your plan when your spouse or dependent changes coverage during Open Enrollment under his or her plan if:

- the other employer's plan permits mid-year changes under this event, and
- the other employer's plan year is different from PEIA

You may make a change in your coverage (add a dependent, for example) that increases your insurance premium, or that has no effect on your premium, without having one of these events, but you'll pay any resulting increased premium on an after-tax basis until the next open enrollment period.

You may not make a change in your coverage that reduces the premium you pay until the next Open Enrollment period unless you have a qualifying change in family status.

For life insurance, the IRS allows you to pay pre-tax premiums on up to \$50,000 of life insurance. This includes the \$10,000 basic plan and up to \$40,000 of optional life insurance. Since you're paying pre-tax premiums on only \$40,000 of optional life insurance, you may terminate any life insurance you have in excess of \$40,000 at any time during the plan year, but you can terminate your basic or the first \$40,000 of optional life insurance only during the premium conversion plan open enrollment each spring.

To make a change in your coverage, get a Change-in-Status form from your benefit coordinator. Two types of changes require additional documentation; they are detailed in the following chart.

Status Change Event	Documentation Required
Divorce	Provide a copy of the divorce decree showing that the divorce is final. Coverage for the ex-spouse will be terminated at the end of the month in which the divorce became final.
Significant Change in Health Coverage Attributable to Spouse's Employment	Documentation from the spouse's employer describing the change in health coverage.

If you have a dependent child between the ages of 24 and 25, your ability to pay your premiums pre-tax may be affected by a recent federal law called the Working Families Tax Relief Act (WFTRA) of 2004. For details of this, please see "Special Eligibility Situations: Full-Time Students Age 19 and Over."

Health Care Benefits

You may get health care benefits through PEIA from a managed care plan or from the PEIA PPB Plan A or B.

If you choose to receive your benefits from a managed care plan, you must enroll with PEIA and choose a plan. You must refer to the information provided by the managed care plan for details of your benefits. This next section, entitled the PEIA PPB Plan, will not apply to you.

If you choose the PEIA PPB Plan A or B, your benefits are described on the following pages. This section describes only the benefits offered under the PEIA PPB Plan.

The PEIA PPB Plan (A or B)

The PEIA PPB Plan pays for a wide range of health care services for employees and their dependents. These benefits include hospital services, medical services, surgery, durable medical equipment and supplies, and prescription drugs. The medical benefits in the PEIA PPB Plan A and B are identical. The only difference is in the deductibles and out-of-pocket maximums, which are detailed on the charts in this section.

Under the plan, certain costs are your responsibility. In addition, to receive maximum benefits for some services, precertification is required or your benefits will be reduced. Please read the health care benefits section carefully so that you will have a clear understanding of your coverage under the plan.

If you have any questions about coverage or payment for health care services, please call:

Who to Call with Questions		
Medical claims, benefits, precertification, case management, preauthorizations and prior approvals for out-of-state care	Acordia	1-888-440-7342
Prescription drug claims and benefits	Express Scripts	1-877-256-4680
Common Specialty Medication claims and benefits	Curascript	1-866-413-4135

PEIA's Networks

The PEIA PPB Plan provides care through several networks of providers. In West Virginia, any health care provider who provides health care services or supplies to a PEIA participant is automatically considered a member of our network. Outside West Virginia, there are several networks available. Access to those networks depends on where you live. Generally, the available networks are:

- Medical Mutual of Ohio's SuperMed Plus Network (in Ohio only). To locate providers in the state of Ohio who participate in Medical Mutual of Ohio's (MMO) SuperMed Plus network, call 1-888-440-7342 or 1-304-353-7820, or check the internet at www.supermednetwork.com.
- The Alliance Network (in Maryland, Washington, DC, and North Carolina only). (For physicians associated with Duke University, PEIA uses the Beech Street Network). To locate providers in Maryland, North Carolina and the District of Columbia (DC) who participate in the Alliance Network, call 1-888-440-7342 or 1-304-353-7820, or check the internet at www.mamsi.com/directory.
- The Beech Street Network in all other states. To locate providers who participate in the Beech Street network, call 1-888-440-7342 or 1-304-353-7820, or check the internet at www.beechstreet.com. Kings Daughters Medical Center and Our Lady of Bellefont Hospital in Ashland, Kentucky, and hospitals in the UPMC Health System are not participating hospitals in the PEIA PPB Plan.

In addition, Acordia National contracts with some out-of-state providers to serve PEIA participants only. To locate a network provider in any of the available networks, call Acordia National at 1-888-440-7342 or 304-353-7820. Care provided by non-network

providers requires prior approval, or it will be paid at the lower out-of-network benefit level (typically 60% of PEIA's maximum allowance with the additional out-of-network deductible).

Not all hospitals in these networks may participate with PEIA. PEIA reserves the right to remove providers from the networks, so not all providers in all networks may be available to you.

Providers who are under sanction by Medicare, Medicaid or both will be expelled from PEIA's network for the duration of their sanction. In cases of expulsion, both the provider and the patient will be notified by mail of the action before claims are denied.

If you have questions about a specific network provider, please contact Acordia National at 1-888-440-7342.

Resident PPB Plan Participants

PEIA PPB Plan participants who live in West Virginia or a bordering county of a surrounding state may access care from any of the following providers without receiving prior approval:

1. any West Virginia health care provider who provides health care services or supplies to a PEIA participant, or
2. any network provider located in those bordering counties.

All services, except emergency care, provided outside of West Virginia beyond the bordering counties requires prior approval.

Non-Resident PPB Plan Participants

For PEIA PPB Plan participants who reside outside the State of West Virginia (beyond the bordering counties of surrounding states), PEIA has made special arrangements. Participants who live more than one county outside the State may seek care from any network provider. Care from network providers does not require prior approval, and that care will be covered at the in-network benefit level (typically 80%). Precertification of inpatient stays and certain outpatient procedures is still required. See page 39 for details.

What You Pay With The PEIA PPB Plan

Medical Deductible

During any plan year, if you or your eligible dependents incur expenses for covered medical services (other than office visits), you must meet a deductible before the plan begins to pay.

Medical deductibles are determined based on your salary, tier of coverage (i.e., individual or family), and whether you get your services within the PEIA network or outside of the network.

The family deductible is twice the individual deductible. The family deductible is divided up among the family members. No one member of the family will pay more than the individual deductible. Once that person has met the individual deductible, the plan will begin paying on that person. When another participant of the family meets the individual deductible, then the plan will begin paying on the entire family. Alternatively, all participants of the family may contribute to the family deductible with no one person meeting the individual deductible; once the family deductible is met, the plan pays on all members of the family. The deductibles are listed on the following chart according to income level and coverage tier.

Deductibles for Family with Employee Spouse coverage are based on the average of the two employees' salaries. This provision does not apply to local government agency or retired employees.

	PEIA PPB Plan In-Network Deductibles				
	Annual Salary	Employee Only	Employee & Child(ren)	Family	Family with Employee Spouse*
PEIA PPB Plan A (state agencies, colleges, universities and county boards of education)	\$ 0 - 20,000	\$100	\$200	\$200	\$200
	\$20,001 - 30,000	\$150	\$300	\$300	\$300
	\$30,001 - 36,000	\$200	\$400	\$400	\$400
	\$36,001 - 42,000	\$225	\$450	\$450	\$450
	\$42,001 - 50,000	\$250	\$500	\$500	\$500
	\$50,001 - 62,500	\$375	\$750	\$750	\$750
	\$62,501 - 75,000	\$400	\$800	\$800	\$800
	\$75,001 - 100,000	\$425	\$850	\$850	\$850
	\$100,001 - 125,000	\$500	\$1,000	\$1,000	\$1,000
	\$125,001 +	\$600	\$1,200	\$1,200	\$1,200
PEIA PPB Plan B (state agencies, colleges, universities and county boards of education)	\$ 0 - 42,000	\$500	\$1,000	\$1,000	\$1,000
	\$42,001 +	\$1,000	\$1,500	\$1,500	\$1,500
Non-state Plan A	Not applicable	\$225	N/A	\$450	N/A
Non-State Plan B	Not applicable	\$500	N/A	\$1,000	N/A
Non-Medicare Retirees	Not applicable	\$375	N/A	\$750	N/A
Medicare Retirees	Not applicable	\$150	N/A	\$300	N/A

For inpatient admissions that span two plan years, the facility charges are paid based on the first plan year, but physician charges are paid based on the date of service, which could be in the first plan year, new plan year or both plan years. For example, if you go into the hospital on June 28 and are released on July 6, the hospital bill is paid based on the date of admission, so it would fall under the old plan year's deductible. Physician charges are paid based on the date of service, so if you have surgery on July 2, the surgeon's bill will be processed based on the new plan year, and the deductible for the new plan year will apply to the surgeon's bill.

The out-of-network deductible satisfies the in-network deductible, but the in-network deductible does not meet the out-of-network deductible. Please note that the amounts listed in the chart are for in-network deductibles. Out-of-network deductibles are twice the amount of the in-network deductibles listed on the previous page.

Prescription drug benefits are subject to a separate deductible. Please see the "Prescription Drug Benefit" section starting on page 65 for information.

Coinsurance for In-Network and Out-of-Network Benefits

	If you live in WV, you will pay:	If you live in a bordering county of a surrounding state, you will pay:	If you live out-of-state (beyond bordering counties), you will pay:
Access care in WV or in a bordering county of a surrounding state using PPO providers	20% coinsurance	20% coinsurance	20% coinsurance
Access care outside WV (beyond bordering counties) using PPO providers <u>with</u> prior approval	20% coinsurance	20% coinsurance	20% coinsurance
Access care outside WV (beyond bordering counties) using non-PPO providers <u>with</u> prior approval	20% coinsurance	20% coinsurance	20% coinsurance
Access care outside WV (beyond bordering counties) using PPO providers <u>without</u> prior approval	40% coinsurance	40% coinsurance	20% coinsurance
Access care outside WV using non- PPO providers <u>without</u> prior approval	40% coinsurance	40% coinsurance	40% coinsurance

The PEIA PPB Plan is designed to provide as much care as possible within the State of West Virginia. The PEIA Preferred Provider Organization (PPO) is made up of West Virginia health care providers who provide health care services or supplies to PEIA participants. For services provided outside of the State, several networks are available. Please see "PEIA's Networks" on page 32 for details.

Resident PPB Plan Participants

PEIA PPB Plan participants who live in West Virginia or a bordering county of a surrounding state may access care from any West Virginia health care provider who provides health care services or supplies to a PEIA participant, or any network provider located in those bordering counties without prior approval. All services provided outside of West Virginia beyond the bordering counties require prior approval to be paid at the highest benefit level. For services of network providers, the plan will pay 80% of the contracted payment rate, and you will be responsible for any copayments, deductible and 20% coinsurance.

For services of non-network providers without prior approval, the plan will pay 60% of PEIA's maximum allowance; you will be responsible for any deductible, 40% coinsurance and any amount which exceeds PEIA's maximum allowance. For non-network providers, PEIA will pay what it would have paid if the services had been provided in-State. You will be responsible for any balance billing, and those amounts are considered non-covered services. They do not count toward the deductible or out-of-pocket maximum.

PPB Plan participants traveling out-of-state have coverage for urgent and emergency care. In an emergency, seek treatment at the nearest facility that is able to provide the needed care, and that care will be paid at the in-network benefit level as an emergency. For non-emergency, urgent care, call Acordia National for a referral to a network provider, or for approval to see an out-of-network provider where you are.

Non-resident PPB Plan Participants

PEIA PPB Plan participants who reside outside West Virginia and beyond the bordering counties may access care using any network provider without prior approval, and the claims will be paid at 80% of the contracted payment rate. You will be responsible for any copayment, deductible and 20% coinsurance.

Care provided by non-network providers must have prior approval. Services of non-network providers will be paid at 60% of PEIA's maximum allowance, unless approved by Acordia National in advance. Precertification requirements apply for inpatient stays and certain outpatient procedures.

Please consult the chart on the previous page to determine your level of coinsurance based on where you reside, where you receive your services, and whether or not you obtain prior approval.

Benefit Design

The following section provides you with a description of services and your cost-share.

Covered in Full

The following services are covered in full in-network:

Type of Service	Your In-network Cost
Routine prenatal care (physician services) ¹	\$0; Covered in full
Well child exams and immunizations as recommended by the American Academy of Pediatrics	\$0; Covered in full
High risk birth score program	\$0; Covered in full
Annual screening mammogram	\$0; Covered in full
Annual Pap smear ²	\$0; Covered in full
Colorectal cancer screening ²	\$0; Covered in full
Prostate cancer screening ²	\$0; Covered in full

¹ Deductible applies only if not met with charges for hospital or other services.

² Testing covered in full; \$10 preventive care office visit copay applies.

Copayment Only

A copayment is a flat dollar amount you pay when you receive service(s) from an in-network provider or an approved non-network provider. When a service is subject to a copayment only, you do not have to meet the deductible before the PEIA PPB Plan begins to pay for that service. The copayment does not count toward your deductible or your out-of-pocket maximum.

Type of Service	Your In-network Cost
Physician Office Visits - preventive care	\$10 copayment per visit with no deductible
Physician Office Visits - treat illness or injury	\$15 copayment per visit with no deductible
Adult Routine Physical Exams	\$10 copayment per visit with no deductible
Second Surgical Opinions*	\$15 copayment per visit with no deductible

* No copayment if required by Acordia National.

All of the services subject to a copayment only are listed in the chart above. See "What is Covered" for a detailed description of individual services.

Copayment, Coinsurance and Deductible

The services listed in the chart are subject to a copayment, annual deductible, and coinsurance.

Type of Service	Your In-network Cost
Emergency Services (including supplies) at emergency room	\$25 copayment + deductible and 20% coinsurance when certified as an emergency
Non-emergency services at emergency room	\$50 copayment + deductible and 20% coinsurance
Ambulatory surgery/Outpatient surgery (facility-based)	\$50 copayment + deductible and 20% coinsurance

Coinsurance and Deductible

Services not listed in the three preceding charts are covered at 80% after the deductible is met for in-network care and at 60% after the out-of-network deductible is met for non-network care which is not preauthorized. You pay your deductible, coinsurance, and any charges for services not covered by the plan directly to your health care provider.

Medical Out-of-Pocket Maximum

The medical out-of-pocket maximum is the most you pay in coinsurance in a plan year. Amounts you pay toward your annual deductibles, for copayments, for precertification penalties, for prescription drugs, for amounts billed in excess of what PEIA pays to non-network providers, and for services that are not covered under the plan do not apply toward your annual medical out-of-pocket maximum. It includes only your medical charges; prescriptions are handled separately. See the "Prescription Drug Benefit" section starting on page 65 for details.

The following chart shows the out-of-pocket maximum amount, which is the same whether you have a single plan or a family plan. It is a per-contract amount, which doesn't change regardless of whether there is just the policyholder on the contract, or the policyholder and several dependents.

Once you have met your out-of-pocket maximum, the plan will pay 100% of your covered charges (less applicable copayments) for the remainder of the plan year. Your out-of-pocket maximum amount depends on your employment status, your salary, where you receive your services, whether your provider is in the PEIA PPO network, and whether out-of-network care is preauthorized.

Amounts paid toward the out-of-network out-of-pocket maximum will also count toward the in-network out-of-pocket maximum, but in-network amounts do not count toward the out-of-network out-of-pocket maximum.

Out-of-Pocket Maximum Amounts			
Employee Status	Employee's Annual Salary	Annual In-Network Out-of-Pocket Maximum	Annual Out-of-Network Out-of-Pocket Maximum
PEIA PPB Plan A (Active, State Agency, Colleges and Universities, Boards of Education)	\$ 0 - 20,000	\$800	\$1,600
	\$20,001 - 30,000	\$1,100	\$2,200
	\$30,001 - 36,000	\$1,250	\$2,500
	\$36,001 - 42,000	\$1,500	\$3,000
	\$42,001 - 50,000	\$1,750	\$3,500
	\$50,001 - 62,500	\$1,800	\$3,600
	\$62,501 - 75,000	\$1,850	\$3,700
	\$75,001 - 100,000	\$1,900	\$3,800
	\$100,001 - 125,000	\$2,000	\$4,000
	\$125,001 +	\$2,250	\$4,500
PEIA PPB Plan B (Active, State Agency, Colleges and Universities, Boards of Education)	Not Applicable	\$2,000/single; \$4,000/family	\$4,000/single; \$8,000/family
Non-State Plan A	Not applicable	\$1,500	\$3,000
Non-State Plan B	Not applicable	\$2,000/single; \$4,000/family	\$4,000/single; \$8,000/family
Retired, Non-Medicare	Not applicable	\$1,500	\$3,000
Retired, Medicare	Not applicable	\$1,000	\$1,000

Out-of-network out-of-pocket maximums are twice the amount of the in-network out-of-pocket maximums.

Benefit Maximums

For certain types of services, the plan will pay up to a set amount per plan year as shown below. Patients experiencing a severe medical episode and patients with very complicated medical conditions are assigned a nurse case manager. For these catastrophic cases, the case manager may, based on medical documentation, recommend additional treatment for services marked with an asterisk (*). For details of these benefits, see "What Is Covered" later in this section.

Annual Benefit Maximums	
Type of Service	Benefit Maximum (per member per plan year)
*Outpatient Mental Health/Chemical Dependency	20 visits
Christian Science Treatment	\$1,000
*Outpatient Therapy Services (includes all benefits listed in this category under What is Covered)	20 visits (total amount allowed for all therapies combined)
Inpatient Rehabilitation	150 days
Skilled Nursing Facility	100 days

* May be extended if approved by Acordia National.

Lifetime Maximum

The PEIA will pay a maximum of \$1,000,000 in benefits per person during the person's lifetime. This maximum includes benefits paid for services rendered under the PEIA Indemnity Plan and the PEIA PPB Plan. Benefits paid under the Prescription Drug Plan are not included.

Pre-existing Medical Conditions

A pre-existing medical condition is one which has been diagnosed or treated, or for which you or your dependents have incurred expenses within the three months immediately before the effective date of the PEIA PPB Plan coverage.

Expenses for a pre-existing condition will not be covered by the PEIA PPB Plan for the first twelve months your coverage is in effect. This limitation is waived if you had creditable coverage under another health plan which terminated no more than 62 days prior to the effective date of the PEIA PPB Plan coverage.

The pre-existing condition limitation does not apply to pregnancy, to any condition meeting the definition of handicap, or to newborn or adopted children who are enrolled in the benefit plan within the calendar month of, or the two calendar months following the date of birth or adoption.

PEIA PPB Plan Fee Schedules and Rates

The PEIA PPB Plan pays health care providers according to a maximum fee schedule and rates established by PEIA. If a provider's charge is higher than the PEIA maximum fee for a particular service, then the plan will allow only the maximum fee. The "allowed amount" for a particular service will be the lower of the provider's charge or the PEIA maximum fee.

Physicians and other health care professionals are paid according to a Resource Based Relative Value Scale (RBRVS) fee schedule. This type of payment system sets fees for professional medical services based on the relative amount of work, practice expense and malpractice insurance expense involved. These rates are adjusted annually. West Virginia physicians who treat PEIA patients must accept PEIA's allowed amount as payment in full; they may not bill additional amounts to PEIA patients.

Most inpatient hospital services are paid on a "prospective" basis. PEIA's reimbursement to hospitals is based on Diagnosis-Related Groups (DRGs), which is the system used by Medicare. It is a Prospective Payment System (PPS) that classifies medical cases and surgical procedures on the basis of diagnoses. Under this system, West Virginia hospitals know in advance what PEIA will pay per day or per admission. West Virginia hospitals have been provided specific information about their reimbursement rates from PEIA. These rates are also adjusted annually.

Precertification/Notification Requirements

Precertification of Inpatient Admissions (Mandatory)

The PEIA PPB Plan requires that certain services and/or types of services be reviewed to determine whether they are medically necessary and to evaluate the necessity for case management. Some services require "precertification," and other services require "notification." Precertification is performed to determine if the admission/service is medically necessary and appropriate based on the patient's medical documentation. Notification to Acordia National is required to evaluate the admission/service in order to determine if the patient's medical condition will require case management, such as discharge planning for home health care services.

Precertification is required for the following:

- Inpatient Admissions
 1. hysterectomy,
 2. laminectomy
 3. insertion of implantable devices (vascular access, pacemakers, implantable pumps, spinal cord stimulators, neuromuscular stimulators, bone growth stimulators),
 4. uvulopalatopharyngoplasty,
 5. Leforte osteotomy,

6. elective and cosmetic surgeries (breast reduction, blepharoplasty, abdominoplasty, breast reconstruction, surgery for varicose veins),
7. bariatric surgery (gastric bypass, etc.),
8. transplants,
9. mental health, and
10. all admissions to out-of-state hospitals/facilities.

Outpatient Services

1. allergy testing for more than 70 skin pricks and/or intradermal sticks,
2. home health care services for more than 3 days/visits,
3. partial/day mental health programs,
4. MRI (magnetic resonance imaging),
5. multidisciplinary pain management programs,
6. durable medical equipment purchases and/or rentals of \$1,000 or more, and
7. surgeries:
 - hysterectomy,
 - implantable devices (vascular access, pacemakers, implantable pumps, spinal cord stimulators, neuromuscular stimulators, bone growth stimulators),
 - uvulopalatopharyngoplasty,
 - Leforte osteotomy,
 - elective and cosmetic surgeries (breast reduction, blepharoplasty, abdominoplasty, breast reconstruction, treatment for varicose veins),
 - bariatric surgery (gastric bypass, etc.), and
 - transplants.

Notification to Acordia National is required for the following inpatient admissions to WV facilities:

1. medical (non-surgical),
2. surgical admissions (except those specifically listed as requiring precertification),
3. emergency (including chest pain and congestive heart failure, and other cardiac events), and
4. maternity and newborn.

Failure to precertify or notify Acordia National of an admission within the timeframes specified in the chart on the following page will result in a reduction of benefits under the PPB Plan of 30%. This 30% penalty will be the responsibility of network providers. For all non-network providers, this 30% penalty will be the responsibility of the insured in addition to any applicable copayment, coinsurance, deductible, and amounts that exceed PEIA's maximum allowance.

If the insured or provider feels that Acordia National inappropriately denied an admission or the extension of an admission, or that extenuating circumstances existed that prevented notification to Acordia National within the timeframes set forth, the insured or provider may file an appeal.

Exception: It is the patient's responsibility to precertify inpatient stays and outpatient procedures when these services are received out-of-network. If you do not precertify these out-of-network services, you must pay the 30% precertification penalty in addition to the out-of-network copayment, coinsurance, deductible and amounts that exceed PEIA's maximum allowance. Prior approval to use out-of-network providers does not precertify services.

Timely Precertification Requirements	
Type of Admission	Advance Notice Required
Scheduled:	
Planned admission	5 business days in advance
Inpatient elective surgery or procedure	5 business days in advance
Maternity (notify Acordia National during your first trimester)	
Term pregnancy	Within 48 hours of admission
Caesarean section (planned)	5 business days in advance
Caesarean section (emergency)	Within 48 hours of admission
Urgent/Emergency	Within 48 hours of admission
Extended stay	Additional days may be recommended based on medical necessity

Preauthorization (Voluntary)

Preauthorization is a program which allows you to contact Acordia National in advance of a procedure to verify that the service is covered and will be paid so that you can make an informed decision about the procedure. Obtaining preauthorization from Acordia National assures that your claim will be paid when it's submitted. To obtain preauthorization, ask your provider to send your request to:

Acordia National
P. O. Box 2451
Charleston, WV 25329-2451

Your provider should include your name, address, telephone number, your Social Security Number, and all information about the procedure that's recommended. Acordia National may contact your physician for more information. Remember, if your request for preauthorization is denied, you will be responsible for paying for the procedure if you choose to have it. Due to specific benefit criteria, preauthorization is recommended for the following procedures:

- Accident-related Dental Services
- Chelation Therapy
- Chiropractic Services for children under age 16
- Massage Therapy
- Orthotics
- Vision Therapy

Prior Approval for Out-of-Network Services (Mandatory)

If you live in West Virginia or a bordering county of a surrounding state, all services outside of the State beyond the bordering counties must have prior approval. For services at preferred providers with prior approval, the plan will pay 80% of the contracted payment rate; you will be responsible for any deductible, copayments and 20% coinsurance.

For services provided by non-network providers without prior approval, the plan will pay 60% of PEIA's maximum allowance. You will be responsible for any deductible, copayments, and 40% coinsurance. Any amount which exceeds PEIA's maximum allowance will be your responsibility. Those amounts are considered non-covered services. They do not count toward the deductible or out-of-pocket maximum.

Special arrangements have been made for participants who live more than one county beyond the borders of West Virginia. See page 36 for more details.

Medical Case Management

If you are experiencing a serious or long-term illness or injury, Acordia National's medical case management program can help you learn about available resources, provide early support for your family, and find ways to contain medical costs, including your out-of-pocket expenses. Through case management Acordia National can:

- arrange home care to prevent hospitalization;
- arrange services in the home to facilitate early hospital discharge;
- obtain discounts for special medical equipment;
- locate appropriate services to meet the patient's health care needs; and
- for catastrophic cases, when medically proven as a part of a comprehensive plan of care, allow additional visits for outpatient mental health or Outpatient Therapy Services.

Acordia National must be notified for medical case management for the following services:

1. home health care of more than three (3) visits, including but not limited to:
 - skilled nursing visits;
 - I.V. therapy in the home;
 - physical therapy, occupational therapy or speech therapy done in the home;
 - hospice care; and
 - medication provided or administered by a home health agency.
2. skilled nursing facility services; and
3. rehabilitation services.

Transition of Care Program (New Participants Only)

If you are new to the PEIA PPB Plan, and have been receiving medical treatment from a non-network provider, you may be concerned that your care will be interrupted in your move to the PEIA PPB Plan. To assist participants receiving treatment for serious medical conditions from non-network providers, PEIA has a Transition of Care (TOC) program. If you qualify for TOC, you can continue to receive medical treatment from a non-network provider during a transition period specified by Acordia National and be covered at the in-network benefit level.

Following this transition period or after your treatment is complete, your medical care must be provided by a network provider to be eligible for the higher in-network level of benefits. Not all conditions will qualify for the TOC program.

Medical conditions likely to qualify for TOC benefits include:

- pregnancy,
- recent acute heart attack,
- newly diagnosed cancer requiring surgery, chemotherapy or radiation therapy,
- total joint replacement requiring physical therapy,
- acute trauma such as a bone fracture,
- certain psychiatric treatment or substance abuse programs, and
- recent surgical procedures with complications.

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

- arthritis,

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

In most cases, a network provider can successfully treat these chronic conditions. If there is not a network provider available to treat your specific illness or condition, PEIA will work with you to provide that care. Conditions limited or excluded from coverage are not eligible for TOC benefits.

To apply for the TOC program, request a copy of the TOC form by calling 1-888-440-7342 or 1-304-353-7820 and submit the completed form to Acordia National as indicated on the form. A separate form must be completed for each out-of-network provider. You will receive a written determination on your request for TOC benefits from the medical management department at Acordia National. You must apply for TOC within three months of your effective date of coverage in the PEIA PPB Plan.

What Is Covered

Medically Necessary Services

Covered services must be medically necessary or be one of the specifically listed preventive care benefits.

Medically necessary health care services and supplies are those provided by a hospital, physician or other licensed health care provider to treat an injury, illness or medical condition. A service is considered medically necessary if it is:

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

The fact that a physician has recommended a service as medically necessary does not make the charge a covered expense. PEIA reserves the right to make the final determination of medical necessity based on diagnosis and supporting medical data.

Who May Provide Services

The PEIA PPB Plan will pay for covered services rendered by a health care professional or facility if the provider is:

- licensed or certified under the law of the jurisdiction in which the care is rendered; and
- providing treatment within the scope or limitation of the license or certification; and
- not under sanction by Medicare, Medicaid or both. Services of providers under sanction will be denied for the duration of the sanction.

Types of Services Covered

Your PEIA PPB Plan covers a wide range of health care services. Some major categories are listed below. The description of each service includes the level of coinsurance and any applicable copayments you must pay when the service is received from a provider who participates in the PEIA PPO within the State of West Virginia or in bordering counties of the surrounding states.

Please keep in mind that for most participants, services you receive from non-network providers are subject to higher levels of coinsurance if not prior approved by Acordia National to ensure the lowest out-of-pocket expense. If you have questions about coverage of services, call Acordia National at 1-888-440-7342 or 1-304-353-7820. Special arrangements that have been made for participants who live more than one county beyond the borders of West Virginia are explained on page 36.

- **Acupuncture.** Services of a licensed acupuncturist for treatment of medical conditions are included in the Outpatient Therapy Benefit (see below) and are covered at 80% after the in-network deductible. Contact Acordia National for specific benefit limitations. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. Office visits are covered with a \$15 copayment and treatments are covered at 80% after the in-network deductible is met.
- **Allergy Services.** Including testing and related treatment; in-network care covered at 80% after in-network deductible is met. Allergy testing (for more than 70 tests) requires precertification.
- **Ambulance Services.** Emergency ground or air ambulance transportation, when medically necessary, to the nearest facility able to provide needed treatment; in-network care covered at 80% after in-network deductible. Non-emergency transportation is not covered.
- **Ambulatory Surgery.** This benefit is subject to a \$50 copayment and 20% coinsurance. The copayment and coinsurance amounts apply after the in-network deductible has been met. See "Outpatient Surgery" on page 47.

Services marked with a ➤ require precertification from Acordia National.

- **Cardiac or Pulmonary Rehabilitation.** Benefits are limited to 3 sessions per week for 12 weeks or 36 sessions per year for the following conditions: heart attack in the 12 months preceding treatment, heart failure, coronary by-pass surgery or stabilized angina pectoris. Covered at 80% after in-network deductible is met.
- **Chelation Therapy.** Benefits for these services are limited. Contact Acordia National for preauthorization. If covered, in-network therapy is paid at 80% after the in-network deductible has been met.
- **Childhood Immunizations.** Immunizations for children through age 16 are covered at 100% of allowed charges, including the office visit. This benefit is not subject to deductible, coinsurance, or copayment.
- **Chiropractic Services.** Services of a chiropractor for acute treatment of neuromuscular-skeletal conditions are included in the Outpatient Therapy Benefit (see below) and are covered at 80% after the in-network deductible. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. Office visits are covered with a \$15 copayment and x-rays are covered at 80% after the in-network deductible is met. Maintenance services are not covered. Preauthorization is recommended for services for children under age 16. See Outpatient Therapy Services for more information.
- **Christian Science Treatment.** Treatment for a demonstrable illness or injury if provided in a facility accredited by the Commission for Accreditation of Christian Science Nursing Facilities/Organizations, Inc. or by a practitioner accredited by the Mother Church is covered at 80% after the in-network deductible. No benefits will be paid for the purpose of rest or study, for communication costs, or if the person requiring attention is receiving parallel medical care. Coverage is limited to a maximum cost to the plan of \$1,000 per plan year. If required, this benefit may be extended for inpatient care for up to 60 days per plan year. Inpatient care must be precertified.
- **Colorectal Cancer Screenings.** Routine screening to detect colorectal cancer is covered at 100% in-network with no deductible or coinsurance required. The related office visit expenses are subject to the applicable preventive care office visit copayment. This benefit is covered as follows:
 - Fecal-occult blood test—1 in 12 months/age 50 and over
 - Flexible sigmoidoscopy—1 in 48 months/age 50 and over
 - Colonoscopy for high risk—1 in 24 months/high risk patients*; 1 in 10 years/age 50 and over
 - X-ray, barium enema—1 in 48 months/age 50 and over
 - X-ray, barium enema—1 in 24 months/high risk patients*

* High risk is defined as a patient who faces high risk for colorectal cancer because of family history; prior experience of cancer or precursor neo-plastic polyps; history of chronic digestive disease condition (inflammatory bowel disease, Crohn's disease, ulcerative colitis); and presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors.

- **Cosmetic/Reconstructive Surgery.** Services provided after trauma, illness or disease to correct conditions resulting from the trauma, illness or disease are covered at 80% in-network after deductible is met.
- **Dental Services (accident-related only).** Services provided within six (6) months of an accident and required to restore tooth structures damaged due to that accident are covered at 80% after the in-network deductible is met. The initial treatment must be provided within 72 hours of the accident. Biting and chewing accidents are not covered. Services provided more than six (6) months after the accident are not covered. Contact Acordia National for more information. For children under the age of 16, the six-month limitation may be extended if an approved treatment plan is provided to Acordia National within the initial six months.
- **Dental Services (impacted teeth).** Medically necessary extraction of impacted teeth is covered at 80% in-network after deductible is met. Extractions for the purpose of orthodontia are not covered.
- **DEXA Scans.** Bone mass measurement by DEXA is limited to one scan every 24 months for members who meet one of the following criteria:
 - 1) Member has received results from a peripheral osteoporosis screen indicating moderate or high risk for osteoporosis; OR
 - 2) Member has documented clinical risk for osteoporosis.

Diagnostic testing is covered at 80% after deductible has been met. Routine screening scans are not covered. Complete details of the DEXA scan payment policy are available on the PEIA website at www.wvpeia.com.

Services marked with a ► require precertification from Acordia National.

- **Diabetes Education.** Services of a diabetes education program that meets the standards of the American Diabetes Association are covered at 80% after in-network deductible is met. Coverage is limited to six (6) visits per patient: three visits with the dietician and three visits with a registered nurse. Contact Acordia National for specific benefit limitations.
- **Durable Medical Equipment (DME) and Prosthetics.** Coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices, and for the rental or purchase (at the plan's discretion) of standard DME, when prescribed by a physician. Prosthetics and DME purchases of \$1,000 or more, or rental for more than 3 months must be precertified by Acordia National. DME and prosthetics are covered at 80% after the in-network deductible is met.
- **Emergency Services (including supplies).** Services received in an emergency room when the condition has been certified as an emergency are subject to a \$25 copayment and 20% coinsurance in-network. The copayment and coinsurance amounts apply after the annual deductible has been met.
- **Emergency Room Treatment.** Services received in an emergency room when the condition is determined to be a non-emergency are subject to a \$50 copayment and 20% coinsurance in-network. The copayment and coinsurance amounts apply after the annual deductible has been met.
- **Home Health Services.** Intermittent health services of a home health agency when prescribed by a physician are covered at 80% after the in-network deductible is met. Services must be provided in the home, by or under the supervision of a registered nurse. The home health services are covered only if they would otherwise have required confinement in a hospital or skilled nursing facility. If more than 3 visits are necessary, precertification is required.
- **Hospice Care.** When ordered by a physician; covered at 80% after the in-network deductible is met.
- **Hypertension Screening.** The PEIA PPB Plan pays for diagnostic screening to determine if you are at risk for high blood pressure, heart disease or stroke. Benefits include coverage for an office visit, blood pressure check, and a blood chemistry profile. The office visit is subject to a \$10 copayment and the blood chemistry is covered at 80% after the in-network deductible is met. The blood pressure check is included as part of the office visit. The plan will pay for this screening:
 - One time between the ages of 20 and 30;
 - Once every three years between ages 31 and 39; and
 - Once every two years after age 40.

• Immunizations.

For children through age 16. The plan covers immunizations and the associated office visit with no deductible, coinsurance, or copayment required. Following is a list of immunizations and the ages at which PEIA covers them.

- Polio (IPV): At 2 months, 4 months, 6-18 months, and 4-6 years.
- Diphtheria-Tetanus-Pertussis (DTaP): At 2 months, 4 months, 6 months, 15-18 months, and 4-6 years.
- Tetanus-Diphtheria (Td): At 11-16 years.
- Measles-Mumps-Rubella (MMR): At 12-15 months and EITHER 4-6 years OR 11-12 years.
- Haemophilus Influenzae type b (Hib): At 2 months, 4 months, 6 months, and 12-15 months OR 2 months, 4 months, and 12-15 months, depending on vaccine type.
- Hepatitis B: At birth-2 months, 1-4 months, and 6-18 months. If missed, get 3 doses starting at age 11 years.
- Chicken Pox (VZV): At 12-18 months. If missed, get between ages 11 and 12 years.
- Hepatitis A: At 24 months-12 years in selected areas.
- Pneumococcal disease (Prevnar™): At 2 months, 4 months, 6 months, and 12-15 months. If missed, talk to your health care provider. Also see "Well Child Care" beginning on page 48.

For adults and children over age 16. The plan covers immunizations as recommended by the American Academy of Family Physicians at 100% in-network. The associated office visit is subject to the applicable copayment. Other immunizations covered with 20% coinsurance after the in-network deductible is met.

- **Inpatient Hospital and Related Services.** Confinement in a hospital including semi-private room, special care units, confinement for detoxification, and related services and supplies during the confinement are covered at 20% coinsurance after the in-

Services marked with a ➤ require precertification from Acordia National.

network deductible is met. In addition to the penalties discussed on page 40, all unapproved out-of-network inpatient admissions are subject to a \$500 deductible per admission.

- **Inpatient Medical Rehabilitation Services.** When ordered by a physician, coverage is subject to 20% coinsurance after the in-network deductible is met and is limited to 150 days per plan year. In addition to the penalties discussed on page 40, all unapproved out-of-network inpatient admissions are subject to a \$500 deductible per admission.
- **Mammogram.** An annual routine mammogram to detect breast abnormalities is covered at 100% in-network with no coinsurance or deductible required. The related office visit expenses are subject to the applicable copayment. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.
- **Massage Therapy.** Services of a licensed massage therapist for treatment of neuromuscular-skeletal conditions are covered under the Outpatient Therapy Benefit when ordered by a physician. Covered at 80% after the in-network deductible is met. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year.
- **Mastectomy.** If you are receiving benefits in connection with a mastectomy due to cancer and elect breast reconstruction in connection with such benefits, you are entitled to the following procedures:
 - Reconstruction of the breast on which the mastectomy was performed;
 - Reconstructive surgery of the other breast to present a symmetrical appearance; and
 - Prostheses and coverage for physical complications at all stages of the mastectomy procedure including lymphedema.
- **Maternity Services.** See "Maternity Benefits" on page 49 for details.
- **Mental Health Services.**
 - Inpatient and partial hospitalization day programs for mental health, chemical dependency and substance abuse services are limited to a maximum of 30 days per patient, per plan year. For outpatient partial/day programs, two (2) outpatient days will be counted as one (1) inpatient day when applying the 30-day maximum. Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment. Precertification is required.

These services are covered at 80% after the in-network deductible is met. Unapproved out-of-network inpatient admissions are subject to a \$500 deductible per admission.

 - Outpatient mental health, chemical dependency and substance abuse services are limited to a maximum of 20 visits per patient per plan year for short-term individual and/or group outpatient mental health and chemical dependency services. This benefit includes evaluation and referral, diagnostic, therapeutic, and crisis intervention services performed on an outpatient basis (includes a physician's office). Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment beyond the 20 visits.

This benefit is covered at 80% after the in-network deductible is met.
- **MRA.** Magnetic Resonance Angiography services when performed on an outpatient basis are covered at 80% after the in-network deductible is met.
- **MRI and MRA.** Magnetic Resonance Imaging services when performed on an outpatient basis must be precertified by Acordia National and are covered at 80% after the in-network deductible is met.
- **Neuromuscular stimulators and bone growth stimulators** when criteria are met are covered at 80% after the in-network deductible is met.
- **Oral Surgery.** Only covered for extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction at 80% after the in-network deductible is met. Preauthorization is recommended for orthognathic procedures and ridge reconstruction procedures. Dental implants are not covered.
- **Organ Transplants.** See "Organ Transplant Benefits" on page 50 for more details.
- **Outpatient Diagnostic and Therapeutic Services.** Laboratory, diagnostic tests, and therapeutic treatments, when ordered by a physician, are covered at 80% after the in-network deductible is met.

Services marked with a ➤ require precertification from Acordia National.

- **Outpatient Surgery.** This benefit is subject to a \$50 copayment and 20% coinsurance in-network when performed in a hospital or alternative facility. When performed in a physician's office, the \$50 copayment does not apply.
- **Outpatient Therapies.** Coverage for the following outpatient therapies are combined into one benefit and are available at 80% after the in-network deductible is met: physical, massage, occupational, speech, and vision therapies, acupuncture, osteopathic manipulations and chiropractic treatment. The benefit is limited to a maximum of 20 visits per person per plan year for all of the therapies combined. Case management is required for more than 20 visits.
 - Acupuncture. Services of a licensed acupuncturist for treatment of medical conditions are covered at 80% after the in-network deductible. Contact Acordia National for specific benefit limitations. Office visits are covered with a \$15 copayment and treatments are covered at 80% after the in-network deductible is met.
 - Chiropractic Treatment. Services of a chiropractor for acute treatment of neuromuscular-skeletal conditions are included in the Outpatient Therapies benefit (see above) and are covered at 80% after the in-network deductible is met. Office visits are subject to the \$15 copayment and x-rays are covered at 80% after deductible is met. Maintenance services are not covered. Preauthorization is recommended for services for children under age 16.
 - Massage Therapy. When ordered by a physician, services of a licensed massage therapist are covered at 80% after the in-network deductible is met.
 - Occupational Therapy. When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible is met.
 - Osteopathic Manipulations. Services of an osteopathic physician to eliminate or alleviate somatic dysfunction and related disorders are covered at 80% after the in-network deductible is met.
 - Outpatient Physical Therapy. When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible is met.
 - Outpatient Speech Therapy. When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible is met.
 - Vision Therapy. Contact Acordia National for preauthorization of these services. This benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible is met.
- **Pain Management Services.** Covered at 80% after the in-network deductible is met. Only Multidisciplinary Pain Management services require precertification.
- **Pap Smear.** An annual Pap smear and the associated office visit to screen for cervical abnormalities are covered. The Pap smear is covered at 100% in-network with no deductible or coinsurance, and the office visit is subject to a \$10 preventive care office visit copayment. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.
- **Periodic Physicals (for Adults).** The PEIA PPB Plan covers a routine physical exam once every two years for adults age 18 and over. Routine physicals are subject to a \$10 copayment per visit. Exams may be provided more often if the patient's medical history indicates a need. This office visit, generally, includes, but is not limited to:
 - height and weight measurement;
 - blood pressure check;
 - health risk and prevention counseling; and
 - physical examination.

Diagnostic testing, lab and x-rays, provided in conjunction with a periodic physical are covered, if medically necessary and billed with a medical diagnosis. The deductible and 20% coinsurance will apply. Only the screenings specifically listed in this "What is Covered" section, will be covered as routine screenings.
- **Physician's Office Visits (treatment for illness, injury, or medical condition).** These visits are subject to a \$15 copayment for in-network services.
- **Professional Services** of a physician or other licensed provider for treatment of an illness, injury or medical condition. Includes outpatient and inpatient services (such as surgery, anesthesia, radiology, and office visits). Office visits for preventive or specialty care are subject to the applicable copayment (see above) while other physician services are covered at 80% after the in-network deductible is met.

Services marked with a ➤ require precertification from Acordia National.

- **Prostate Cancer Screening.** Coverage is provided for an annual office visit and exam to detect prostate cancer in men age 50 and over with a \$10 preventive care office visit copayment. The PSA blood test associated with this screening is covered at 100% with no deductible or coinsurance in-network.
- **Second Surgical Opinions.** Office visits for second surgical opinions are subject to a \$15 copayment per visit. Second surgical opinions are paid at 100% if required by Acordia National.
- **Skilled Nursing Facility Services.** Confinement in a skilled nursing facility including semi-private room, related services and supplies is covered at 80% after the in-network deductible is met. Confinement must be prescribed by a physician in lieu of hospitalization. Coverage is limited to 100 days per plan year. In addition to the penalties discussed on page 40, all unapproved out-of-network inpatient admissions are subject to a \$500 deductible per admission.
- **Smoking Cessation.** See "Tobacco Cessation" on page 51 for details.
- **Well Child Care.** For children through age 16, the plan covers routine office visits for preventive care as recommended by the American Academy of Pediatrics. These visits are covered at 100% of allowed charges and are not subject to copayment or coinsurance or deductible. This office visit, generally, includes, but is not limited to:
 - height and weight measurement;
 - blood pressure check;
 - vision and hearing screening;
 - developmental/behavioral assessment; and
 - physical examination.

There is a \$10 copayment for routine preventive care office visits for adolescents over the age of 16.

Well Child Care office visits are recommended by the American Academy of Pediatrics at the following ages:

- Infancy: 1 month, 2 months, 4 months, 6 months, 9 months and 12 months.
- Early childhood: 15 months, 18 months, 24 months, 3 years and 4 years.
- Late childhood: 5 years, 6 years, 8 years, 10 years and 12 years.
- Adolescence: 14 years and 16 years.

Services marked with a ➤ require precertification from Acordia National.

Maternity Benefits

The PEIA PPB Plan provides coverage for maternity-related professional and facility services, including prenatal care, midwife services and birthing centers. Maternity related services are covered only for the employee or the employee's enrolled spouse.

Contact Acordia National during the first trimester of your pregnancy or as soon as your pregnancy is confirmed. Acordia National can assist you in identifying possible factors that may put you at risk for premature labor and delivery. If risk factors are identified, Acordia National nurses will work with you and your doctor to help safeguard the health of mother and baby.

You will need to contact Acordia National anytime you are admitted to the hospital during your pregnancy and within 48 hours of your admission for delivery, even if you are discharged in less than 48 hours.

Payment Level

Maternity services for routine prenatal care, delivery and follow-up are paid at 100% of allowed charges under a global fee after the deductible has been met. An obstetrical profile and one ultrasound are also paid at 100% of allowed charges after the deductible is met. Other maternity services, including hospital charges and anesthesia services, are paid at the regular PEIA PPB Plan level of 80% of allowed charges after the deductible is met, for in-network care.

Maternity Pre-payment Benefit

If your attending provider requests a deposit for maternity care before delivery, the PEIA PPB Plan will make an advance payment of up to \$500. This will be deducted from the global fee paid after delivery. To receive this benefit, please contact Acordia National and request a Maternity Pre-payment form.

High Risk Birth Score Program

For infants identified at birth as being at risk for health problems, the PEIA PPB Plan will pay for six office visits between the age of two weeks and 24 months in addition to PEIA's regular Well Child Care benefits. These additional visits are paid at 100% of allowed charges and are not subject to the deductible. Acordia National will notify those families who qualify for this benefit.

Enrolling Your Newborn

Please be sure you remember to add your newborn to your PEIA PPB Plan coverage by completing a Change-in-Status form. See the Eligibility Section at the front of this booklet for more information.

Nursery Charges

If the baby is enrolled for coverage under the PEIA PPB Plan, charges for the newborn nursery care will be paid in the baby's name. If the baby is not enrolled for coverage under the PEIA PPB Plan, charges for a normal, healthy newborn's nursery care will be covered as part of the mother's maternity benefit. If the newborn is covered under another plan, coordination of benefits rules will apply.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

PEIA is required by law to provide you with the following statement of rights. PEIA's maternity benefit meets or exceeds all of the requirements of the Newborns' and Mothers' Health Protection Act.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Organ Transplant Benefits

Organ transplants are covered when deemed medically necessary and non-experimental. They are subject to precertification and case management by Acordia National. You should contact Acordia National as soon as you learn that you or a member of your family covered by the PEIA PPB Plan may need a transplant.

All transplants require precertification for determination of medical necessity. When it is determined by your physician that you are a potential candidate for any type of transplant, Acordia National should be contacted immediately. They will identify Centers of Excellence available to you through the PEIA Transplant Network with experience in the specific type of transplant you require. You should advise your physician that Acordia National needs to coordinate the care from the initial phase when considering a transplant procedure, initial workup for transplant through the performance of the procedure and the care following the actual transplant.

Any services and supplies that are required for donor/procurement as a result of a surgical transplant procedure for a participant will be covered. Benefits for such charges, services and supplies are not provided under the PPB Plan if benefits are provided under another group plan or any other group or individual contract or any arrangement of coverage for individuals in a group (whether an insured or uninsured basis), including any prepayment coverage.

Testing for persons other than the chosen donor is not covered.

Organ Transplant Network (OTN)

The PEIA PPB Plan uses network providers for organ transplant services. This helps to control health care costs for both you and the plan.

PEIA uses a specialized transplant network called LifeTrac, as well as special contracts with West Virginia University hospitals for bone marrow transplants, and with Charleston Area Medical Center for kidney transplants. Acordia National will work with patients and physicians to determine which network facility best serves the patient's medical needs.

OTN Benefits

Reduced Costs: Once the annual deductible and out-of-pocket maximum have been met, you will pay no more coinsurance on the negotiated fees for pre-transplant, transplant, and follow-up services. Copayments for office visits and other services described on page 37 will still apply.

Travel Allowance: Because network facilities may be located some distance from the patient's home, benefits include up to \$5,000 for patient travel, lodging and meals. A portion of this benefit is available to cover the travel, lodging and meals for a member of the patient's family or a friend providing support. Receipts are required for payment; mileage and cost estimates are not acceptable.

Medical Case Management: Acordia National offers support and assistance in evaluating treatment options and referrals to the prescription drug administrator. Management begins early when the potential need for a transplant is identified, and continues through the surgery and follow-up. When the need for a transplant presents itself, call Acordia National at 1-888-440-7342 or 1-304-353-7820.

You should contact Acordia National as soon as you learn that you or a member of your family covered by the PEIA PPB Plan may need a transplant. All transplants must be precertified through Acordia National.

Out-of-Network Organ Transplant Benefits

For patients who choose to use a non-network facility for transplant services, there will be a \$10,000 deductible applied to the cost of the hospital admission; this is in addition to your annual deductible and out-of-pocket maximum. This deductible will be waived only if treatment at a non-network facility is approved as medically necessary in advance by Acordia National. No travel benefits will be provided for out-of-network transplants (except medically necessary ambulance transport).

Transplant-Related Prescription Drugs

The PEIA PPB Plan covers transplant-related immunosuppressant prescription drugs at 100%, after you have met your prescription drug deductible (if they are filled at a network pharmacy). These are covered through the Prescription Drug Plan and processed by the prescription drug administrator. Details of the PEIA Prescription Drug Plan are found in the "Prescription Drug Benefits" section starting on page 65.

Medical case management of transplant patients includes referral to the prescription drug administrator for waiver of copayment on transplant-related immunosuppressant drugs. Acordia National will make arrangements with the prescription drug administrator to waive copayments on drugs used to sustain the transplant.

Tobacco Cessation

The PEIA PPB Plan provides benefits for participants who wish to quit smoking or using smokeless tobacco products. To enroll in the tobacco cessation program, call the Quit Line at 1-877-966-8784. The Quit Line will provide counseling and support, including written materials to each program enrollee. PEIA covers both prescription and non-prescription tobacco cessation products for those who have enrolled in the tobacco cessation program. Non-prescription drugs will be covered only if prescribed by a physician.

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

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

Payment Level

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

- Nicotine withdrawal therapy is covered with a \$5 generic copayment for a month's supply.
- Zyban is covered with a \$15 preferred brand copayment for a month's supply.

For details, see the "Prescription Drug Benefits" section starting on page 65.

Dr. Dean Ornish Program for Reversing Heart Disease

PEIA is offering a pilot project of the Dr. Dean Ornish Program for Reversing Heart Disease. A limited number of slots has been allocated for participants who have the PEIA PPB Plan as their primary insurance. The Ornish approach does not use drugs or surgery, but relies upon diet, physical activity, group support and counseling as part of an intensive life style change program. Applicants are screened by their local participating Ornish hospital to determine if they meet the medical criteria for participation: coronary artery disease, Type II diabetes, or at high risk of heart disease.

The program is covered at 100% after a participant copayment of \$50 per month. Participants with annual household income below \$20,000 per year may qualify for a copayment waiver.

For more information about this program, contact PEIA's customer service unit at 1-888-680-7342.

Weight Management Program

PEIA offers a weight management program for PEIA PPB plan members who have a Body Mass Index (BMI) of 30 or greater or a BMI of 25 or greater with related conditions such as hypertension, diabetes, heart disease, or sleep apnea.

Currently, the program is available in Charleston, Huntington, Morgantown, Bluefield, Martinsburg and Clarksburg. We anticipate that more sites will become available as the program develops.

The program includes comprehensive services from registered and licensed dietitians, degreed exercise physiologists and personal trainers at approved fitness centers.

To enroll, you must submit some medical information and written approval from your physician. For more information or to enroll in the program, contact 1-866-688-7493.

What Is Not Covered

Some services are not covered by the PEIA PPB Plan regardless of medical necessity. Specific exclusions are listed below. If you have questions, please contact Acordia National at 1-888-440-7342 or 1-304-353-7820. The following services are not covered:

1. Aqua therapy.
2. Biofeedback, except in the case of mental health services.
3. Birth control drugs, devices, and services for dependent children.
4. Breast pumps.
5. Chemical dependency treatments when a patient leaves the hospital or facility against medical advice.
6. Coma stimulation.
7. Cosmetic or reconstructive surgery when not medically required as the result of accidental injury or disease, or unless the surgery is performed to correct birth defects. Services resulting from or related to these excluded services also are not covered.
8. Custodial care, intermediate care (such as residential treatment centers), domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living, or for behavioral modification.
9. Dental services including dental implants, routine dental care, x-rays, treatment of cysts or abscesses associated with the teeth, or any other dentistry and dental procedures.
10. Daily living skills training.
11. Duplicate testing, interpretation or handling fees.
12. Education, training and/or cognitive services, unless specifically listed as covered services.
13. Elective abortions.
14. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts.
15. Experimental, investigational or unproven services, unless pre-approved by Acordia National.
16. Fertility drugs and services.
17. Foot care. Routine foot care including:
 - Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), or hypertrophy (growth of tissue under the skin);
 - Cutting, trimming, or partial removal of toenails;
 - Treatment of flat feet, fallen arches, or weak feet; and
 - Strapping or taping of the feet.
18. Genetic testing.
19. Glucose monitoring devices, except Bayer Ascensia models covered under the prescription drug benefit.
20. Homeopathic medicine.
21. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery.
22. Hypnosis.
23. Incidental surgery performed during medically necessary surgery.
24. Infertility and sterility services of in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, and donor semen, any other method of artificial insemination, and any other related services.
25. Maintenance chiropractic services.

26. Marriage counseling.
27. Medical equipment, appliances or supplies of the following types:
- augmentative communication devices.
 - bathroom scales.
 - educational equipment.
 - environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors.
 - equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs; recliners; contour chairs; adjustable beds; or tilt stands.
 - equipment which is widely available over the counter such as wrist stabilizers and knee supports.
 - exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines.
 - hearing aids.
 - hygienic equipment such as bed baths, commodes, and toilet seats.
 - motorized scooters.
 - nutritional supplements, food liquidizers or food processors.
 - orthopedic shoes, unless attached to a brace.
 - over-the-door and/or gravity traction.
 - professional medical equipment such as blood pressure kits or stethoscopes.
 - supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags.
 - vibrators.
 - whirlpool pumps or equipment.
 - wigs or wig styling.
28. Medical rehabilitation and any other services that are primarily educational or cognitive in nature.
29. Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning.
30. Optical services. Routine eye examinations, refractions, eye glasses, contact lenses and fittings. Glasses and/or contact lenses following cataract surgery are not covered.
31. Orientation therapy.
32. Orthodontia services.
33. Orthotripsy.
34. Physical examinations and routine office visits except those covered under the Periodic Physicals benefit.
35. Personal comfort and convenience items or services (whether on an inpatient or outpatient basis) such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician.
36. Physical conditioning and work hardening. Expenses related to physical conditioning programs and work hardening such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation.
37. Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered under the plan, when such services are:
- conducted for purposes of medical research;

- for participation in athletics;
 - needed for marriage or adoption proceedings;
 - related to employment;
 - related to judicial or administrative proceedings or orders;
 - to obtain or maintain a license or official document of any type; or
 - to obtain or maintain insurance.
38. Pregnancy-related conditions for dependent children.
 39. Provider charges for phone calls, prescription refills, or physician-to-patient phone consultations.
 40. Radial keratotomy and other surgery to correct vision.
 41. Reversal of sterilization and associated services and expenses.
 42. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities.
 43. Screenings, except those specifically listed as covered benefits.
 44. Services rendered by a provider with the same legal residence as a participant, or who is a member of the policyholder's family. This includes spouse, brother, sister, parent, or child.
 45. Services rendered outside the scope of a provider's license.
 46. Sex transformation operations and associated services and expenses.
 47. Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit.
 48. Stimulation therapy.
 49. Take-home drugs provided at discharge from a hospital.
 50. TMJ. Treatment of temporomandibular joint (TMJ) disorders. Including intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for temporomandibular joint dysfunction not caused by documented organic disease or acute physical trauma.
 51. The difference between private and semi-private room charges.
 52. Therapy and related services for a patient showing no progress.
 53. Therapies rendered outside the United States that are not medically recognized within the United States.
 54. Transportation other than medically necessary emergency ambulance services, or as approved under the Organ Transplant Network benefit.
 55. War-related injuries or illnesses. Treatment in a State or federal hospital for military or service-related injuries or disabilities.
 56. Weight loss. Health services and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight control programs, weight control drugs, screening for weight control programs, and services of a similar nature, except those services provided through a pilot program offered by PEIA.
 57. Work-related injury or illness.

How to File a Claim

Filing a Medical Claim

Medical claims are processed by Acordia National and should be submitted to:

Acordia National
P.O. Box 2451
Charleston, WV 25329-2451

This post office box should be used only for PEIA claims. Please do not submit PEIA claims to other Acordia National post office boxes. This will only delay their processing.

To process a medical claim, Acordia National requires a complete itemization of charges including:

- the patient's name;
- the nature of the illness or injury;
- date(s) of service;
- type of service(s);
- charge for each service;
- diagnosis and procedure codes;
- identification number of the provider; and
- Medical ID number of the policyholder.

If the necessary information is printed on your itemized bill, you do not need to use a PEIA claim form to submit your charges. Cash register receipts and canceled checks are not acceptable proof of your claim.

If you have other insurance (including Medicare) which is primary, you need to submit an Explanation of Benefits (EOB) from the other insurance with each claim, or ask your provider to do so if the claim is being submitted for you.

You have six (6) months from the date of service to file a medical claim. If PEIA is your secondary insurer (even if you have Medicare), you have six (6) months from the date of your primary insurer's Explanation of Benefits processing date to file your claim with PEIA. If you do not submit claims within this period, they will not be paid, and you will be responsible for payment to the provider.

If your claim is for an illness or injury wrongfully or negligently caused by someone else, and you expect to be reimbursed by another party or insurance plan, you must file a claim with PEIA within six (6) months of the date of service to ensure that the covered services will be paid. Later, if you receive payment for the expenses, you will have to repay the amount you received from PEIA. See "Subrogation" on page 63 for details.

Medicare Crossover Claims

If you are a PEIA PPB Plan participant who has Medicare as the primary insurer, Acordia National has a program that allows providers to bill PEIA electronically as your secondary insurance after Medicare has adjudicated the claim. This program, called Medicare Crossover, saves you the time and trouble of filing the claim yourself.

Filing Claims for Court-ordered Dependents (COD)

If you are the custodial parent of a child who is covered under the other parent's PEIA plan as a result of a court order, you may submit claims directly to Acordia National using the special claim forms provided by PEIA. You can also receive all benefit information published by PEIA, and reimbursements for medical claims can be sent directly to you. For prescription drugs, you must use your I.D. card at a participating pharmacy. To make arrangements for this, please contact PEIA at 1-304-558-7850 or toll-free at 1-888-680-7342.

Claims Incurred Outside of the U.S.A.

If you or a covered dependent incur medical expenses while outside the United States, you may be required to pay the provider yourself. Request an itemized bill containing all the information listed above from your provider and submit the bill along with a claim form to Acordia National or the prescription drug administrator.

Acordia National or the prescription drug administrator will determine, through a local banking institution, the currency exchange rate and you will be reimbursed according to the terms of the PEIA PPB Plan.

Appealing A Claim

PEIA PPB Plan

If you are a PEIA PPB Plan participant or provider and think that an error has been made in processing your claim or reviewing a service, the first step is to call the Third Party Administrator to verify that a mistake has been made. (For information about prescription drug appeals, see page 77.) All appeals must be initiated within 60 days of claim payment or denial.

Type of Error	Who to Call	Where to Write
Medical claim denial, out-of-state care denial, pre-certification or case management	Acordia National 1-888-440-7342	Acordia National P. O. Box 2451 Charleston, WV 25329-2451
Prescription drug claim	Express Scripts 1-877-256-4680	Express Scripts, Inc. Clinical Appeals - (Client-WVA) BL0390 6625 W. 78th Street Bloomington, MN 55439

If your medical claim or service has been denied, or if you disagree with the determination made by Acordia National, the second step is to appeal in writing within 60 days of the denial to Acordia National. Explain what you think the problem is, and why you disagree with the decision. Acordia National will respond to you by reprocessing the claim or sending you a letter.

If this does not resolve the issue, the third step is to appeal in writing to the director of the PEIA. The participant, provider or covered dependent must request a review in writing within sixty (60) days of getting the decision from Acordia National. Facts, issues, comments, letters, Explanations of Benefits (EOBs), and all pertinent information about the case should be included. Third step appeals should be mailed to:

Director
Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, WV 25305-0710

When your request for review arrives, the PEIA will reconsider the entire case, taking into account any additional materials which have been provided.

A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the insured or his or her authorized representative.

If additional information is required to render a decision, this information will be requested in writing. The additional information must be received within 60 days of the date of the letter. If the additional information is not received, the case will be closed.

Managed Care Plan Members

If you are a managed care plan member, and you think that an error has been made in processing your claim, the first step is to call your managed care plan to discuss the matter.

If your claim has been denied, or if you disagree with the determination made by your managed care plan, the second step is to appeal in writing within 60 days of the denial to your managed care plan. Instructions for filing that appeal are in your "Evidence of Coverage" provided by your managed care plan.

If you are not satisfied with the response from your managed care plan, you may appeal in writing to the director of the PEIA. You or your covered dependents must request a review in writing within sixty (60) days of getting the decision from your managed care plan. Facts, issues, comments, letters, Explanations of Benefits (EOBs), and all pertinent information about the claim and review should be included. The appeal should be mailed to:

Director
Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, WV 25305-0710

When your request for review arrives, the PEIA will reconsider the entire case, taking into account any additional materials that have been provided. A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the insured or his or her authorized representative.

If additional information is required to render a decision, this information will be requested in writing. The additional information must be received within 60 days of the date of the letter. If the additional information is not received, the case will be closed.

If you disagree with the decision of the PEIA director, you have one final level of appeal to the West Virginia Insurance Commissioner. Instructions for this appeal are also provided in your "Evidence of Coverage" from your managed care plan.

Controlling Costs

Prohibition of Balance Billing

The PEIA PPB Plan is governed in part by the Omnibus Health Care Act which was enacted by the West Virginia Legislature in April 1989. This Law requires that any West Virginia health care provider who treats a PEIA insured must accept assignment of benefits and cannot balance bill the insured for any portion of charges over and above the PEIA fee allowance or for any discount amount applied to a provider's charge or payment. This is known as the "prohibition of balance billing."

The prohibition of balance billing applies when services are provided in West Virginia and when the PEIA PPB plan is the primary payor. When the PEIA PPB plan is the secondary payor, the provider may bill you for disallowed amounts and for the provider discounts. Remember, you are always responsible for deductibles, copayments, coinsurance amounts and non-covered services.

A PEIA insured who has Medicare as the primary payor has protection against balance billing when the provider accepts Medicare assignment. If the provider accepts Medicare assignment, you are not responsible for amounts which exceed the Medicare allowances.

New Technologies

Upon FDA approval of new technology, PEIA determines whether or not to cover the item, service or procedure. These new technologies may or may not be covered. PEIA often waits until the new technology proves effective before approving coverage. If you have concerns about coverage of a new technology, contact Acordia National for details.

Preferred Provider Organizations

For services provided outside the State of West Virginia, Acordia National utilizes several network relationships. These networks review their providers for quality standards like licensing, background and treatment patterns. As part of their agreement with the network, the amount paid for services is a discounted amount.

For details of which networks Acordia National uses, see "PEIA's Networks" on page 32.

After you receive medical attention, your claim will be routed to Acordia National. All PPO providers are paid directly, relieving you of any hassle and worry. You will need to pay for out-of-pocket expenses (deductibles, copayments, coinsurance amounts and non-covered services). Acordia National will send you an Explanation of Benefits (EOB).

Out-of-State Provider Waiver

To assist participants who receive medical treatment outside of West Virginia from providers who do not participate in any Preferred Provider Organization, guidelines have been established to review and approve waiver requests when you are billed for the balance not paid by PEIA and not applied to your out-of-network deductible and out-of-pocket maximum. The first \$500 of expenses which exceed the allowed amount will be your responsibility. Amounts in excess of \$500 may be eligible for an out-of-state provider waiver when:

1. the PEIA PPB Plan is the primary payor for the services provided; and
2. you are billed for amounts which exceed the fee allowance; and
3. you must receive out-of-state services because:
 - an emergency arises; or
 - the insured lives or is traveling out-of-state; or
 - the medically necessary service is not available in West Virginia (or within a reasonable travel time); or
 - due to geographic location, PEIA has determined that services are only available out-of-state; and
4. you do not have other insurance which will pay toward the balance.

Expenses eligible for waivers are those which exceed the maximum fee allowances. Amounts applied toward your out-of-network deductible, your out-of-network coinsurance amount, penalties, and non-covered services will not be considered for a waiver.

To request a waiver, send your balance bill from the provider, a copy of your Explanation of Benefits (EOB) indicating the amount already paid by PEIA, and a written request including the reason you chose an out-of-state provider to:

Director
Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0710

You may obtain a PEIA Out-of-State Waiver Form by calling PEIA at 1-304-558-7850 or toll-free at 1-888-680-7342. A waiver form is not required if you send the above-requested information. The request for an Out-of-State Waiver must be submitted within six months of the processing date on the Explanation of Benefits (EOB) to be eligible for additional payments.

Patient Audit Program

The Patient Audit Program offers rewards when you help detect and correct mistakes on your health care bills. Examine your medical bills for these two types of mistakes:

- Charges for services not received; and
- Overcharges or overpayments resulting from clerical error or miscalculation.

Reported errors must be at least \$50.00 to qualify for the Patient Audit Program and must be submitted within 60 days of the processing date on the Explanation of Benefits (EOB). Complete the Patient Audit Report Form from PEIA and submit it, along with an itemized bill from the provider, the corrected bill (or explanation of disagreement), and a copy of the EOB, to PEIA.

PEIA and Acordia National or Express Scripts will investigate and recover the overpayment, if justified, from the provider of services. When the overpayment is processed you will be paid 50% of the recovered amount, up to \$1,000 per plan year.

HMO members are not eligible to participate in the Patient Audit Program.

Coordination Of Benefits

In its effort to control health care costs, the PEIA PPB Plan has a coordination of benefits (COB) provision. Under this provision, when a person covered by PEIA also has coverage under another policy (or policies), there are certain rules determining which policy is required to pay benefits first. The policy paying first is called the primary plan, and any other applicable policy is called the secondary plan.

Acordia National, on PEIA's behalf, will request information about other coverage using a questionnaire mailed to the policyholder periodically. If the policyholder fails to respond to the questionnaire, claims will be denied until the information is received.

If you have health insurance coverage in addition to the PEIA PPB Plan, it is important to understand how the coordination of benefits provision works. In many instances, if the PEIA PPB Plan is secondary and your primary plan is other than Medicare, PEIA will pay little or nothing of the balance of your medical bill. An example of this situation is provided on the next page. In some cases it may be financially advisable to elect only one insurance coverage. If, after reviewing this section, you have questions concerning how PEIA's coordination of benefits provision may affect you, contact a PEIA claims representative at 1-304-558-7850 or toll-free at 1-888-680-7342.

Coordinating PEIA Benefits with Other Plans

COB will occur when an employee, retired employee or dependent has health coverage under the PEIA PPB Plan and also under:

1. any government program or other coverage required or provided by law;
2. any plan covering individuals as a group, including insured, uninsured and pre-payment arrangements;
3. automobile insurance medical pay provisions whether individual or group. PEIA will pay as primary plan and subrogate against the medical payment coverage;
4. group-type hospital indemnity benefits exceeding \$100 per day;
5. for spouses and dependents only, individual hospital and surgical or major medical insurance in which that spouse or dependent is the policyholder. Individual and surgical or major medical insurance does not include any individual supplemental accident and sickness policy which meets the definition of a "limited benefits policy or certificate" under W. Va. Code §3-16E-2(a). These individual policies must meet all of the following conditions:
 - the policy covers a specified disease, accident only, disability, or other limited benefits;
 - the policy is specifically designed, represented and sold as a supplement to other basic sickness and accident coverage; and
 - the entire premium for the policy is paid by the insured or insured's family.

Which Plan Pays First

For active employees, the PEIA PPB Plan is your primary plan in almost every circumstance. If your spouse is covered through his or her employer, that plan is usually the primary plan for your spouse. The primary plan is determined by the first of the following rules which applies:

- a. any plan with no coordination of benefits provision is always primary;
- b. the plan which covers the person as an active or retired employee, member or subscriber (other than as a dependent) is always primary to a plan which covers the person as a dependent. When two public employees, both eligible to enroll for PEIA coverage in their own names, are married and covered under one PEIA family plan, then the spouse, covered as a dependent, will be treated as an employee under these rules;
- c. for a dependent child of parents not separated or divorced, if two or more plans cover the child as a dependent:
 1. the plan of the parent whose birthday falls earlier in the year will be primary; or
 2. if both parents have the same birthday, the plan which has covered one parent longer will be primary; or
 3. if the other plan uses the parent's gender to determine benefits, and the plans do not agree on the order of benefits, then the rule of the other plan will determine the order of benefits.
- d. for a dependent child of parents who are separated or divorced, if two or more plans cover the child as a dependent, benefits are determined in this order:
 1. the plan of the parent who has custody will pay first;

2. the plan of the spouse of the parent who has custody will pay next;
3. the plan of the parent who does not have custody will pay last.

Exception: If a court decree states that one of the parents is responsible for the health care expenses of the child, and the plan of that parent has knowledge of those terms, then that plan is primary. The plan of the other parent will then be secondary, and the plan of the spouse of the parent with custody of the child will pay third. For PEIA to pay according to this paragraph, you need to provide a copy of the court decree.

- e. for a dependent child of divorced parents with joint custody, if the court decree does not specify which parent is responsible for health care coverage, then Rule "c." above will apply;
- f. for a dependent child of separated parents with joint custody, if the court decree does not specify which parent is responsible for health care coverage, then Rule "c." above will apply;
- g. a plan which covers an employee (and, consequently, his or her dependents) as an active employee, rather than as a laid-off employee or retired employee, will pay before a plan which covers a laid-off or retired employee. If the other plan does not have this rule, and the plans disagree about the order of benefits, this paragraph is disregarded;
- h. if a person is covered under a right of continuation policy as required by the Consolidated Omnibus Reconciliation Act (COBRA) of 1987, as amended, and is also covered under another plan, the following rules will apply:
 1. the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent) will be primary;
 2. the benefits under the continuation coverage will be secondary.
- i. if none of the above rules applies, the plan which has covered the employee, member or subscriber the longest will be primary.

How Coordination of Benefits Works

When a claim is made, the primary plan pays its benefits without regard to any other plans. Then the secondary plan pays its benefits, adjusting for the benefit paid by the primary plan. The amount that the PEIA PPB Plan will pay as a secondary plan depends on what the primary plan pays.

To calculate the amount PEIA will pay as a secondary plan, you subtract the amount your primary plan pays from the amount PEIA would have paid if there were no other insurance. If the other plan paid as much or more than PEIA would have paid as the primary plan, then PEIA will pay nothing as the secondary plan. If the other plan paid less than PEIA, then PEIA will pay the difference up to what it would have paid if there had been no other insurance.

As you can see in the following chart, the PEIA PPB Plan will pay very little or nothing as a secondary plan. For this reason, you should consider whether it makes sense to keep both plans.

"Carveout" Coordination of Benefits Example			
If PEIA is primary:		If PEIA is secondary:	
Total Charge	\$120	Total Charge	\$120
PEIA Allowed Amount	\$100	Other Plan's Allowed Amount	\$96
PEIA Pays	\$80	PEIA Pays	\$0
*You Owe	\$20	*You Owe	\$24

* Assumes any deductible has been met.

There are several issues to consider if you are thinking about dropping one of your plans:

- Prescription Drug Coverage: PEIA's coverage is generous. Compare the benefits of both plans, including deductibles.
- Mental Health Benefits: Many plans pay only 50% or limit the number of admissions per lifetime. The PEIA PPB Plan pays 80% in-network with no limit when services are precertified.
- Maternity Services: PEIA pays 100% of the physician's allowed charges, after the deductible is met.

- **Balance Billing Prohibition:** PEIA protects you from network providers billing you for amounts which exceed PEIA's allowed amounts, but only if the PEIA PPB plan is the primary payor. In the above example, with the PEIA plan as your primary plan, you would not be responsible for the difference between the total charge and the amount allowed by PEIA. The balance billing provision does not apply when the PEIA PPB plan is the secondary plan or when the provider is not in the PEIA PPB plan network. If the primary plan denies payment and the PEIA PPB plan is the secondary insurer, then PEIA becomes the primary plan for the denied services.

If you have questions about your coverage, or need help comparing plans, you may call the PEIA Customer Service Unit at 1-304-558-7850 or toll-free 1-888-680-7342.

Medicare Coordination

The PEIA PPB Plan will reimburse the difference between the amount allowed by Medicare and the amount paid by Medicare if the balance is not more than the PEIA PPB Plan would have paid as the primary plan.

When Medicare is your primary insurer, all services are considered in-network and are processed at the higher benefit level.

If you have met your PEIA PPB Plan annual medical deductible, PEIA will usually pay the balance and you will pay nothing. This is referred to as "traditional" coordination of benefits.

Medicare Order of Determination

For retirees covered by PEIA and Medicare, regardless of age (see exception below), Medicare is the primary insurer and PEIA is the secondary insurer. All claims must be submitted to Medicare and then to PEIA along with an Explanation of Medicare Benefits (EOMB). Generally claims are submitted to Medicare and then to PEIA by your provider or by Medicare through the Medicare Cross-over program.

When you become an eligible beneficiary of Medicare, you must enroll in Medicare Part A and Medicare Part B. Part A is an entitlement program and is available without payment of a premium to most individuals. Part B is the supplementary medical insurance program that covers physician services, outpatient laboratory and x-ray tests, durable medical equipment and outpatient hospital care. Part B is a voluntary program that requires payment of a monthly premium.

If you do not enroll in Medicare Part B, PEIA will process your claims as if you did have the Part B coverage. In other words, PEIA will pay only the amount we would have paid if Medicare had processed your claim and made a payment.

If you or your dependents have other coverage in addition to PEIA and Medicare, contact Acordia National or PEIA to determine what coverage will be primary, secondary or tertiary (third) and whether you need to enroll in Medicare Part B.

Exception: If you are entitled to Medicare as an End Stage Renal Disease (ESRD) beneficiary, call Acordia National or PEIA to determine who the primary insurer will be.

Medicare for Active Employees

For PEIA PPB Plan active employees who are age 65 or older and eligible for Medicare, as long as you are an active employee, PEIA will be your primary insurer, except in a few rare cases. As long as you are an active employee, you do not need to sign up for Medicare Part B and pay the premium. When you prepare to retire, you must enroll for Medicare Part B. If you do not enroll in Medicare Part B, PEIA will process your claims as if you did have the Part B coverage. In other words, PEIA will pay only the amount we would have paid if Medicare had processed your claim and made a payment.

For PEIA PPB Plan active employees who are also eligible for Medicare, and Medicare is the primary payor, PEIA will use the traditional method of coordinating benefits.

If you become eligible for Medicare prior to age 65, please send a copy of your Medicare card to PEIA. This notification may allow PEIA to reduce your premiums, and will make the claims payment process go much more smoothly.

Recovery Of Incorrect Payments

If PEIA discovers that a claim has been paid incorrectly, or that the charges were excessive or for non-covered services, PEIA has the right to recover its payments from any person or any entity.

You must cooperate fully with the PEIA to help it recover any such payment. The PEIA may request refunds or deduct overpayments from a provider's check in order to recover incorrect payments. This provision shall not limit any other remedy provided by law.

Subrogation and Reimbursement

PEIA may pay medical expenses on an insured's behalf in those situations where an injury, sickness, disease or disability, is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of a PEIA insured where other insurance (such as auto or homeowners) is available. As a condition of receiving such expenses, the PEIA and its agents have the right to recover the cost of such medical expenses from the responsible party directly (whether an unrelated third party or another covered insured) or from their insured, if they have already been reimbursed by another. This right is known as subrogation.

The PEIA is legally subrogated to its insured as against the legally responsible party, but only to the extent of the medical expenses paid on the insured's behalf by the PEIA attributable to such sickness, injury, disease, or disability. PEIA has the right to seek repayment of expenses from, among others, the party that caused the illness or injury, his or her liability carrier or the PEIA insured's own auto insurance carrier in cases of uninsured, underinsured motorist coverage, or medical pay provisions. Subrogation applies, but it is not limited to, the following circumstances:

- a. payments made directly by the person who is liable for a PEIA insured's sickness, injury, disease or disability, or any insurance company which pays on behalf of that person, or any other payments on his or her behalf;
- b. any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured, underinsured motorist policy or medical pay provisions on the insured's behalf; and
- c. any payments from any source designed or intended to compensate a PEIA insured for sickness, injury, disease, or disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.

Your Responsibilities:

It is the obligation of the PEIA insured to:

1. notify the PEIA in writing of any injury, sickness, disease or disability for which the PEIA has paid medical expenses on behalf of a PEIA insured that may be attributable to the wrongful or negligent acts of another person;
2. notify the PEIA in writing if the insured retains services of an attorney, and of any demand made or lawsuit filed on behalf of a PEIA insured, and of any offer, proposed settlement, accepted settlement, judgment, or arbitration award;
3. provide the PEIA or its agents with information it requests concerning circumstances that may involve subrogation, provide any reasonable assistance requested in assimilating such information and cooperate with the PEIA or its agents in defining, verifying or protecting its rights of subrogation and reimbursement; and
4. promptly reimburse the PEIA for benefits paid on behalf of a PEIA insured attributable to the sickness, injury, disease, or disability, once they have obtained money through settlement, judgment, award, or other payment.

Non-Compliance

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

- the PEIA's withholding payment of further benefits; and
- an obligation by the PEIA insured to pay costs, attorneys' fees and other expenses incurred by the PEIA in obtaining the required information or reimbursement.

By acceptance of benefits paid under the plan, the PEIA insured agrees that PEIA's rights of subrogation and reimbursement shall have a priority lien and the right of first recovery against any settlement or judgment obtained by or on behalf of an insured. This right shall exist without regard to allocation or designation of the recovery.

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

Please note: As with any claim, the claims resulting from an accident or other incident which may involve subrogation should be submitted within the PEIA's timely filing requirement of six (6) months. It is not necessary that any settlement, judgment, award, or other payment from a third party have been reached or received before filing a claim with the PEIA or with one of the managed care plans associated with the PEIA.

Prescription Drug Benefits

Along with your PEIA PPB Plan medical coverage, you also have prescription drug coverage. The prescription drug program is administered by Express Scripts. There are three parts to the program:

- the Retail Pharmacy Program gives you access to local participating pharmacies to get your prescriptions filled.
- the Express Scripts Mail Service Pharmacy Program lets you order your prescriptions through the mail, saving you time and money by having your maintenance medications delivered to your door.
- the Curascript Specialty Medication Program provides your common specialty medications through the mail, saving you time by having your medications delivered to your door or to your physician's office.

Your prescription drug benefits pay for a wide range of medications, with differing copayments depending on where you purchase those drugs, and how large a supply you buy.

Deductible

During any plan year, if you or your eligible dependents incur expenses for covered prescription drugs, you must meet a deductible before the plan begins to pay. The deductibles are:

Prescription Drug Deductibles		
	PPB Plan A	PPB Plan B
Policyholder Only	\$75	\$150
Policyholder & Child(ren)	\$125	\$300
Family	\$125	\$300
Family with Employee Spouse	\$125	\$300

This means you will pay the amount listed in the chart above before the plan begins to pay.

The family deductible is greater than the individual deductible. The family deductible is divided up among the family members. No one member of the family will pay more than the individual deductible. Once that person has met the individual deductible, the plan will begin paying on that person. When another member of the family meets the individual deductible, then the plan will begin paying on the entire family. Alternatively, all members of the family may contribute to the family deductible with no one person meeting the individual deductible; once the family deductible is met, the plan pays on all members of the family.

After you meet your deductible, you will pay copayments based on the amount and type of drug you're taking. The chart on the next page shows the copayments.

What You Pay

Once you meet your deductible, you pay a copayment to obtain drugs. Copayments are the portion of the cost that you are required to pay per new or refill prescription. The rest of the cost is paid by PEIA. Several factors determine your copayment.

Generic Drugs

The brand name of a drug is the product name under which the drug is advertised and sold. Generic medications have the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs. Please ask your doctor to prescribe generic drugs whenever possible.

West Virginia Preferred Drug List (WVPDL)

The West Virginia Preferred Drug List (WVPDL) is a list of carefully selected medications that can assist in maintaining quality care while providing opportunities for cost savings to the PEIA PPB Plan. Under this program, your plan requires you to pay a lower

copayment for medications on the WVPDL and a higher copayment for medications not on the WVPDL. By asking your doctor to prescribe WVPDL medications, you can maintain high quality care while you help to control rising health-care costs.

Here's how the copayment structure works:

- **Highest Copayment:** You will pay the highest copayment for brand-name drugs that are not listed on the WVPDL.
- **Middle Copayment:** You will pay a mid-level copayment for brand-name drugs that are listed on the WVPDL.
- **Lowest Copayment:** You will pay the lowest copayment for all generic drugs. Generic drugs are subject to the same rigid U.S. Food and Drug Administration standards for quality, strength and purity as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs. Please ask your doctor to prescribe generic drugs for you whenever possible.

Sometimes your doctor may prescribe a medication to be "dispensed as written" when a WVPDL brand name or generic alternative drug is available. As part of your plan, an Express Scripts pharmacist or your retail pharmacist may discuss with your doctor whether an alternative formulary or generic drug might be appropriate for you. Your doctor always makes the final decision on your medication, and you can always choose to keep the original prescription at the higher copayment.

Drugs on the WVPDL are determined by the Express Scripts Pharmacy and Therapeutics Committee. The committee, made up of physicians, meets quarterly to review the medications currently on the Formulary, and to evaluate new drugs for addition to the Formulary. The Formulary may change periodically, based on the recommendations adopted by the committee.

If you have any questions about the copayment structure or about your WVPDL, please call Express Scripts Member Services at 1-877-256-4680.

Prescription Drug Co-payments			
PEIA PPB Plan A			
	Up to a 34-day supply	35- to 68-day supply*	69- to 90-day supply*
Generic Drug	\$5	\$10	\$15
Brand-name drug listed on the WV Preferred Drug List	\$15	\$30	\$45
Brand-name drug not listed on the WV Preferred Drug List	\$30	\$60	\$90
Common Specialty Medications	\$50	not available	not available
PEIA PPB Plan B			
Generic Drug	\$5	\$10	\$15
Brand-name drug listed on the WV Preferred Drug List	\$20	\$40	\$60
Brand-name drug not listed on the WV Preferred Drug List	\$50	\$100	\$150
Common Specialty Medications	\$50	not available	not available
* For maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. You may be able to get a discount on your maintenance medications through a Retail Maintenance Network pharmacy or through Mail Service. Read on for details.			
Should your doctor prescribe or you request the brand-name drug when a generic drug is available, you must pay the difference in price, plus the applicable generic co-payment.			

Prescription Out-of-Pocket Maximum

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

Getting Your Prescriptions Filled

Using A Retail Network Pharmacy

Express Scripts has a nationwide network of pharmacies. To get a prescription filled, simply present your medical/prescription drug ID card at a participating Express Scripts pharmacy. You can purchase both acute and maintenance medications at an Express Scripts network pharmacy.

Your ID card contains personalized information that identifies you as a PEIA PPB Plan member, and ensures that you receive the correct coverage for your prescription drugs.

If you use an Express Scripts pharmacy, you do not have to file a claim form. The pharmacist will file the claim for you online, and will let you know your portion of the cost.

If you use a network pharmacy and choose not to have the pharmacist file the claim for you online, you will pay 100% of the prescription price at the time of purchase. You may submit the receipt with a completed claim form to Express Scripts for reimbursement. The prescription receipt must be attached to the form. You will usually be reimbursed within 21 days from receipt of your claim form. You will be reimbursed the amount PEIA would have paid, less your required copayment, your deductible (if applicable), and a \$3 fee. This reimbursement may be less than you paid for the prescription.

If you need claim forms, call Express Scripts Member Services at 1-877-256-4680 or visit their website at www.express-scripts.com.

To find the participating pharmacies nearest you, call Express Scripts Member Services at 1-877-256-4680 and use the voice-activated Pharmacy Locator System. If you have Internet access, you can find a pharmacy online at www.express-scripts.com.

Using the Retail Maintenance Network

If you take a drug on a long-term basis, you may be able to purchase a 90-day supply of that drug if it is on the maintenance list (see the Maintenance Drug List). PEIA offers a Retail Maintenance Network of pharmacies that will fill your 90-day prescription for just two copayments. You can buy two months and get one month free. Check with your local pharmacist to verify participation.

Using Non-Network Pharmacies

If you use a non-participating pharmacy, you will pay 100% of the prescription price at the time of purchase, and submit a completed claim form to Express Scripts. The prescription receipt must be attached to the form. You will usually be reimbursed within 21 days from receipt of your claim form. You will be reimbursed the amount PEIA would have paid at a participating pharmacy, less your required copayment, your deductible (if applicable), and a \$3 fee. This reimbursement may be less than you paid for the prescription.

If you need claims forms, call Express Scripts Member Services at 1-877-256-4680 or visit their website at www.express-scripts.com.

Using the Express Scripts Mail Service Pharmacy Program

Express Scripts provides a convenient mail service pharmacy program for PEIA PPB Plan insureds. You may use the mail service pharmacy if you're taking medication to treat an ongoing health condition, such as high blood pressure, asthma, or diabetes.

When you use the mail service pharmacy, you can order up to a 90-day supply of a medication on the maintenance list, as prescribed by your doctor, and pay only two copayments. Express Scripts' licensed professionals fill every prescription following strict quality and safety controls. If you have questions about your prescription, registered pharmacists are available around the clock to consult with you.

New Prescriptions and the Mail Service Pharmacy

If you want to use the mail service pharmacy, the first time you are prescribed a medication that you will need on an ongoing basis, ask your doctor for two prescriptions: the first for a 14-day supply to be filled at a participating retail pharmacy; the second, for up to a 90-day supply, to be filled through the mail service pharmacy. There are several ways to submit your mail service prescriptions. Just follow the steps below. Some restrictions apply.

1. Ordering new prescriptions. Ask your doctor to prescribe your medication for up to a 90-day supply for maintenance medications, plus refills if appropriate. Mail your prescription and required copayment along with an order form in the

envelope provided. Or ask your doctor to fax your order to 1-800-636-9494. You will need to give your doctor your member ID number located on your ID card.

2. Refilling your medication. A few simple precautions will help ensure you don't run out of your prescription. Remember to reorder on or after the refill date indicated on the refill slip. Or reorder when you have less than 14 days of medication left.
 - Refills online: Log on to Express Scripts' website at www.express-scripts.com. Have your member ID number, the prescription number (it's the 9-digit number on your refill slip), and your credit card ready when you log on.
 - Refills by phone: Call 1-877-256-4680 and use the automated refill system. Have your member ID number, refill slip with the prescription number, and your credit card ready.
 - Refills by mail: Use the refill and order forms provided with your medication. Mail them with your copayment.
3. Delivery of your medication. Prescription orders receive prompt attention and, after processing, are usually sent to you by U.S. mail or UPS within two weeks. Your enclosed medication will include instructions for refills, if applicable. Your package may also include information about the purpose of the medication, correct dosages, and other important details.
4. Paying for your medication. You may pay by check, money order, VISA, MasterCard, Discover or American Express. Debit cards are not accepted for payment.

Please note: *The pharmacist's judgment and dispensing restrictions, such as quantities allowable, govern certain controlled substances and other prescribed drugs. Federal law prohibits the return of any dispensed prescription medicines.*

Maintenance Drug Co-payments				
	PEIA PPB Plan A		PEIA PPB Plan B	
	Up to 34-day supply	35 to 90-day supply*	Up to 34-day supply	35 to 90-day supply*
Generic medication	\$5	\$10	\$5	\$10
Brand-name medication listed on the WV Preferred Drug List	\$15	\$30	\$20	\$40
Brand-name medication not listed on the WV Preferred Drug List	\$30	\$60	\$50	\$100
* For maintenance medications only. See the Maintenance Medications section for the list of qualifying medicationst.				
Should your doctor prescribe or you request the brand-name drug when a generic drug is available, you must pay the difference in price, plus the applicable generic co-payment.				

Prior Authorization

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

PEIA will cover, and your pharmacist can dispense, up to a five-day supply of a medication requiring prior authorization for the applicable copayment. This policy applies when your doctor is either unavailable or temporarily unable to complete the prior authorization process promptly. Prior authorizations may be approved retroactively for up to 30 days to allow time for the physician to work with and provide documentation to RDT. If the prior authorization is ultimately approved, your pharmacist will be able to dispense the remainder of the approved amount with no further copayment for that month's supply if you have already paid the full copayment.

The medications listed below require prior authorization:

1. becaplermin (Regranex®)

2. Botox®*
3. Brand-name medically necessary prescriptions. If the medication your doctor prescribes is a multi-source drug (that is, more than one manufacturer markets the drug), and there is an FDA-approved—or "A-B-rated"—generic on the market, then PEIA will pay only for the generic version, unless your physician provides medical justification for coverage of the brand-name drug. If prior authorization is granted, these drugs will be covered as non-preferred brand-name drugs.
4. ciclopirox (Penlac®)
5. erythroid stimulants (Epogen®, Procrit®, Aranesp®)*
6. fentanyl (Actiq® and Duragesic®)
7. fluconazole (Diflucan®)
8. growth hormones*
9. itraconazole (Sporanox®)
10. legend oral contraceptives for dependents (covered for treatment of medical conditions only)
11. leuprolide (Lupron®, Lupron Depot®)*
12. modafinil (Provigil®) for adults (*for pharmacy benefits, PEIA defines "adults" as 19 years of age and older.*)
13. Myobloc®*
14. oxycodone hydrochloride (Oxycontin®)
15. tazarotene (Tazorac®)
16. terbinafine (Lamisil®)
17. teriparatide (Forteo®)*
18. tretinoin cream (e.g. Retin-A) for individuals 27 years of age or older
19. topiramate (Topamax®)
20. vacation supplies of medication for foreign travel (allow 7 days for processing)
21. voriconazole (VFEND®)
22. zonisamide (Zonegran®)

* These drugs must be purchased through the Common Specialty Medications Program. See information later in this section.

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

Drugs with Special Limitations

Step Therapy

Step Therapy promotes appropriate utilization of first-line drugs and/or therapeutic categories. Step Therapy requires that participants receive one or more first-line drug(s), as defined by program criteria before prescriptions are covered for second-line drugs in defined cases where a step approach to drug therapy is clinically justified.

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

- Angiotensin-Converting Enzyme (ACE) Inhibitors (Accuretic®, Accupril®, Aceon®, Altace®, Capoten®, Capozide®, Lexxel®, Lotesin/HCT®, Lotrel®, Mavik®, Monopril/HCT®, Prinivil®, Prinizide®, Tarka®, Uniretic®, Univasc®, Vasotec®, Vaseretic®)
- Angiotensin II Receptor Antagonists (Atacand/HCT®, Teveten/HCT®, Avapro®, Cozaar®, Benicar/HCT®, Micardis/HCT®, Diovan/HCT®, Avalide®, Hyzaar®)
- Disease-modifying Antirheumatic Drugs (e.g., Enbrel®, Kineret®, Humira®) [Must be purchased through the Common Specialty Medication Program. See information later in this section.]
- Inspira®
- Leukotriene Inhibitors (e.g., Accolate®, Singulair®)
- Non-Steroidal Anti-inflammatory Drugs (brand-name NSAID e.g., Celebrex®, Arthrotec®, Mobic®),

- Proton Pump Inhibitors (e.g., omeprazole, Prilosec®, Prevacid®, Nexium®, Aciphex®, Protonix®),
- Selective Serotonin Reuptake Inhibitors (e.g., Celexa®, Lexapro®, Luvox®, Paxil®, Paxil CR®, Prozac®, Prozac Weekly®, Zoloft®),
- Strattera®, and
- Xopenex®

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

Quantity Limits

Under the PEIA PPB Plan Prescription Drug Program, certain drugs have preset coverage limitations (quantity limits). Quantity limits ensure that the quantity of units supplied in each prescription remains consistent with clinical dosing guidelines and PEIA's benefit design. Quantity limits encourage safe, effective and economic use of drugs and ensure that members receive quality care. Select medications from the quantity limit list are provided on the following page. If you are taking one of the medications listed below and you need to get more of the medication than the plan allows, ask your pharmacist or doctor to call RDT to discuss your refill options.

1. Anzemet®, Emend®, Kytril®, Zofran® coverage limitations:

- Anzemet® is limited to 1 tablet per prescription
- Emend® 80mg is limited to 2 capsules per prescription.
- Emend® 125mg is limited to 1 capsule per prescription.
- Emend® Tri-fold Pack is limited to 1 package per prescription.
- Kytril® is limited to 2 tablets per prescription
- Zofran® 24 mg is limited to 1 tablet per prescription
- Zofran® 4 mg and 8 mg are limited to 12 tablets per prescription
- Zofran® Solution is limited to 3 bottles per prescription

2. Diflucan® 150 mg. Coverage is limited to two tablets per prescription.

3. Migraine medications. Coverage is limited to quantities listed in the chart on the next page.

4. New drugs approved by the FDA that have not yet been reviewed by Express Scripts' Pharmacy and Therapeutics Committee will have a non-preferred status. PEIA reserves the right to exclude a drug or technology from coverage until it has been proven effective.

5. Non-sedating antihistamines (Allegra®, Clarinex®, Zyrtec®). PEIA will cover 34 days of therapy in a 180-day period. Therapy beyond 34 days requires prior authorization from RDT.

6. Toradol. Coverage is limited to one course of treatment (5 days) per 90-day period.

7. Tamiflu® and Relenza®. Coverage is limited to one course of treatment within 180 days. Additional quantities require prior authorization from RDT.

Generic name	Brand name	Quantity Limit Per dispensing	Total Quantity Level Limit within a 28-Day Period
Almotriptan tablets 6.25 mg, 12.5 mg	Axert® - Pharmacia	6 tablets	18 tablets
Dihydroergotamine nasal spray	Migranal® - Novartis	4 spray devices	2 kits = 8 unit dose sprays
Eletriptan tablets 20mg, 40mg	Relpax® - Pfizer	6 tablets	18 tablets
Frovatriptan tablets 2.5 mg	Frova® - ELAN	9 tablets	27 tablets
Naratriptan tablets 1 mg, 2.5 mg	Amerge® - GSK	9 tablets	18 tablets
Rizatriptan tablets 5 mg, 10 mg, orally disintegrating tablets	Maxalt-MLT® - Merck	6 tablets	24 tablets
Rizatriptan tablets 5 mg, 10 mg	Maxalt® - Merck	6 tablets	24 tablets
Sumatriptan injection syringes	Imitrex® - GSK	1 Kit (2 syringes)	8 kits = 16 injections
Sumatriptan injection vials	Imitrex® - GSK	2 vials	16 vials
Sumatriptan nasal spray 20 mg	Imitrex® - GSK	6 spray devices	3 boxes = 18 unit dose spray devices
Sumatriptan nasal spray 5 mg	Imitrex® - GSK	6 spray devices	6 boxes = 36 unit dose spray devices
Sumatriptan tablets 25 mg, 50 mg, 100 mg	Imitrex® - GSK	9 tablets	18 tablets
Zolmitriptan tablets 2.5 mg, 5 mg, orally disintegrating tablets	Zomig-ZMT® - AstraZeneca	6 tablets for 2.5 mg 3 tablets for 5 mg	18 tablets
Zolmitriptan tablets 2.5 mg, 5 mg	Zomig® - AstraZeneca	6 tablets for 2.5 mg 3 tablets for 5 mg	18 tablets

Maintenance Medications

You may receive up to a 90-day supply of the following medications and classes listed below. Only the medications on this list are available in 90-day supplies.

1. alendronate sodium (Fosamax®)
2. antiarthritics
3. anticoagulants
4. anticonvulsants
5. antidementia drugs
6. antihypertensives
7. antiparkinsonism agents
8. antispasmodics: urinary tract
9. benign prostatic hypertrophy/micturition
10. bronchodilators
11. calcitonin (Miacalcin®)
12. cardiovascular agents
13. cholinergic stimulants (urinary retention)
14. corticosteroids, bronchial
15. cromolyn sodium (Intal®)

16. diabetic therapies
17. digestants
18. disposable needles and syringes
19. diuretics
20. enzymes, systemic
21. estrogens and progestins
22. gastrointestinal, colitis
23. glaucoma agents
24. gout medications
25. hormones, misc.
26. immunosuppressive agents
27. legend vitamins (including legend hematinics, vitamin K)
28. leukotriene receptor antagonists (asthma agents)
29. lipotropics (cholesterol lowering agents)
30. mucolytics (pulmonary agents)
31. oral contraceptives
32. legend potassium
33. raloxifene (Evista®)
34. risedronate (Actonel®)
35. selective serotonin reuptake inhibitors (antidepressants in this class only)
36. thyroid medications
37. tuberculosis medications
38. xanthines (asthma agents)

Common Specialty Medications

Beginning July 1, 2005, PEIA has selected CuraScript as the exclusive pharmacy for common specialty medications. This means you will only be able to purchase these specialty medications through CuraScript, and the medication will be mailed to either your home or physician's office. Most often these are self-administered injections.

After you have met your prescription drug deductible, the copayment on these medications will be \$50 for any medications in this class.

Please refer to the list of the most "Common Specialty Medications" on the next page. These drugs are not available in 90-day supplies.

In addition to providing these specialty medications to our members, CuraScript offers:

- A Patient Care Coordinator who serves as your personal advocate and point of contact.
- Delivery of your specialty medications directly to you or your doctor.
- Supplies to administer your medications — at no additional cost.
- Care management programs to help you get the most from your medications.

If you are prescribed one of these common specialty medications, call CuraScript toll-free at 1-866-413-4135 (8 a.m. – 9 p.m., Eastern time, Monday-Friday and 9 a.m. – 1 p.m., Eastern time, Saturday). A Patient Care Coordinator will contact your physician and work with you to schedule a delivery time for the medication.

Common Specialty Medications List

Drug Name	Category
Acthar	Multiple Sclerosis
Aldurazyme	Mucopolysaccharidosis
Aranesp [PA]	Anemia
Arixtra	Anti-Coagulant
Avonex	Multiple Sclerosis
Betaseron	Multiple Sclerosis
Bicillin C-R	Anti-Infectives
Botox [PA]	Migraine, Cerebral Palsy
Cerezyme	Gaucher Disease
Copaxone	Multiple Sclerosis
Copegus	Hepatitis C
Desferal	Diagnostic
Enbrel [ST]	Rheumatoid Arthritis
Epogen [PA]	Anemia
Fabrazyme	Fabry Disease
Fortaz	Anti-Infectives
Forteo [PA]	Osteoporosis
Fragmin	Anti-Coagulant
Fuzeon	HIV
Genotropin [PA]	Growth Hormone
Geref [PA]	Growth Hormone
Humatrope [PA]	Growth Hormone
Humira [ST]	Rheumatoid Arthritis
Infergen	Hepatitis C
Innohep	Anti-Coagulant
Intron A	Interferons
Iressa	Anti-Neoplastic
Kineret [ST]	Rheumatoid Arthritis
Leukine	Hematopoietic
Leuprolide [PA]	Anti-Neoplastic
Lovenox	Anti-Coagulant

Drug Name	Category
Lupron [PA]	Anti-Neoplastic
Lupron Depot [PA]	Endometriosis, Anti-Neoplastic, Precocious Puberty
Myobloc [PA]	Neurologic
Neulasta	Neutropenia
Neumega	Hematopoietic
Neupogen	Neutropenia
Norditropin [PA]	Growth Hormone
Nutropin [PA]	Growth Hormone
Pegasys	Hepatitis C
Peg-Intron	Hepatitis C
Procrit [PA]	Anemia
Protropin [PA]	Growth Hormone
Pulmozyme	Cystic Fibrosis
Rebetol	Hepatitis C
Rebetron	Hepatitis C
Rebif	Multiple Sclerosis
Ribavirin	Hepatitis C
Kimso-50	Anti-Neoplastic
Rocephin	Anti-Infectives
Roferon-A	Anti-Neoplastic
Saizen [PA]	Growth Hormone
Sensipar	Hyperparathyroidism
Serostim [PA]	Growth Hormone
Tarceva	Anti-Neoplastic
Temodar	Anti-Neoplastic
Tev-Tropin [PA]	Growth Hormone
Thalomid	Anti-Neoplastic
Thyrogen Kit	Diagnostic
Tobi	Cystic Fibrosis
Xeloda	Anti-Neoplastic
Zavesca	Gaucher Disease
Zorbtive [PA]	Growth Hormone

[PA] -- This drug requires Prior Authorization from RDT

[ST] -- This drug requires Step Therapy

Diabetes Management

Blood Glucose Monitors: Covered diabetic insureds can receive a free Bayer Ascensia Elite®, Ascensia Elite® XL, Ascensia DEX2®, Ascensia Breeze® or Ascensia Contour® blood glucose monitor with a current prescription. Simply ask your pharmacist, and he or she will contact Bayer by fax or mail to request the monitor.

Glucose Test Strips: The plan covers only Bayer Ascensia Elite®, Ascensia® Autodisc, or Ascensia® Microfill test strips at the preferred copayment of \$15 per 34-day supply. Other brands require a 100% copayment.

Needles/Syringes and Lancets: You can obtain a supply of disposable needles/syringes and lancets for the copayments listed below:

Coverage	Needles/Syringes	Lancets
At the retail pharmacy:		
Up to a 34-day supply	\$10	\$5
35- to 68-day supply	\$20	\$10
69- to 90-day supply	\$30	\$15
Through the mail service and retail maintenance network pharmacies:		
Up to a 34-day supply	\$10	\$5
35- to 90-day supply	\$20	\$10

Tobacco Cessation Program

PEIA has a tobacco cessation program that includes coverage for Zyban® and nicotine withdrawal drugs. The drugs are covered under your prescription drug program after you call the PEIA Quit Line: 1-877-966-8784. The program also includes phone coaching services and printed information.

What is Covered?

After the Quit Line is contacted, PEIA will cover prescription and over-the-counter (OTC) tobacco cessation products only if they are dispensed with a prescription. Coverage is limited to one twelve-week cycle per plan year, two cycles per lifetime. Zyban® is available for the Brand-preferred copayment. Nicotine withdrawal therapy is available for the generic copayment of \$5 for up to a 34-day supply.

From time to time PEIA may offer special discounts on nicotine withdrawal therapy. Call the Quit Line at 1-877-966-8784 for details.

Who is Eligible for Tobacco Cessation?

PEIA PPB Plan insureds will be screened for eligibility and readiness. Pregnant women will be offered 100% coverage during any pregnancy.

Drugs or Services That Are Not Covered

Your plan does not cover the following medications or services:

1. Amounts paid by Medicare for drugs covered by Medicare
2. Anorexients (any drug used for the purpose of weight loss)
3. Anti-wrinkle agents (e.g., Renova®)
4. Birth control drugs for dependent children
5. Bleaching agents (e.g., Eldopaque®, Eldoquin Forte®, Melanex®, Nuquin®, Solaquin®)
6. Charges for the administration or injection of any drug

7. Contraceptive devices and implants
8. Drugs dispensed by a hospital, clinic or physician's office
9. Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs not approved by the FDA, even though a charge is made to the individual
10. Drugs prescribed for uses not approved by the FDA
11. Drugs requiring a prescription by State law, but not by federal law (State controlled) are not covered
12. Erectile dysfunction medications
13. Fertility drugs
14. Fioricet® with Codeine
15. Fiorinal® with Codeine
16. Hair growth stimulants
17. Homeopathic medications
18. Immunizations, biological sera, blood or blood products, Hyalgan®, Synvisc®, Remicade®, Synagis®, Xolair®, Amevive®, Raptiva® (these are covered under the medical plan)
19. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, sanitarium, or extended care facility
20. Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, or any State or governmental agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member
21. Non-legend drugs (except when included in a compound with a legend drug)
22. Pentazocine/Acetaminophen (Talacen®)
23. Prescription drug charges not filed within 6 months of the purchase date, if PEIA is the primary insurer, or within 6 months of the processing date on the Explanation of Benefits (EOB) from the other plan, if PEIA is secondary
24. Replacement medications for lost or stolen drugs
25. Requests for more than a 90-day supply of maintenance medications, or requests for more than a 34-day supply of short-term medications
26. Stadol® Nasal Spray
27. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those listed above
28. Vacation supplies, unless leaving the country.

Other Important Features of Your Prescription Drug Program

Your prescription drug program is designed to provide the care and service you expect, whether it's keeping a record of your medication history, providing toll-free access to a registered pharmacist, or keeping you in touch with any changes to your program.

Express Scripts uses the health and prescription information about you and your dependents to administer your benefits. They also use information and prescription data from claims submitted nationwide for reporting and analysis without identifying individual patients.

When your prescriptions are filled at one of Express Scripts' mail service pharmacies or at a participating retail pharmacy, pharmacists use the health and prescription information on file for you to consider many important clinical factors including drug selection, dosing, interactions, duration of therapy and allergies. Express Scripts' pharmacists may also use information received from your network retail pharmacy.

Drug Utilization Review

Under the drug utilization review program, prescriptions filled through the mail service pharmacy and participating retail pharmacies are examined by Express Scripts for potential drug interactions based on your personal medication profile. The drug utilization review is especially important if you or your covered dependents take many different medications or see more than one doctor. If there is a question about your prescription, your pharmacist may notify your doctor before dispensing the medication.

Education and Safety

You will receive information about critical topics like drug interactions and possible side effects with every new prescription Express Scripts mails. Your retail pharmacy may also provide you with drug information.

By visiting www.express-scripts.com, you also can access other health-related information. Click on Drug Information or Health Information to browse information relative to specific health interests, get safety tips and answers to the most commonly asked medication questions, or just keep up with timely health issues. To view health information personalized to fit your interests, register with www.express-scripts.com. Any written health information cannot replace the expertise and advice of health care practitioners who have direct contact with a patient. All Express Scripts health information is designed to help you communicate more effectively with your doctor and, as a result, understand more completely your situation and choices.

Health Management

Based on your prescription and health information, Express Scripts may provide information to you on one or more of Express Scripts' Care Management programs, provided as a service to you by PEIA. Program participants generally receive educational mailings and may receive a follow-up call from an Express Scripts pharmacist or nurse. Express Scripts develops these programs to support your doctor's care, and they may contact your doctor regarding your participation in these programs.

Coordination of Benefits

If another insurance carrier is the primary insurer for a policyholder or a dependent, or if you are Medicare-eligible, PEIA will pursue coordination of benefits.

1. Commercial Insurance: As a secondary payor, PEIA will pay only if the other insurance plan's benefit is less than what PEIA would have provided as the primary insurer. If PEIA is the secondary insurer, you must submit the following documentation to Express Scripts to have the secondary claim processed:
 - a. a completed Express Scripts claim form;
 - b. the receipt from the pharmacy; and
 - c. an Explanation of Benefits from the primary plan or a pharmacy printout that shows the amount paid by the primary plan.

You will usually be reimbursed within 21 days from receipt of your claim form.

If you need claims forms, call Express Scripts' Member Services at 1-877-256-4680 or visit their website at www.express-scripts.com.

2. Medicare: If Medicare is the primary insurer, Medicare must be billed first for any drugs covered by Medicare Part B. Your pharmacist should bill Medicare Part B as the primary insurer. Acordia will receive the crossover claims from Medicare Part B and pay the pharmacy directly. This will save you money since PEIA will pay the member responsibility for prescription drugs covered by Medicare Part B. You should not pay any deductible or co-insurance for Medicare Part B-covered drugs. You can find a listing of pharmacies willing to bill Medicare and accept assignment on our web page at www.wvpeia.com or by calling our customer service unit at 1-888-680-7342. These classes of drugs are usually covered by Medicare Part B:
 - Immunosuppressants
 - Oral Chemotherapeutic medications
 - Drugs for nausea associated with chemo meds
 - Diabetic testing supplies
 - Limited Inhalation therapies

Medicare Part D

Beginning January 1, 2006, Medicare will offer a new program, Medicare Part D (prescription drug coverage). Please be aware that you DO NOT have to purchase Medicare Part D (prescription drug coverage) when it becomes available. PEIA will continue to provide prescription drug coverage to our Medicare members, and Medicare Part D will be of little or no use to you.

Appealing a Claim

If you think that an error has been made in processing your prescription drug claim or in a prescription benefit determination or denial, first call Express Scripts or RDT (depending on the nature of your complaint) to ask for details. If you are not satisfied with the outcome of your telephone inquiry, the second step is to appeal to Express Scripts or RDT in writing. Please have your physician provide any additional relevant clinical information to support your request. Mail your request with the above information to:

Type of Error	Who to Call	Where to Write
Prior Authorization error or denial	RDT 1-800-847-3859	Rational Drug Therapy Program WVU School of Pharmacy PO BOX 9511 HSCN Morgantown, WV 26506
Prescription drug claim payment error or denial	Express Scripts 1-877-256-4680	Express Scripts, Inc. Clinical Appeals - (Client-WVA) BL0390 6625 W. 78th Street Bloomington, MN 55439

Express Scripts or RDT will respond in writing to you and your physician with a letter explaining the outcome of the appeal. If this does not resolve the issue, the third step is to appeal in writing to the director of PEIA. Your physician must request a review in writing within sixty (60) days of receiving the decision from Express Scripts or RDT. Mail third step appeals to:

Director
Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, WV 25305-0710

Facts, issues, comments, letters, Explanations of Benefits (EOBs), and all pertinent information about the claim and review should be included. When your request for review arrives, PEIA will reconsider the entire case, taking into account any additional materials that have been provided. A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the covered person or his or her authorized representative. For more information about your drug coverage, please contact Express Scripts at 1-877-256-4680.

How to Reach Express Scripts

On the Internet: Reach Express Scripts at www.express-scripts.com. Visit Express Scripts' website anytime to learn about patient care, refill your mail service prescriptions, check the status of your mail service pharmacy order, request claim forms and mail service order forms or find a participating retail pharmacy near you.

By Telephone: For those insureds who do not have access to Express Scripts via the Internet, you can learn more about your program by calling Express Scripts Member Services at 1-877-256-4680, 24 hours a day, 7 days a week.

Special Services: Express Scripts continually strives to meet the special needs of PEIA's insureds:

- You may call a registered pharmacist at any time for consultations at 1-877-256-4680.
- PEIA's hearing-impaired insureds may use Express Scripts' TDD number at 1-800-972-4348.
- Visually impaired insureds may request that their mail service prescriptions include labels in Braille by calling 1-877-256-4680.

Prescription Drug Copayment Assistance Program

PEIA offers a program to assist retired employees who struggle to deal with increasing prescription drug costs in the PEIA PPB Plan. This assistance reduces prescription drug copayments for those who qualify.

Who Qualifies for the Assistance Program?

Retired employees whose annual household income falls below 250% of the federal poverty level, and who are members of the PEIA PPB Plan can qualify for assistance. Retired employees who receive Premium Assistance from PEIA are automatically enrolled in

this program. Retired employees who are using sick or annual leave or years of service to extend their employer-paid insurance qualify for this program if their annual income meets the guidelines.

What is Available under the Program?

If you qualify for assistance, PEIA will provide you with the reduced prescription copayments based on your years of service as shown in the chart on the next page, as well as generic drugs for \$3 for each 30-day supply regardless of your years of service. These reduced copayments are available to you at your local pharmacy or through the Express Scripts Mail Service Pharmacy Program. To take full advantage of the Prescription Drug Copayment Assistance Program, it is best to get your maintenance medications in 90-day supplies. When you fill a 90-day prescription through mail order or at a Retail Maintenance Network pharmacy, you'll pay for only two thirty-day supplies—you get one thirty-day supply for no copayment. See "Getting Your Prescriptions Filled" for details of the benefits of the Retail Maintenance Network and the Express Scripts Mail Service Pharmacy Program.

Years of active service	Brand-Preferred Co-payment		Brand Non-preferred Co-payment	
	30-day supply at a Retail Pharmacy	Up to 90-day supply by mail or at a Retail Maintenance Network Pharmacy	30-day supply at a Retail Pharmacy	Up to 90-day supply by mail or at a Retail Maintenance Network Pharmacy
20 or more	\$6	\$12	\$21	\$42
10 through 19	\$9	\$18	\$29	\$58
5 through 9	\$12	\$24	\$30	\$60
less than 5	\$15	\$30	\$30	\$60

How Do You Apply for Assistance?

If you believe you qualify, contact PEIA for an application, or you can print a copy at www.wvpeia.com.

Amending the Benefit Plan

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

If you have questions about this notice, please contact the person listed under "[Who to Contact](#)" at the end of this notice.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary

In order to provide you with benefits, PEIA will receive personal information about your health, from you, your physicians, hospitals, and others who provide you with health care services. We are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

Occasionally, we may use members' information when providing treatment. We use members' health information to provide benefits, including making claims payments and providing customer service. We disclose members' information to health care providers to assist them to provide you with treatment or to help them receive payment, we may disclose information to other insurance companies as necessary to receive payment, we may use the information within our organization to evaluate quality and improve health care operations, and we may make other uses and disclosures of members' information as required by law or as permitted by PEIA policies.

Kinds Of Information That This Notice Applies To

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you.

Who Must Abide by This Notice

PEIA

All employees, staff, students, volunteers and other personnel whose work is under the direct control of PEIA.

The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

Our Legal Duties

We are required by law to maintain the privacy of your health information

We are required to provide this notice of our privacy practices and legal duties regarding health information to anyone who asks for it.

We are required to abide by the terms of this notice until we officially adopt a new notice.

How We May Use or Disclose Your Health Information.

We may use your health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. **Treatment.** We may use your health information to provide you with medical care and services. This means that our employees, staff, students, volunteers and others whose work is under our direct control, may read your health information to learn about your medical condition and use it to help you make decisions about your care. For instance, a health plan nurse may take your blood pressure at a health fair. We will also disclose your information to others to provide you with options for medical treatment or services. For instance, we may use health information to identify members with certain chronic illnesses, and send information to them or to their doctors regarding treatment alternatives.
2. **Payment.** We will use your health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our customer service department or at our claims processing administrator may use your health information to help pay your claims. And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the subscriber and each dependent who are enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information confidentially: see the "[Confidential Communication](#)" section in this notice. We may also disclose some of your health information to companies with whom we contract for payment-related services. For instance, if you owe us money, we may give information about you to a collection company that we contract with to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.
3. **Health Care Operations.** We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may also provide health information to students who are authorized to receive training here. We may disclose your health information as necessary to others who we contract with to provide administrative services or health care coverage. This includes our third-party administrators, available managed care plans, lawyers, auditors, accreditation services, and consultants, for instance.
4. **Legal Requirement to Disclose Information.** We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the state health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by state auditors. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.
5. **Public Health Activities.** We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.
6. **To Report Abuse.** We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.
7. **Law Enforcement.** We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations.
8. **Specialized Purposes.** We may disclose the health information of members of the armed forces as authorized by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, and protection of the president. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution.
9. **To Avert a Serious Threat.** We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

10. **Family and Friends.** We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.
11. **Research.** We may disclose your health information in connection with medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.
12. **Information to Members.** We may use your health information to provide you with additional information. This may include sending newsletters or other information to your address. This may also include giving you information about treatment options, alternative settings for care, or other health-related options that we cover.
13. **Health Benefits Information.** If your enrollment in PEIA's health plan is offered through your employer, your employer may receive limited information, as necessary, for the administration of their health benefit program. The employers will not receive any additional information unless it has been de-identified or you have authorized its release.

Your Rights

1. **Authorization.** We may use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. If you authorize us to use or disclose your health information, in additional circumstances you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the person listed under **"Who to Contact"** at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.
2. **Request Restrictions.** You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.
3. **Confidential Communication.** If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your health information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will agree to any reasonable request.
4. **Inspect And Receive a Copy of Health Information.** You have a right to inspect the health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under **"Who to Contact"** at the end of this notice. We will respond to your request within 30 days. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.
5. **Amend Health Information.** You have the right to ask us to amend health information about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.
6. **Accounting of Disclosures.** You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. We cannot include disclosures made before April 14, 2003. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.
7. **Paper Copy of this Privacy Notice.** You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under **"Who to Contact"** at the end of this notice.
8. **Complaints.** You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under **"Who to Contact"** at the end of this notice. You may also file a complaint directly with the:
 Region III, Office for Civil Rights
 U.S. Department of Health and Human Services
 150 South Independence Mall West, Suite 372, Public Ledger Building
 Philadelphia, PA 19106-9111.
All complaints must be in writing. We will not take any retaliation against you if you file a complaint.

Our Right to Change This Notice

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all subscribers within 60 days of the effective date.

Who to Contact

Contact the person listed below:

- For more information about this notice, or
- For more information about our privacy policies, or
- If you want to exercise any of your rights, as listed on this notice, or
- If you want to request a copy of our current notice of privacy practices.

Privacy Officer, West Virginia Public Employees Insurance Agency
 Building 5, Room 1001, 1900 Kanawha Blvd. E.
 Charleston, WV 25305-0710
 304-558-7850 or 1-888-680-7342

Copies of this notice are also available at the reception desk of the PEIA office at the address above. This notice is also available by e-mail. Send an e-mail to: peia@peia.state.wv.us.



**Public Employees
Insurance Agency**

State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, WV 25305-0710

PRSRT STD
U.S. POSTAGE
PAID
CHARLESTON,
WV
PERMIT NO. 55

WHO TO CALL WITH QUESTIONS

**Health Claims, Benefits, Preauthorizations
and Prior Approvals for Out-of-State Care**

Acordia National 1-304-353-7820
or 1-888-440-7342 (toll-free)
or on the web at: www.acordianational.com

Precertification and Utilization Management

Acordia National 1-304-353-7820
or 1-888-440-7342 (toll-free)
or on the web at: www.acordianational.com

Prescription Drug Benefits and Claims

Express Scripts
1-877-256-4680 (toll-free)
or on the web at: www.express-scripts.com

Subrogation and Recovery

Beacon Recovery Group
1-800-874-0500 (toll-free)

PEIA

*Answers to questions about eligibility,
life insurance and third-level claim appeals.*
WV Public Employees Insurance Agency
1-304-558-7850

or 1-888-680-7342 (toll free)
or on the web at: www.wvpeia.com

Mountaineer Flexible Benefits

*Dental, vision, and disability insurance and
flexible spending accounts.*

Fringe Benefits Management Company
1-800-342-8017 (toll free)
or on the web at: www.fbmc-benefits.com

Managed Care Plans

Carelink
1-800-348-6961 (toll-free)
or on the web at: www.cvty.com

The Health Plan

1-800-624-6961 (toll-free)
or 1-740-695-3585
or on the web at: www.healthplan.org

Joe Manchin III
Governor



Keith Huffman
Acting Co-Director
and
General Counsel

WV Toll-free: 1-888-680-7342 • Phone: 1-304-558-7850 • Fax: 1-304-558-2516 • Internet: www.wvpeia.com

September 15, 2005

The Honorable Betty Ireland
Secretary of State
1900 Kanawha Boulevard, East
Building 1, Suite 157-K
State Capitol
Charleston, West Virginia 25305

Re: PEIA Plan Document
For Plan Year 2006

FILED
2005 SEP 15 A 10:00
OFFICE WEST VIRGINIA
SECRETARY OF STATE

Dear Secretary Ireland:

Enclosed, for filing, please find the West Virginia Public Employees Insurance Agency's Plan Document for Plan Year 2006, which became effective July 1, 2005. This version of the Plan Document will remain in affect until amended or replaced.

Thank you very much for your attention to this matter.

Sincerely,

B. Keith Huffman
General Counsel and Acting Co-Director

BKH/pb

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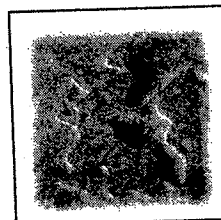
Value life's benefits

2004/2005 Mountaineer Flexible Benefits Plan
Public Employees Insurance Agency

Employee Benefits Resource Directory

COMPANY	DEPARTMENT	HOURS	PHONE/WEB ADDRESS
Delta Dental of West Virginia (Dental)	Member Services	M-F 8 a.m. - 8 p.m. ET	1-800-932-0783 www.MidAtlanticDeltaDental.com
Vision Service Plan (Vision)	Customer Service	M - F 8 a.m. - 7 p.m. ET	1-800-877-7195 www.vsp.com
Standard Insurance Company (STD, LTD)	STD/ LTD Claims	M-F 8:30 a.m. - 5 p.m. ET	1-800-368-2859 www.standard.com
Fringe Benefits Management Co. (Flexible Spending Accounts)	FBMC Customer Service Automated Services	M - F 7 a.m. - 10 p.m. ET 24 hours a day	1-800-342-8017 1-800-865-FBMC (3262) www.fbmc-benefits.com
Trustmark Insurance Company* (LifeEvents®)	Customer Service	M-F 7 a.m. - 6 p.m. CT	1-800-918-8877 www.trustmarkinsurance.com
Hyatt Legal Plans, Inc. (Legal)	Client Service Center	M-Th 8 a.m. - 7 p.m. ET F 8 a.m. - 6 p.m. ET	1-800-821-6400 www.legalplans.com

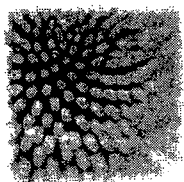
*Trustmark will no longer offer new LifeEvents® policies. Employees who currently have LifeEvents® may continue coverage.



Mountaineer Flexible Benefits Plan

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Access Your Benefits *On the web and over the phone*

FBMC Web Site

FBMC's Web site provides comprehensive information regarding your benefits and details on your Flexible Spending Account(s).

Enter www.fbmc-benefits.com into your Internet browser. This will bring you to FBMC's homepage. Navigational tabs to customer links are located along the top portion of the page. By simply clicking on one of these tabs and entering your Social Security Number and Personal Identification Number (PIN), you'll be able to access the information you need. The following Web site customer links are available to meet your benefit needs:

Account Information

If you select the 'Account Information' tab, you'll be prompted to enter your Social Security Number and PIN, which is the last four digits of your Social Security Number on first use. After entering your PIN, follow the prompts to access your FSA details. You'll notice a navigational menu on the left panel of the Web page. These menu items allow you to check the history of your FSA transactions, current balance and claims you submitted. You may also view change in status requests from the menu.

Downloading Forms

If you select the 'Download Forms' tab, a choice of forms, including a FSA Reimbursement Request Claim Form, Medical Necessity Form and Direct Deposit Form, are posted for your convenience. You'll need Acrobat Reader to view and print these forms. A link to download the Acrobat Reader application is located at the bottom of the Web page.

Frequently Asked Questions

The 'Frequently Asked Questions' tab will provide answers to many of your general questions regarding Flexible Spending Accounts and enrollment information. Any questions not answered in this section may be addressed to Fringe Benefits Management Company Customer Service.

FBMC Customer Service

The 'Customer Service' tab gives you a direct link to the FBMC Customer Service Center.

FBMC Interactive Benefits

FBMC's 24-hour automated phone system allows you to access your benefits any time to check on a claim, verify the status of a Flexible Spending Account, request forms and more! Getting connected to your benefits is easy. Call the Information Line at: 1-800-865-FBMC (3262).

A Word About Your PIN

To access both the FBMC Web site and the Interactive Voice Response system, all you need is your Social Security Number (SSN). The last four digits of your SSN will be your first Personal Identification Number (PIN). Then:

On the Web

The site will ask you to select your own confidential four-digit PIN for future use. This new PIN cannot be the last four digits of your SSN, as it was previously. If you forget your PIN, you may send an e-mail to a Customer Service Representative by clicking on the link at the upper left hand corner of the page. A representative will respond via e-mail or call with further instructions. Once you've selected your new PIN, you may access information about your benefits.

Over the Phone

The system will ask you to select your own confidential four-digit PIN for future use. This new PIN cannot be the last four digits of your SSN, as it was previously. If you forget your PIN, you may press '0' at any time to speak with a Customer Service Representative. Once you've selected your new PIN, the system will give you the following list of options from which to choose.

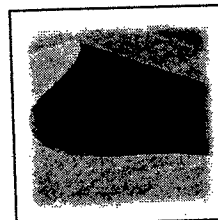
Please keep your PIN in a safe place. The PIN you select will give you access to both the Interactive Voice Response system and the FBMC Web site.

MAIN MENU OPTIONS:

- Press 1 Flexible Spending Accounts
- Press 2 Form requests
- Press 3 Current Benefits administered by FBMC
- Press 4 Change PIN
- Press 5 Verify address

Other Options:

- Press 0 Customer Service Representative
- Press 9 Main Menu
- Press * Repeat the menu
- Press # Exit Information Line



Enrollment At A Glance

IMPORTANT DATES TO REMEMBER

Your Open Enrollment dates are: April 5, 2004 to May 7, 2004

Your Period of Coverage dates are: July 1, 2004 to June 30, 2005

What's New?

- Delta Dental will offer three plans (Dental Assistance, Basic and Enhanced Indemnity). The Dental Assistance Plan is new this year. CompBenefits Dental coverage will no longer be offered.
- If you were enrolled in CompBenefits Dental coverage and wish to continue dental insurance, you must select one of the three Delta Dental plans available. CompBenefits Dental coverage will terminate on June 30, 2004. Enrollment in dental insurance is not automatic; you must complete an enrollment form.
- Your other benefit selections, including Flexible Spending Accounts, will continue for the new plan year as currently enrolled. Fill out an enrollment form if you would like to add, change or cancel coverage.
- Trustmark will no longer offer new LifeEvents® policies. Employees who currently have LifeEvents® may continue their coverage.
- Over-the-Counter items, drugs, and medicines are now eligible for reimbursement through your Medical Expense FSA. See Page 13 for details.
- As an enhancement to your Medical Expense FSA, the EZ REIMBURSE® MasterCard® Card will be offered. See Page 14 for details.
- Flexible Spending Account participation fees have been reduced.

Important Enrollment Information

Open Enrollment will be held April 5 through May 7, 2004. If you are enrolling for the first time or are changing your benefits, you must complete an enrollment form and return it to your Benefits Coordinator no later than May 7, 2004. Mountaineer Flexible Benefits Enrollment Counselors will be available at the Benefit Fairs (see Page 36 for a complete schedule).

Benefit Fairs

Benefit Fairs will take place April 6, 2004 through April 22, 2004. Benefit Fairs allow you access to specific information on each of your benefits. You're invited to ask questions, share your concerns and gain more knowledge about the coverages you select.

Enrollment Counselors will be available at the Benefit Fairs to:

- provide you with detailed benefit information
 - answer any benefit questions and
 - help you complete your enrollment form.
 - bring your dependents' Social Security Numbers and dates of birth with you to complete the dependent section of the enrollment form.
- Remember, an Enrollment Counselor's incentive and objective is your satisfaction!

See the schedule of Benefit Fairs on the back page of this booklet for times and locations.

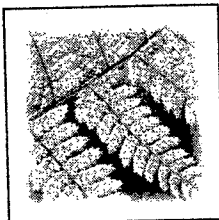
Enrollment Forms

- **Enrolling for the First Time?** You must complete an enrollment form and make your benefit selections by checking the "Add Coverage" box.
- **Changing Your Benefits?** You must complete an enrollment form and change your selections by checking the "Change Coverage" box. Complete the line with the new coverage information.
- **Adding a New Benefit?** You must complete an enrollment form and make your selections by checking the "Add Coverage" box. Complete the line with the new coverage information.
- **Keeping your benefits?** You do not have to do anything. All benefits will continue as currently enrolled, except for CompBenefits Dental coverage. You must enroll in one of the Delta Dental plans if you wish to continue dental coverage.
- **Canceling Current Benefits?** You must complete an enrollment form and check the "Cancel Coverage" box for the benefit you want to cancel; otherwise it will automatically continue for the 2004/2005 Plan Year, except for CompBenefits Dental coverage. You must enroll in one of the Delta Dental plans if you wish to continue dental coverage.

Enrollment Deadline: Sign and date your enrollment form.

Remember to keep the bottom goldenrod copy for your records. Submit the top three copies to your Benefits Coordinator no later than **May 7, 2004.**

Attn: Benefit Coordinators—All applications must be sent to Fringe Benefits Management Company (FBMC) postmarked by May 14, 2004.



Completing Your Enrollment Form

Who needs to complete an enrollment form?

- New participants who want to enroll for the first time.
- Employees who want to add, change or cancel coverage for the new plan year.
- Employees currently enrolled in one of the CompBenefits Plans who want to continue dental coverage.

If you are not making any changes to your benefits, you do not need to fill out an enrollment form. However, if you wish to participate in the new EZ REIMBURSE® MasterCard® Card program, you must complete an enrollment form.

Enrollment Form Section 1

Complete all of your personal information.

Enrollment Form Section 3

For each benefit you are adding, changing or canceling, you must check the appropriate box next to the corresponding benefit. For the benefit selections you are not altering, check the "keep coverage" box. If you complete an enrollment form but do not indicate your desire to cancel or change an existing benefit, that benefit will continue regardless of other benefits which may or may not be indicated on the enrollment form. However, CompBenefits Dental participants' coverage will terminate on June 30, 2004.

Remember to complete all requested information for your benefits.

Dental Care: You may select a Delta Dental plan.

- If you are currently eligible but not enrolled in one of the current dental plans, you may enroll in either the Delta Assistance or Basic Plan only.
- New hires are eligible to enroll in any Delta Dental plan.
- Check the type of coverage you are choosing and enter the cost-per-pay-period amount in the box on the right.
- If you are selecting 'Employee and Children,' 'Employee and Spouse,' or 'Employee and Family' coverage, you must complete the dependent information in Section 4.
- If you are currently enrolled in the Delta Dental Basic Plan, or the CompBenefits Managed Core Plan, you may change to the Delta Dental Enhanced Plan.

Vision care: You may choose either the Full Service Plan or the Exam Plus Plan, but not both. Check the type of coverage you are choosing, and enter the cost per pay period in the box on the right. If you select 'Employee and Family' coverage, you must complete the

dependent information in Section 4.

Long-Term Disability Income Protection: This benefit is for employees only. You must select a coverage level of either 60 percent or 40 percent of your salary. See Page 24 for help in calculating your per-paycheck deduction amount, then enter this cost per pay period on your enrollment form.

Short-Term Disability Income Protection: This benefit is for employees only. See Page 25 for help in calculating your per-paycheck deduction amount, then enter this cost per pay period on your enrollment form.

Medical Expense Flexible Spending Account: Enter your per-pay-period contribution in the space to the right. Refer to the FSA worksheets on Page 17 for help in computing your amount.

Dependent Care Flexible Spending Account: Enter your per-pay-period contribution in the space to the right. Refer to the FSA worksheets on Page 17 for help in computing your amount.

Add your total per-pay-period administrative fees (\$1.96/month for one or both FSA accounts) to your per-pay-period benefit costs. This is your total tax-free salary deduction amount per pay period.

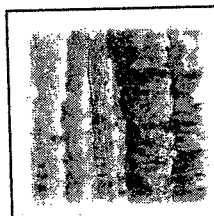
Hyatt Legal Plan: Enter the cost per pay period. Remember, this premium is paid on a post-tax basis.

Enrollment Form Section 4

If you selected dependent coverage (child, spouse, family) for dental, vision or legal benefits, you must complete this section. This includes the dependents' names, relationship to you, birth dates and Social Security numbers.

Sign and date the form at the bottom. Please keep the goldenrod copy for your records. Return the top three copies of your completed form to your Benefits Coordinator no later than May 7, 2004.

Your Benefits Coordinator will process your application and send it to FBMC for receipt no later than May 14, 2004.



Eligibility Requirements

Who is Eligible?

All active employees of State Agencies, colleges and universities, and participating County Boards of Education are eligible to participate in this program. This program is now offered to non-state agencies. Please check with your benefits department to see if you are eligible.

Upon certain qualifying events, spouses, children and employees may be eligible for group health plan coverage under COBRA law. Please contact FBMC at 1-800-342-8017 for more information.

Period of Coverage

Your period of coverage begins on July 1, 2004, and continues until June 30, 2005, unless you:

- terminate employment
- go on an unpaid leave of absence or
- change your benefit elections in limited circumstances as further discussed under "Changes During the Plan Year."

COBRA Coverage

If you terminate your employment, retire or go on unpaid leave, you can continue certain benefits by calling FBMC Customer Service at 1-800-342-8017. You may also contact Customer Service at webcustomerservice@fbmc-benefits.com. According to federal and state law, you can continue your own and your dependent's coverage if you terminate employment or have certain other Qualifying Events under COBRA laws. You will be notified of your rights and any continuing benefits you may have after you have notified FBMC that you have a Qualifying Event. Call FBMC at 1-800-342-8017 for details.

If you participated in a Medical Expense FSA and a triggering event occurred during the plan year making you eligible to continue your Medical Expense FSA under COBRA until that plan year ended, your Medical Expense FSA coverage will be cancelled at the end of the plan year in which the triggering event occurred, unless otherwise required by law.

HIPAA-Special Enrollment Rights Pertaining to Group Health Plans

If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after the other coverage ends.

Employees on Leave

Approved Medical Leave: if you go on medical leave because of your own disability (which includes pregnancy and disabilities resulting from pregnancy complications), your premium deductions will continue through the Mountaineer Flexible Benefits Plan as long as you receive a salary. The Family and Medical Leave Act may affect your rights concerning the continuation of your health benefits while on unpaid leave. Call FBMC at 1-800-342-8017 for further information.

Approved Unpaid Leave: you can continue to receive coverage for certain benefits for the duration of your leave if you pay your premium to FBMC on an after-tax basis.

If you have not maintained a current premium status while on leave, you will be required to resatisfy eligibility requirements when you return to active status, except as otherwise provided by law. Call Customer Service at 1-800-342-8017 for further information on billing if you go on leave. You may also contact Customer Service at webcustomerservice@fbmc-benefits.com.

Appeal Process

If you have a request (an FSA claim for reimbursement, Change In Status (CIS) request, or other similar request) denied, in full or in part, you have the right to appeal the decision by sending a written request for review within 30 days of the denial.

Your appeal must state: (i) why you think your request should not have been denied, (ii) the name of your employer, (iii) the date of the services for which your request was denied, (iv) a copy of the denied request, (v) the denial letter you received, and (vi) any additional documents, information or comments you think may have a bearing on your appeal. Call FBMC Customer Service at 1-800-342-8017 to discuss your appeal.

Upon FBMC's receipt of your appeal and supporting documentation, it will be reviewed. You will normally be notified of the results of this review within 30 days from receipt of your written appeal. In unusual cases, such as when review of your appeal requires additional documentation, the review may take longer than 30 days. If your appeal is approved, additional processing time is required to modify your benefit elections.

PLEASE NOTE: Appeals are approved only if the extenuating circumstances and supporting documentation are within IRS regulations governing the plan.

Flexible Spending Accounts

What is a Flexible Spending Account?

A Flexible Spending Account (FSA) is an IRS-approved, tax-free account that saves you money on eligible medical and dependent care expenses. You authorize per-pay-period deposits to your FSA from your before-tax salary. Then, as you incur eligible expenses, you request tax-free withdrawals from your account to reimburse yourself. There are two kinds of FSAs: a Medical Expense FSA and a Dependent Care FSA. If you incur both types of expenses, you can establish both accounts.

Why would I enroll in a FSA? To Save Money!

Over a year's time, you will probably spend a part of your salary on healthcare or dependent care expenses. You can save money by putting that amount directly into a Flexible Spending Account.

Get the facts about FSAs

If you have questions, call FBMC Customer Service (Monday-Friday, 7 a.m.-10 p.m.) at 1-800-342-8017, or visit www.fbmc-benefits.com. You may also e-mail Customer Service at webcustomerservice@fbmc-benefits.com. **Please note that due to FBMC's Privacy Policy, we will not discuss your account information with others without your verbal or written authorization.**

Receiving Reimbursement

Your reimbursement will be issued within five business days from the time we receive your properly completed and signed reimbursement request form. To avoid delays, follow the instructions for submitting your requests located in the FSA materials you will receive following enrollment.

Direct Deposit

Enroll in Direct Deposit to ensure that your FSA reimbursement checks are automatically deposited into your checking or savings account. There is no fee for this service, and you don't have to wait for postal service delivery of your reimbursement (however, you will receive notification that the claim has been processed). To apply, complete the application form available from your Enrollment Counselor, call FBMC Customer Service at 1-800-342-8017, or visit www.fbmc-benefits.com. Please note that processing your Direct Deposit application may take four to six weeks.

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Medical Expense FSA or vice versa.

3. You have a 90-day grace period (until September 30, 2005) at the end of the plan year for reimbursement of eligible FSA expenses incurred during your period of coverage within the 2004/2005 Plan Year.
4. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
5. You cannot deduct reimbursed expenses for income tax purposes.
6. You may not be reimbursed for a service which you have not yet received.
7. Be conservative when estimating your medical and/or dependent care expenses for the 2004/2005 Plan Year. IRS regulations state that any unused funds which remain in a FSA after a plan year ends and all reimbursable requests have been submitted and processed cannot be returned to you nor carried forward to the next plan year.

Written Certification

When enrolling in either or both FSAs, written notice of agreement with the following will be required:

- I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents;
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA;
- I will not seek reimbursement through any other source; and
- I will collect and maintain sufficient documentation to validate the foregoing.

Without an FSA: (Example)*

\$50.00	monthly budget for a medical expense
- 11.33	taxes on that \$50 taken from your paycheck
\$38.67	amount you have left for medical expense

With an FSA: (Example)

\$50.00	monthly FSA deposit for a medical expense
- 0.00	no taxes (no taxes on FSA deposits)
\$50.00	amount you have left for medical expense

* Based upon a 22.65% tax rate (15% federal and 7.65% Social Security).

Because the money you deposit in your Medical Expense and Dependent Care FSA is deducted before taxes, the income you use for these expenses is ALWAYS TAX FREE.

Flexible Spending Accounts^{Continued}

What documentation of expenses do I need to keep?

The IRS requires FSA customers to maintain complete documentation, including keeping copies of receipts for reimbursed expenses, for a minimum of one year.

How do I get the forms I need?

To receive forms you will need after enrolling in either a Medical Expense or Dependent Care FSA, such as a FSA Reimbursement Form, Medical Necessity Form or Direct Deposit Form, you can contact FBMC Customer Service at 1-800-342-8017, or visit FBMC's Web site, www.fbmc-benefits.com. For more information, refer to the Access Your Benefits section of this booklet.

Why is my signature needed on the FSA Reimbursement Request Form?

Your Flexible Spending Accounts are tax-favored accounts, and must follow strict guidelines. Your signature on the form submitted for reimbursement serves as a required certification that you are abiding by the plan rules. We cannot process your request without it!

Are prescriptions eligible for reimbursement?

Yes, most filled prescriptions are eligible for reimbursement. However, in response to new state and federal privacy standards, some pharmacy chains have discontinued listing prescription names on their receipts. The IRS requires this information to ensure that the drug is eligible for reimbursement, so the complete name and prescription number of the drug must be obtained and documented on your receipt before submitting it with your request to FBMC for reimbursement.

Is transportation for medical care reimbursable?

Yes, it is reimbursable, as long as a receipt, statement or bill is sent along with your request to validate your visit. Travel expenses for medical care, including healthcare provider and pharmacy visits, can include:

- actual roundtrip mileage*
- parking fees
- tolls and
- transportation to another city, if the trip is primarily for, and essential to, receiving medical care.[†]

Guidelines on eligible travel expenses and how to calculate and submit expenses for reimbursement will be included in the materials you receive, following enrollment in a Medical Expense FSA.

Do contributions to my FSA reduce my earned income for purposes of the Federal Earned Income Tax Credit (EITC)?

Yes. Salary reductions made under a cafeteria plan will lower your taxable income and taxes. Depending on the State, additional State income tax savings or credits may be available. Salary reductions (including contributions to one or both FSAs) will reduce earned income for purposes of the Federal Earned Income Tax Credit (EITC). Depending on your income level, your EITC may either increase or decrease if you make salary reductions under a cafeteria plan. This means that for some of you, participation in either FSA or both, may provide to you an additional advantage by increasing your EITC (based on 2003 tax tables).

The EITC is available to certain households whose earned income is less than the following threshold amounts: \$29,666 for individuals filing as single or head of household with one child, \$33,692 with two or more children. For married individuals filing jointly: \$30,666 with one child; \$34,692 with two or more children. To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information.

Termination or Leave Medical Expense FSAs

If you terminate employment or go on unpaid leave, you may change or continue your Medical Expense FSA election upon completion of the appropriate forms and requirements. To inquire about changing your MFSA election or continuing your MFSA period of coverage, contact FBMC within 30 days of the event by calling FBMC Customer Service at 1-800-342-8017 or by e-mail at webcustomerservice@fbmc-benefits.com.

You have a grace period within which to submit eligible Medical Expense FSA expenses incurred during your period of coverage within the plan year. Refer to the "FSA Guidelines" portion of the Flexible Spending Accounts section for more information.

The Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Please contact your employer for further information, the appropriate forms and requirements.

Dependent Care FSAs

If you terminate employment or go on unpaid leave, you cannot continue contributing to your Dependent Care FSA. You can, however, continue to request reimbursement for eligible expenses incurred while employed until you exhaust your account balance or the plan year ends.

* Calculate the mileage on the actual receipt detailing the following: mileage multiplied by the current IRS rate per mile (\$0.14, subject to federal change each tax year) and the name of the provider visited.

† (IRS Publication 502)

Medical Expense FSA

Minimum Annual Deposit: \$150*
Maximum Annual Deposit: \$3,000*

*plus administrative fee

Who is eligible?

Under the Medical Expense FSA, you may be reimbursed for eligible expenses incurred by the following:

- yourself
- your spouse and
- your tax dependents. To qualify as your tax dependent, an individual must meet all the following criteria:
 - a) must be your relative, or, if not your relative, live with you for the entire calendar year
 - b) must be a U.S. citizen or a resident of the U.S., Mexico or Canada and
 - c) you must have provided the individual with at least half of their total support and/or expenses during the calendar year.

An eligible child of divorced parents is treated as a dependent of both parents. Therefore, either or both parents can establish a Medical Expense FSA.

Availability

Once you sign up for a Medical Expense FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible medical expenses will be available throughout your period of coverage, provided the request does not exceed your annualized contribution.

It's like a cash advance because you don't have to wait for the cash to accumulate in your account before you can use it to pay for your uninsured, eligible medical expenses. Your money is tax free and interest free!

Submission Order

Expenses must first be submitted for payment to any health plan(s) provided by your employer in which you participate. Any remaining out-of-pocket expenses may then be submitted for reimbursement from your Medical Expense FSA.

FSA vs. Claiming Expenses on IRS Form 1040

Unless your itemized medical expenses exceed 7.5 percent of your adjusted gross income*, you can't get a break by claiming them on your IRS Form 1040. But you can save taxes by paying for your uninsured, out-of-pocket medical expenses through a tax-free Medical Expense FSA.

For instance, if your adjusted gross income is \$45,000, the IRS would only allow you to deduct itemized expenses that exceed \$3,375 or 7.5 percent of your adjusted gross income. But, if you have \$2,000 in eligible medical expenses, the FSA saves you \$653 on your medical expenses in federal income (25 percent) and Social Security taxes (7.65 percent).

With a Medical Expense FSA, the money you set aside for medical expenses is deducted from your salary before taxes. So, it is ALWAYS tax free, regardless of the amount. By enrolling in a Medical Expense FSA, you guarantee your savings.

Ineligible Expenses

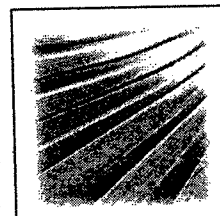
- Insurance premiums
- Vision warranties and service contracts
- Health or fitness club membership fees
- Cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition

Setting Aside Funds

Remember to estimate your expenses carefully.

A change during the plan year in the cost, type or level of medical care or services provided to you or your family will not permit you to change your Medical Expense FSA election.

* Both you and your spouse's incomes must be included for the purposes of determining adjusted gross income.



Medical Expense FSA *Continued*

Orthodontia

Orthodontia treatment designed primarily to improve one's appearance is not reimbursable. Orthodontia treatment designed to treat a specific medical condition is reimbursable if the following documentation is attached to the initial Flexible Spending Account Form each plan year:

1. A written statement (e.g., bill) from the treating dentist/orthodontist showing the date the service was rendered, the identity of the individual receiving the service and the cost for the service.
2. A Letter of Medical Necessity from the treating dentist/orthodontist. Visit the FBMC Web site at www.fbmc-benefits.com, or call FBMC Customer Service at 1-800-342-8017 to obtain this letter.
3. A copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment.

For payment options available under your employer's plan, refer to the information sheet provided following your enrollment, or call FBMC Customer Service at 1-800-342-8017.

Requesting Reimbursement

To request reimbursement from your Medical Expense FSA, you must mail or fax a correctly completed FSA Reimbursement Request Form along with one of the following:

- a receipt, invoice or bill from your healthcare provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided
- an Explanation of Benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost and
- Some medical services require additional supporting documentation, including a Letter of Medical Necessity from the treating healthcare provider, a Personal Use Letter from the patient and an independent Capital Expense Appraisal Letter. Visit FBMC's Web site at www.fbmc-benefits.com to obtain sample letters. You may request reimbursement for IRS-qualified expenses that are eligible under your employer's plan.

**Mail to: Contract Administrator
Fringe Benefits Management Co.
P.O. Box 1800
Tallahassee, FL 32302-1800**
Fax to: 850-425-4608

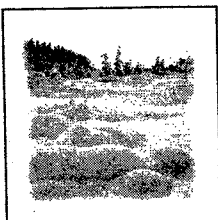
Partial List of Eligible Expenses*

Acupuncture¹
Ambulance service
Birth control pills and devices
Chiropractic care¹
Contact lenses (corrective)²
Dental fees¹
Diagnostic tests/health screening
Doctor fees¹
Drug addiction/alcoholism treatment
Drugs (prescription and eligible over-the-counter³)
Experimental medical treatment¹
Eyeglasses²
Guide dogs
Hearing aids and exams
Injections and vaccinations
In vitro fertilization
Nursing services¹
Optometrist fees
Orthodontic treatment¹
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery¹
Transportation for medical care
Vitamins/natural supplements¹
Weight-loss programs/meetings¹
Wheelchairs
X-rays

1. Some treatments or services require a letter of medical need from the treating health-care provider.
2. Expenses are reimbursable based on the date available to be picked up, not the date ordered.
3. Not all drugs requiring a prescription are approved by the IRS as eligible for reimbursement.

Note: Budget conservatively. No reimbursement or refund of Medical Expense FSA funds is available for services/surgeries that do not occur.

* IRS-qualified medical expenses are subject to federal regulatory change at any time during a tax year.



* EOBs are not required if your coverage is through a HMO.

OTC Category Reimbursement

Over-the-Counter Expenses

Over-the-Counter (OTC) items, medicines and drugs are now reimbursable through your Medical Expense FSA! You can save valuable tax dollars on certain categories of Over-the-Counter items, medicines and drugs. You may be reimbursed for OTC expenses through your Medical Expense FSA if:

- the item, medicine or drug was used for a specific medical condition for you, your spouse and/or your dependent(s)
- the submitted receipt clearly states the purchase date and name of the item, medicine or drug
- the reimbursement request is for an expense allowed by your Medical Expense FSA and IRS regulations and
- you submit your reimbursement request in a timely and complete manner, already described in your benefits enrollment information.

Note: OTC items, medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost.

The list of eligible OTC categories will be updated on a quarterly basis by FBMC. It is your responsibility to remain informed of updates to this listing, which can be found at www.fbmc-benefits.com. As soon as an OTC item, medicine or drug becomes eligible under any of the categories below, it will be reimbursable retroactively to the start of the current plan year.

Newly eligible OTC items, medicines and drugs are not considered a valid change in status event that would allow you to change your annual Medical Expense FSA election or salary reduction amount. Be sure to maintain sufficient documentation to submit receipts for reimbursement. You may resubmit a copy of your receipt from your records if a rejected OTC expense becomes eligible for reimbursement later in the same plan year.

Eligible Expense Categories

Allergy

Antihistamines
Nasal sprays

Antacids

Heartburn medicines

Cold Remedies

Cough drops
Decongestants
Nasal strips
Nasal sprays
Sinus medications
Throat lozenges

Pain Relief

Bug bite medication
Fever reducers
First aid creams (diaper, fever blister, poison ivy)
Menstrual cycle products for pain and cramp relief
Products for muscle or joint pain
Special ointments or creams for sunburn
Topical creams

Other Medical Remedy Items

Anti-diarrheals
Anti-fungals
Antibiotics
Asthma medications
Bandages, gauze pads, rubbing alcohol, liquid adhesives
Carpel tunnel wrist supports
Cold/hot packs for injuries
Corn/callus removers
Eye products (including reading glasses, contact lens cleaning solutions)
First aid kits
Hemorrhoid treatments
Laxatives
Motion sickness treatments
Nicotine gum or patches for smoking cessation purposes
Thermometers
Wart removers

Items Requiring Special Documentation*

Botanicals/herbals
Feminine hygiene products
Hormones
Minerals
Nasal sprays for snoring
Sunscreens
Vitamins
Weight-loss drugs to treat a specific disease

Ineligible OTC Expenses

Cosmetics
Toiletries
OTC items primarily for general health and well-being

* Contact FBMC Customer Service by e-mail at webcustomerservice@fbmc-benefits.com, or by calling 1-800-342-8017 for more information or to obtain a sample Letter of Medical Need, Personal Use Statement or Third-Party Appraisal Statement.

EZ REIMBURSE® MasterCard® Card

Basics about the EZ REIMBURSE® Card

The EZ REIMBURSE® Card electronically debits funds from your Medical Expense Flexible Spending Account when an eligible, uninsured medical expense is incurred.*

Much like other debit cards, there is no risk of overspending or exceeding your account limits. If funds are not available because your annualized amount has been spent down, the transaction is denied. Because no credit is being extended, cards are available to anyone who signs up for a Medical Expense FSA.

About 50 percent of all FSA medical claims are for prescription drugs. FBMC and its partners developed a system enabling online, real-time, adjudication of prescription drug claims. When you present the card at participating pharmacies to buy a prescription drug or to pay the prescription co-payment, your FSA is automatically debited. You also avoid the double-hit to your wallet while waiting for reimbursement.

You may use the card for:

- co-payments at doctor/dentist/ophthalmologist/optometrist offices
- deductibles
- prescription co-payments or
- uncovered prescriptions and other health-related expenses.

IRS guidance reduces the need for submitting documentation to FBMC for eligible prescription expenses, co-payments and recurring expenses. For all other healthcare expenses, you must send or fax a copy of your statement, bill or receipt (showing date of service, type or service, and total amount) along with a Receipt Transmittal Cover Letter for processing. However, you **must** keep all substantiating documents for your records for a minimum of one year and submit immediately to FBMC or the IRS upon request. You do not have to wait for reimbursement; as long as the vendor accepts MasterCard® and is appropriately coded as a health care facility, the expense is still debited from your FSA... and not from your wallet! Instructions on when to submit receipts will be provided to card participants with post-enrollment materials.

Visit www.fbmc-benefits.com for a list of frequently asked questions and to view participating pharmacies.

You must keep your receipts for a minimum of one year and submit to FBMC upon request.

What are the advantages of the EZ REIMBURSE® Card?

- Instant reimbursements – cash-free transactions!
- Paperless prescription medication purchases – instant claims adjudication
- Save taxes by participating in a Medical Expense FSA

How do I get an EZ REIMBURSE® Card?

When you sign up for a Medical Expense FSA, you must elect to receive your EZ REIMBURSE® Card on your enrollment form. It comes to you just like a regular credit card in the mail; you call the toll-free number on the front to activate the card. For additional information regarding the EZ REIMBURSE® Card, call FBMC Customer Service at 1-800-342-8017, Monday through Friday, 7 a.m. – 10 p.m. ET.

What agreement am I making when I use the EZ REIMBURSE® Card?

By using the EZ REIMBURSE® Card, you are agreeing to the certification set out in the "Written Certification" portion of the *Flexible Spending Accounts* section in this booklet.

What does it cost to use the EZ REIMBURSE® Card?

There is a \$20 annual fee for using the card. This amount is automatically deducted from your MFSA when you activate your card. When you budget for your FSA deductions, you may want to consider the fee in your calculations.

When do I use paper claim forms?

If a merchant or vendor does not accept the EZ REIMBURSE® Card, you must submit a paper claim form. These instances include using your card for over-the-counter drug expenses and for mail-order prescriptions. You will need to submit a FSA Reimbursement Request Form, attach a copy of your documentation and wait for the reimbursement. To shorten the wait, you can apply for direct deposit and speed up your reimbursement.

What should I do if my pharmacist doesn't know how to use the card?

For questions or assistance, your provider/pharmacist may contact the Pharmacy Help Desk at 1-800-361-4542 (M – F 8 a.m. – 7 p.m., ET).

What do I do if I lose my card?

If your card is lost or stolen, call 1-866-785-3621 immediately.

* Please see the Beyond Your Benefits section of this book for information about debit card reimbursement.

Dependent Care FSA

Minimum Annual Deposit: \$150*

Maximum Annual Deposit: The maximum contribution depends on your tax filing status as the list indicates.*

*plus administrative fee

How the Dependent Care Flexible Spending Account Could Work for You

A Dependent Care FSA can help recover some of the money you spend to ensure your dependents (child, adult or elder) are taken care of while you and your spouse (if married) are working.

Whose expenses are Eligible?

Under the Dependent Care FSA, you may be reimbursed for eligible dependent care expenses incurred by the following:

- children 12 years or younger who reside in your household and
- adults/children mentally or physically incapable of self-care who spend at least eight hours a day in your household.

Tax Filing Status:

- If you are married and filing separately, your maximum is \$2,500.
- If you are single and head of household, your maximum is \$5,000.
- If you are married and filing jointly, your maximum is \$5,000.
- If either you or your spouse earn less than \$5,000 a year, your maximum is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

Dependent Care FSA vs. Dependent Care Tax Credit

As the taxpayer, you must determine whether participation in the DFSA, claiming a federal (and state) tax credit or exclusion, or using a combination of the taxable and tax-free benefits, is best for you. Your decision will depend on a number of factors, such as your tax filing status (e.g., married, single, head of household), number of qualifying dependents, amount of dependent care expenses, earned income, etc. Claiming the dependent care tax credit does not affect the amount of one's earned income or the amount of one's Earned Income Tax Credit.

Generally, if you are in a higher tax bracket, participation in the DFSA may produce a better tax benefit with possibly two exceptions. You may realize a slightly greater tax benefit by claiming the dependent care tax credit if your W-2 income before FSA salary reductions is:

- less than \$15,000; or
- about \$37,000 - \$39,000, you have only one qualifying dependent, and your eligible dependent care expenses for the tax year are less than \$3,000.

The DFSA may be better for you if you incur significantly more than \$3,000 in dependent care expenses and have one qualifying dependent. The maximum DFSA limit of \$5,000 may be available to you while only \$3,000 of the expenses can be calculated for the dependent care tax credit. The DFSA may be better for you if you are not eligible for the Earned Income Credit and you fall within the 25 percent marginal tax bracket (which starts at taxable income, not gross wages). The tax bracket begins at \$56,800 which is taxable income, not gross wages (for married individuals filing jointly based on 2003 tax tables).

If you meet the criteria to combine the tax benefits of both the dependent care tax credit and the DFSA in the same tax year, coordinating tax rules will apply. Please see your tax advisor for further information.

Note: You cannot use the dependent care tax credit if you are married and filing separately. Any dependent care expenses reimbursed through your DFSA cannot be filed for the dependent care tax credit and vice versa.

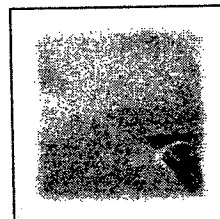
To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information. Visit www.fbmc-benefits.com to complete a tax-savings analysis.

Eligible Expenses

Generally, child, adult and elder care costs that allow you and your spouse to work or actively look for work are eligible for reimbursement. If you are married, your spouse must work, be a full-time student or be mentally or physically incapable of self-care.

Examples:

- Day care facility fees
- Local day camp fees
- Baby-sitting fees for at-home care while you and your spouse are working (care cannot be provided by you, your spouse or other tax dependent)



Dependent Care FSA *Continued*

Ineligible Expenses:

- Child support payments or child care if you are a non-custodial parent
- Payments for dependent care services provided by your dependent, your spouse's dependent or your child who is under age 19
- Healthcare costs or educational tuition
- Overnight care for your dependents (unless it allows you and your spouse to work during that time)
- Nursing home fees
- Diaper services
- Books and supplies
- Activity fees
- Kindergarten expenses
- Sports Camps (unless primary purpose is custodial care)

Requesting Reimbursement:

Each Dependent Care FSA reimbursement request sent by mail or fax must include a properly completed FSA Reimbursement Request Form, including receipts showing the following:

- the date your dependent received the care (for example, October 11, 2004 through October 15, 2004)—not the date you paid for the service
- the name and address of the facility or
- the name, address and signature of the individual providing the dependent care service (including Tax ID Number or Social Security Number).

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

Mail to: Contract Administrator

Fringe Benefits Management Co.

P.O. Box 1800

Tallahassee, FL 32302-1800

Fax to: 850-425-4608

Note: If you elect to participate in the Dependent Care FSA, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this could result in the IRS not allowing your pre-tax exclusion.

Be certain you obtain and submit all needed information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

A properly completed signed and dated request will help speed along the process of your reimbursement, allowing you to receive your check or Direct Deposit promptly.

When to Request Reimbursement

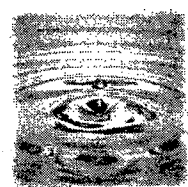
You can request reimbursement as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed.

For example, if you pay your dependent care provider on October 1 for the entire month of October, you can submit your reimbursement request for all of October, however, payment will be made only after the last day of care (indicated on the form) for that month has been received.

Make sure that your FSA Reimbursement Request Form is signed, dated and includes all required information (detailed above). For timely processing of your reimbursement, your payroll contributions must be current.

What is my Dependent Care FSA Availability?

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Medical Expense FSA, the entire maximum annual amount is not available at the beginning of the plan year, but rather funds are available after each payroll deduction is received.



FSA Worksheets

To figure out how much to deposit in your FSA, refer to the following worksheets. Calculate the amount you expect to pay during the plan and calendar year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount (including the administrative fees) cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this booklet for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

TAX-FREE MEDICAL EXPENSE WORKSHEET

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year, which is July 1, 2004 through June 30, 2005.

YOUR ELIGIBLE UNINSURED MEDICAL EXPENSES

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

SUBTOTAL

Estimated uninsured expenses for your period of coverage during the plan year. Amount cannot exceed \$3,000.

\$ _____

DIVIDE

by the number of paychecks you will receive during the plan year*.

\$ _____

This is your pay period contribution.**

\$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

TAX-FREE DEPENDENT CARE WORKSHEET

Estimate your eligible dependent care expenses for the plan year, which is July 1, 2004 through June 30, 2005. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

NUMBER OF WEEKS

you will have eligible dependent care expenses from July 1, 2004 through June 30, 2005.

Remember to subtract holidays, vacations and other times you may not be paying for eligible child, adult or elder care.

MULTIPLY

by the amount of money you expect to spend each week.

\$ _____

SUBTOTAL

Remember, your total contribution cannot exceed IRS limits for the plan year and the calendar year.

\$ _____

DIVIDE

by the number of paychecks you will receive during the plan year*.

\$ _____

This is your pay period contribution.**

\$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Don't forget to include deductibles, co-payments and co-insurance when calculating your Medical Expense FSA contributions.

**** You will be assessed a per-pay-period FSA Administrative Fee (whether you select one or both plans). The per-pay-period fees are as follows:**

10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
\$2.35	\$1.96	\$1.31	\$1.18	\$1.12	\$1.07	\$0.98	\$0.90



Delta Dental

Strong, healthy teeth create beautiful smiles. To give your smile the care and attention it deserves, Delta Dental offers you the Dental Assistance, Basic and Enhanced Indemnity dental care plans.

You may receive services from the dentist of your choice, or you may select a dentist from the Participating Provider Network, which includes more than 470 dental office locations in West Virginia. If you choose a participating dentist, he/she will file claims on your behalf and has agreed to accept Delta's Maximum Plan Allowance (MPA)* or the dentist's fee – whichever is less – as payment in full, giving you the opportunity to save money. However, you may have co-payments and deductibles.

The Dental Assistance plan is a discounted fee-for-service, managed-cost dental plan that allows employees the freedom to choose any dentist for treatment, but they receive the greatest benefits from a dentist participating in the DeltaPremier network.

The Basic plan is a low-cost plan designed to cover preventive and basic services only. Please look carefully at the plan descriptions in the chart before making your choice.

To enroll in the Enhanced plan, you must be currently enrolled in the Delta Dental Basic plan or one of the CompBenefits dental plans.

You may cover your spouse and any children, stepchildren or foster children up to the age of 19, or age 25 if they are unmarried, full-time students depending on you for support.

See the chart to the right for a partial list of covered services. For more information concerning your benefits or to request a claim form, call the Interactive Benefits Information Line at 1-800-865-FBMC (3262).

Submit claim forms to: Delta Dental of West Virginia, One Delta Drive, Mechanicsburg, PA 17055-6999 Customer Service: 1-800-932-0783 TTY/TDD: 1-888-373-3582.

* Maximum Plan Allowance is an amount, determined by Delta, from claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area. These charges are blended by Delta with dentist fee information from a number of other sources, using various factors, subject to regulatory limitations and adjustment for extraordinary circumstances, such as extreme difficulty or unusual circumstances.

Your Tax-Free Rates

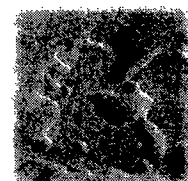
Plan I (Basic)	10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
Employee Only	\$22.50	\$18.75	\$12.50	\$11.25	\$10.71	\$10.23	\$9.38	\$8.65
Employee & Children	\$45.06	\$37.55	\$25.03	\$22.53	\$21.46	\$20.48	\$18.78	\$17.33
Employee & Spouse	\$50.22	\$41.85	\$27.90	\$25.11	\$23.91	\$22.83	\$20.93	\$19.32
Employee & Family	\$72.84	\$60.70	\$40.47	\$36.42	\$34.69	\$33.11	\$30.35	\$28.02
Plan II (Enhanced)	10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
Employee Only	\$36.30	\$30.25	\$20.17	\$18.15	\$17.29	\$16.50	\$15.13	\$13.96
Employee & Children	\$72.60	\$60.50	\$40.33	\$36.30	\$34.57	\$33.00	\$30.25	\$27.92
Employee & Spouse	\$84.30	\$70.25	\$46.83	\$42.15	\$40.14	\$38.32	\$35.13	\$32.42
Employee & Family	\$120.42	\$100.35	\$66.90	\$60.21	\$57.34	\$54.74	\$50.18	\$46.32
Plan III (Dental Assistance)	10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
Employee Only	\$12.72	\$10.60	\$7.07	\$6.36	\$6.06	\$5.78	\$5.30	\$4.89
Employee & Children	\$25.50	\$21.25	\$14.17	\$12.75	\$12.14	\$11.59	\$10.63	\$9.81
Employee & Spouse	\$28.44	\$23.70	\$15.80	\$14.22	\$13.54	\$12.93	\$11.85	\$10.94
Employee & Family	\$41.28	\$34.40	\$22.93	\$20.64	\$19.66	\$18.76	\$17.20	\$15.88

Partial List of Covered Services

	BASIC PLAN	ENHANCED PLAN	DENTAL ASSISTANCE PLAN
DEDUCTIBLE	You pay \$25 (applies to all services)	You pay \$50 (diagnostic, preventative and ortho are exempt)	You pay \$25 (applies to all services)
Maximum deductibles	3	3	3
Plan year max (per person)	\$500	\$1,000	\$500
Ortho Lifetime Max	N/A	\$1,000	N/A
TMJ Disorder	N/A	\$500	N/A
BENEFIT	Plan pays	Plan pays	Plan pays
Diagnostic/Preventive Services	80% of MPA	100% of MPA	50% of MPA
Visits/Exams (twice in a 12-month period)			
Routine cleaning			
Fluoride treatments (to age 19)			
X-rays (twice in a 12-month period)			
Space maintainers (to age 16)			
Sealants (permanent teeth only) -- to age 14 once in any 36-month period on unfilled permanent first and second molars			
Basic Restorative	80% of MPA	80% of MPA	50% of MPA
Amalgam ("silver") and Composite ("white" non-molar) fillings			
Oral Surgery	80% of MPA	80% of MPA	50% of MPA
Extractions			
Oral surgery procedures			
General Anesthesia w/ oral surgery procedures			
Endodontics	80% of MPA	80% of MPA	50% of MPA
Pulpal therapy			
Root canal therapy			
Periodontics	80% of MPA	80% of MPA	50% of MPA
Treatment for gums and Supporting structures			
Major Restorative	NOT COVERED	50% of MPA*	NOT COVERED
Inlays, onlays, crowns			
Prosthodontic	NOT COVERED	50% of MPA*	NOT COVERED
Bridges			
Full and partial dentures			
Denture adjustments/relining			
Orthodontia**	NOT COVERED	50% of MPA*	NOT COVERED
TMJ	NOT COVERED	50% of MPA*	NOT COVERED

*** IMPORTANT:** You must have been enrolled in either the Dental Assistance, Basic or Enhanced Plan for 12 months to qualify for these coverages in the Enhanced Plan.

****** For eligible employee, spouse and dependent children to age 19.



Vision Service Plan

The Vision Service Plan (VSP) offers you the Full Service Plan to help pay for your eyecare needs.

Full Service Plan

The Full Service Plan covers you and your family for all routine eye care including eye exams, eyeglass lenses and frames, or contact lenses. When it's time for an eye exam and/or eyeglasses, you can see any VSP doctor you want, or use a non-member doctor.

The deductible for materials is \$20. A member may receive an examination and contact lenses or spectacle lenses once every 12 months. Contact lenses are in lieu of lenses and frames. In other words, if a member chooses to use the contact lens benefit, this utilizes the lenses and frame benefit. The member would then be eligible for the frame benefit 12 months later.

Participants receive a 20 percent discount on additional pairs of prescription glasses. You can also receive a 15 percent discount on the participating doctor's professional fees when you purchase prescription contact lenses. This benefit is available in conjunction with your VSP contact lens allowance, or you can use it to purchase contacts in addition to glasses.

These discounts may be used for 12 months following the date of the covered eye examination. These discounts are only offered through the VSP participating doctor who provided the last covered eye examination.

VSP's Laser Vision Care Program now provides discounts for LASIK and PRK surgeries from network laser surgery centers. Call VSP for the name and address of the nearest laser surgery center.

You may choose to cover your family by selecting the "Employee & Family" rates. Coverage for dependents terminates at the end of the month in which they reach age 19 or age 25, if a full-time student.

Full Service Plan

	VSP MEMBER DOCTOR	NON-MEMBER DOCTOR
Co-payments[†]		
Exam	\$20	\$20
Prescription Glasses	\$20	\$20
	Plan Pays	Plan Pays
Vision Examination** (every 12 months)	Covered in Full	\$35
Lenses (every 12 months)***		
Single Vision Lenses**	Covered in full*	\$25
Bifocal Lenses**	Covered in full*	\$40
Trifocal Lenses**	Covered in full*	\$55
Lenticular Lenses**	Covered in full*	\$80
Frames (every 24 months)*** (up to \$150 allowance)	Covered in full*	\$45
Contacts Lenses** (in place of lenses and frames) Medically Necessary	Covered in full	Exam & \$210

[†] Co-payments apply in-network (VSP Member Doctor) at the time of service. Co-payments apply out-of-network and will be deducted from the doctor's charge.

* Within Plan Limitations. If you select a frame that costs more than your plan allowance, there will be an additional charge you will pay out of pocket. When you visit the VSP member doctor, ask him/her which frames are covered in full. The allowance is very competitive and ensures a good choice with little or no out-of-pocket cost.

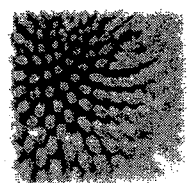
There will be an extra cost if you select materials or services that are elective or cosmetic in nature, such as tints, scratch coatings and progressive lenses. (These charges are audited by VSP to ensure that you are not paying more than necessary.)

** Exam and contact lenses are also covered once every 12 months, if necessary, provided you have not received spectacle lenses in the same 12-month period. You may receive eyeglass frames every 24 months. You may receive either spectacle lenses or contact lenses in the 12-month period, but not both.

***There is a single materials copay of \$20 on lenses and frames

Your Tax-free Rates

Full-service plan	10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
Employee only	\$13.20	\$11.00	\$7.33	\$6.60	\$6.29	\$6.00	\$5.50	\$5.08
Employee & Family	\$32.08	\$26.73	\$17.82	\$16.04	\$15.28	\$14.58	\$13.37	\$12.34



Vision Service Plan *Continued*

Exam Plus Vision Plan

Exam Plus is an alternative to the full service plan. Under this plan, you must obtain services through a VSP member doctor. Benefits include an eye exam every 12 months and discounts on materials and professional services through VSP member doctors. Your co-payment is \$10 for your eye exam.

For glasses, a 20 percent discount will be applied to a VSP doctor's usual and customary fee for prescription glasses and spectacle lens options.

For contact lenses, a 15 percent discount will be applied on VSP member doctor's professional services associated with all prescription contact lenses.

You may choose to cover your family by selecting the 'Employee and Family' rates. Coverage for dependents terminates at the end of the month in which they reach age 19 or age 25, if a full-time student.

How To Use These Plans

To obtain vision care benefits, call a VSP member doctor, identify yourself as a VSP patient, and make an appointment. The doctor's office will verify the patient's eligibility and plan coverage and obtain authorization from VSP.

The doctor will explain any additional charges. After you pay your co-payment, the doctor will take care of all the paperwork.

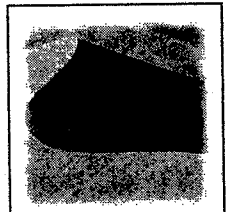
If you prefer, you can visit a nonmember doctor and pay the doctor's normal charges. Save your itemized receipt and mail it within six months of service date to:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105

For more information, contact VSP's Customer Service Line at 1-800-877-7195.

Your Tax-free Rates

Exam Plus plan	10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
Employee only	\$2.20	\$1.83	\$1.22	\$1.10	\$1.05	\$1.00	\$0.92	\$0.85
Employee & Family	\$5.00	\$4.17	\$2.78	\$2.50	\$2.38	\$2.27	\$2.09	\$1.93



VSP Member Doctors

BARBOURSVILLE

Mark D. Cox, O.D.
6171 Childers Rd.
(304) 736-3054

BECKLEY

David R. Holliday, O.D.
624 Neville St.
(304) 253-8822

Charles B. Waitkus, O.D.
624 Neville St.
(304) 253-8822

BEVERLY

Craig C. Hyre, O.D.
Files Creek Rd.
(304) 637-1010

BLUEFIELD

G. Frank Britton, III, O.D.
3101 E. Cumberland Rd.
(304) 325-3603

Joseph I. Rodgin, O.D.
401 Bland St.
(304) 327-5019

BRIDGEPORT

John W. Barnes, O.D.
107 Doctors Dr.
(304) 842-6226

Gregory A. Groves, O.D.
107 Doctors Dr.
(304) 842-6226

Theodore D. Kress, O.D.
920 W. Main St.
(304) 842-4444

Harry M. Murray, III, O.D.
107 Doctors Dr.
(304) 842-6226

Harry M. Murray, Jr., O.D.
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10 Amalia Dr.
(304) 472-2100

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(304) 472-1235

Timothy S. Reese, O.D.
RR 6
(304) 472-2433

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Somerset Village Center, Ste. 2A
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(304) 342-5900

Dennis W. Hedrick, O.D.
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(304) 344-3937

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(304) 925-4761

George E. Toma, M.D.
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(304) 622-7172

CRAB ORCHARD
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1623 Robert C Byrd Dr.
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R. Keith King, O.D.
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126 W. 2nd Ave.
(304) 235-2020

PLEASE NOTE: By acceptance and use of this VSP doctor list, recipient recognizes and agrees that the information contained herein is protected proprietary information and publication or dissemination of the information contained herein for any purpose other than the normal and necessary implementation of the VSP vision care plan is prohibited.

All VSP doctors accept new patients. The VSP doctors contained in this list were VSP doctors at the time the list was created. However, this list is subject to change without notice. Please check with the VSP doctor of your choice when making your appointment to ensure he or she is currently participating with VSP and provides the services you require. This list is also available on our Web site at www.vsp.com and is updated weekly.

Long-Term Disability Income Plans

Employee Only, Pre-tax Benefit

Long-Term Disability (LTD) insurance can help safeguard your family's lifestyle and provide some peace of mind in the event you become disabled and are unable to work.

Because the State of West Virginia's retirement plan may not provide you adequate protection in the event you become disabled, you should consider enrolling in one of the two Long-Term Disability insurance plans offered by Standard Insurance Company.

When am I considered disabled?

During the benefit waiting period and the next 24 months you are considered disabled if, due to injury, physical disease, pregnancy, or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation, or you are unable to earn more than 80 percent of your predisability earnings while working in your own occupation.

Thereafter, you are considered disabled if, due to an injury, physical disease, pregnancy, or mental disorder, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience, or you are unable to earn more than 60 percent of your predisability earnings while working in your own or any other occupation.

What is the LTD benefit?

The monthly LTD benefit is based on your earnings from your public employer. The group insurance policy refers to these earnings as pre-disability earnings. The group policy has an actively-at-work requirement you must meet before your insurance will become effective.

You may apply for coverage under either Plan 1 or Plan 2. The monthly benefit under each plan is determined as follows:

Plan 1: 40 percent of the first \$5,000 of your predisability earnings, reduced by deductible income. The maximum monthly benefit is \$2,000.

Plan 2: 60 percent of the first \$4,167 of your predisability earnings, reduced by deductible income. The maximum monthly benefit is \$2,500.

Both Plans have a minimum monthly LTD benefit of \$100.

What is deductible income?

Deductible Income is income you receive or are eligible to receive from other sources. It includes, but is not limited to: sick pay or other salary continuation, workers' compensation benefits, Social Security benefits, disability benefits from any other group insurance, 50 percent of earnings from work activity while you are disabled, and disability or retirement benefits you receive or are eligible to receive because of your disability under any state disability benefit law or similar law or your retirement plan.

When do LTD benefits become payable?

If your LTD claim is approved by Standard Insurance Company, LTD benefits become payable at the end of the 180-day benefit waiting period. Refer to the Beyond Your Benefits section for information on taxes you may have to pay on insurance payments you receive.

How long can LTD benefits continue?

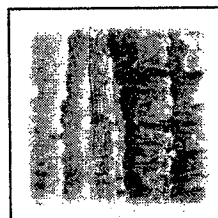
If you become continuously disabled before age 61, LTD benefits can continue during disability until age 65. If you become continuously disabled at age 62 or older, LTD benefits can continue during disability for a limited time. See the chart on Page 24.

What are the exclusions and limitations?

You are not covered for a disability caused or contributed to by: 1) a pre-existing condition (except as provided in your Certificate), 2) an intentionally self-inflicted injury, or 3) war or any act of war. Benefits are not payable for more than 24 months for each period of disability caused or contributed to by a mental disorder, or for any period when you are not under the ongoing care of a physician.

What are some of the features of this coverage?

- Coverage for disabilities occurring 24 hours a day both on or off the job.
- Insurance continues without premium payments while LTD benefits are payable.
- A survivors' benefit may be applicable if you die while LTD benefits are payable.



Long-Term Disability Income Plans *Continued*

Employee Only, Pre-tax Benefit

How long are benefits payable?

Your benefits are payable according to the following schedule:

Age	Maximum Benefit Period
age 61 or younger	to age 65 (or 3 years, 6 months, if longer)
age 62	3 years, 6 months
age 63	3 years
age 64	2 years, 6 months
age 65	2 years
age 66	1 year, 9 months
age 67	1 year, 6 months
age 68	1 year, 3 months
age 69 +	1 year

PRE-TAX RATES FOR PLAN 1 (40% Coverage Level)

Age*	Monthly Premium Rate per \$100 of Salary
to 29	\$.20
30-34	.23
35-39	.29
40-44	.41
45-49	.59
50-54	.87
55-59	1.22
60-64	1.38
65-69	1.75
70 and over	2.25

*Age as of July 1, 2004. Disability Income Protection premiums are adjusted on an annual basis according to the employee's age and salary.

DISABILITY INCOME PROTECTION FORMULA

1. Enter your monthly salary (maximum \$5,000) _____
2. Divide by 100 _____
3. Find your age on the chart above and enter the figure from the "Rate" column _____
4. Multiply the amount in line 2 by the amount in line 3 to get your monthly premium (based on 12 months). _____
Monthly Premium

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

5. Enter the monthly premium amount from line 4 _____
6. Multiply by 12 _____
7. This is your annual premium _____
8. Divide by the number of regular paychecks you receive annually. _____
Per Paycheck Deduction

Benefits are limited to 24 months for each period of continuous disability caused or contributed by a mental disorder. This limitation will not apply if you are confined in a hospital at the end of the 24 months.

This description is designed to answer some common questions about the Long-Term Disability coverage. It is not intended to provide a detailed description of the plans. If you become insured, a more detailed description will be available in group insurance certificates provided to you. The controlling provisions are in the master group insurance policies. This description and the certificates do not modify the group policies or the insurance in any way.

For rules governing the taxes on the insurance payments you may receive, please read the Beyond Your Benefits section in the back of this booklet.

PRE-TAX RATES FOR PLAN 2 (60% Coverage Level)

Age*	Monthly Premium Rate per \$100 of Salary
to 29	\$.38
30-34	.46
35-39	.58
40-44	.81
45-49	1.19
50-54	1.77
55-59	2.32
60-64	2.48
65-69	2.77
70 and over	2.97

*Age as of July 1, 2004. Disability Income Protection premiums are adjusted on an annual basis according to the employee's age and salary.

DISABILITY INCOME PROTECTION FORMULA

1. Enter your monthly salary (maximum \$4,167) _____
2. Divide by 100 _____
3. Find your age on the chart above and enter the figure from the "Rate" column _____
4. Multiply the amount in line 2 by the amount in line 3 to get your monthly premium (based on 12 months). _____
Monthly Premium

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

5. Enter the monthly premium amount from line 4 _____
6. Multiply by 12 _____
7. This is your annual premium _____
8. Divide by the number of regular paychecks you receive annually. _____
Per Paycheck Deduction

Short-Term Disability Income Plans

Employee Only, Pre-tax Benefit

When am I considered disabled?

You are considered disabled if, due to sickness, injury or pregnancy, you are unable to perform with reasonable continuity the material duties of your own occupation, or you are unable to earn more than 60 percent of your predisability earnings while working in your own occupation.

What is the STD benefit?

The weekly Short-Term Disability (STD) benefit is based on your earnings from your public employer. The group insurance policy refers to these earnings as predisability earnings.

The weekly benefit is 60 percent of your predisability earnings, reduced by deductible income. The maximum weekly benefit is \$500. The minimum weekly benefit is \$15.

What is deductible income?

Deductible income includes 50 percent of earnings from work activity while you are disabled, and disability benefits you receive or are eligible to receive because of your disability under any state disability benefit law or similar law.

When do STD benefits become payable?

If your STD claim is approved by Standard Insurance Company, STD benefits become payable at the end of the 30-day benefit waiting period. The Group Policy has an actively-at-work requirement you must meet before your insurance will become effective.

How long can STD benefits continue?

STD benefits can continue during disability until no longer disabled, but no longer than the 180th day of disability.

What are the exclusions and limitations?

You are not covered for a disability caused or contributed to by: 1) a work-related injury, 2) an intentionally self-inflicted injury, or 3) war or any act of war. Benefits are not payable for any period when you 1) receive or are eligible to receive sick leave, 2) are working for any employer other than the State of West Virginia or your public employer, 3) are eligible for any benefits under a workers' compensation act or similar law, or 4) are not under the ongoing care of a physician.

This description is designed to answer some common questions about the Short-Term Disability coverage. It is not intended to provide a detailed description of the plan. If you become insured, a more detailed description will be available in group insurance certificates provided to you. The controlling provisions are in the master group insurance policies. This description and the certificates do not modify the group policies or the insurance in any way.

For rules governing the taxes on the insurance payments you may receive, please read the Beyond Your Benefits section in the back of this booklet.

YOUR PRE-TAX RATES

Example:

If your weekly salary is \$350, your monthly premium would be calculated: $\$350 \times \$0.092 = \$32.20$ per month.

Worksheet

1. Your weekly salary _____
X _____
\$0.092
2. This is your monthly premium _____

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

3. Enter the monthly premium amount from line 2 _____
4. Multiply by 12 _____
5. This is your annual premium _____
6. Divide by the number of regular paychecks you receive annually. _____

For Paycheck Deduction

Policy #611506-B



Group Legal Plan

A payroll deductible, post-tax benefit

Here's an Affordable Solution To Help With Your Legal Needs.

Finding an affordably priced lawyer to represent you when you buy or sell your home or even prepare your will can be a challenge. Did you ever wish you could pick up the phone and call a lawyer for some quick advice? For just pennies a day, the Legal Plan gives you your own "Attorney on retainer." The Legal Plan also covers full representation for many important personal legal services.

How Do I Use the Plan?

When you face a situation that you think may have legal implications, simply pick up the phone and call 1-800-821-6400 Monday-Thursday 8 a.m. to 7 p.m., and Friday 8 a.m. to 6 p.m. (Eastern Time). A knowledgeable client service representative will be available to assist you in locating a Plan Attorney near your home or workplace. Plan Attorneys are generally available to meet with you on weekdays, evenings and even Saturdays. Or, visit www.legalplans.com. If you're enrolled, click "Members Log In." If you have questions as you decide to enroll, click "Thinking about Enrolling?" and use WVA (all capital letters) as your Password.

In or Out-Of-Network?

Hyatt has more than 3,500 law firms in its nationwide network. When you use a Plan Attorney, covered legal services are provided at no additional attorney fees. Of course, you also have the flexibility to use a non-Plan Attorney and get reimbursed for covered services according to a set fee schedule. You will be responsible to pay the difference between the plan's payment and the Attorney's fees. It's completely your choice.

What's Covered?

- In-office Consultation & Telephone Advice with an attorney on virtually any personal legal matter
- Divorce & Separation
- Wills and Codicils * (see note)
- Powers of Attorney
- Sale, Purchase of your Home
- Eviction Defense & Tenant Negotiations
- Juvenile Court Defense
- Traffic Ticket Defense (except DUI)

- Restoration of Driver's License (except DUI)
- Criminal Misdemeanor Defense
- Consumer Protection Matters
- Debt Collection Defense
- Uncontested Adoption
- Identity Theft Defense
- Uncontested Guardianship
- Preparation of Deeds, Mortgages, Notes and Demand Letters

This is a brief summary of the Legal Plan.
For definitions of covered services,
visit Hyatt at www.legalplans.com
or call 1-800-821-6400
and request a Fact Sheet.

- * Preparing for the future may be the most important thing you'll ever do for your family. Estate planning can be complex, and may require tax planning. You may need assistance from an accountant or financial planner. If you do require tax planning, whether it's done by an accountant, a financial planner, or your Plan Attorney, you are responsible for paying the portion of the fees charged for tax planning. The Legal Plan does not cover the tax planning necessary to decide what documents you need.

Not Covered?

If your legal matter is not listed as covered or excluded, your initial advice and consultation are free. If you need representation on a non-covered matter, your Plan Attorney will give you a written fee agreement in advance. This means that you will know, up front, what these services will cost.

What's Excluded?

- Legal services for matters involving the State of West Virginia and any employment related matter
- Any business-related matters (including owned rental property)
- Appeals, class action suits and any matter where a spouse or dependent's interest might conflict with yours
- Payments made to a third party (someone other than the lawyer), such as court costs, witness fees or fines, filing fees, transcripts, recording fees or judgements

This Group Legal Services plan is offered by Hyatt Legal Plans, Inc., Cleveland, OH. In certain states, provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, RI.

Your Rates for the Hyatt Legal Plan

	10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
Employee & Family	\$19.80	\$16.50	\$11.00	\$9.90	\$9.43	\$9.00	\$8.25	\$7.62

Changing Your Coverage

Am I permitted to make mid-plan year election changes?

Under some circumstances, your employer's plan(s) and the IRS may permit you to make a mid-year change to your benefit elections, or vary a salary reduction amount, depending on the qualifying event.

How do I make a change?

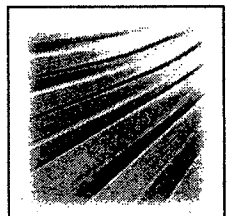
You can change your Flexible Spending Account (FSA) election(s), or vary the salary reduction amounts you have selected during the plan year, only under limited circumstances as provided by your employer's plan(s) and established IRS guidelines. Partial lists of permitted and not permitted qualifying events under your employer's plan(s) appear on the following pages. Election changes must be consistent with the event. Your employer's designee, **Fringe Benefits Management Company (FBMC), P. O. Box 1878, Tallahassee, FL 32302-1878—FBMC Customer Service at 1-800-342-8017** will, in its sole discretion, review on a uniform and consistent basis, the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

To Make a Change: Within **60 days** of an event that is consistent with one of the events on the following pages, you must complete and submit a Change in Status/Election Form to FBMC. Contact FBMC to obtain this form. Documentation supporting your election change request is required. Upon the approval and completion of processing your election change request, your existing benefit elections will be stopped or modified (as appropriate). Generally, mid-plan year, pre-tax election changes can only be made prospectively, no earlier than the first of the month following the approval of your election change, unless otherwise provided by law. If your benefit election change request is denied, you will have **30 days**, from the date you receive the denial, to file an appeal with FBMC. For more information, refer to the *Appeal Process* section on Page 8.

What is my Period of Coverage?

Your period of coverage for incurring expenses is your full plan year, unless you make a permitted mid-plan year election change. A mid-plan year election change will result in split periods of coverage, creating more than one period of coverage within a plan year and expenses incurred must be reimbursed from the correct period of coverage. For example, Ms. Stevens contributes \$300 to her Medical Expense FSA. She has requested reimbursement and submitted receipts in accordance with IRS rules. She exhausts all her funds. Five months into the plan year, Ms. Stevens gets married. Because she realizes her medical expenses will increase, she adds another \$300 to her second period of coverage. Ms. Stevens can now use the second installment of \$300 for expenses that occurred after her Change in Status event (her marriage).

In some cases, a more complicated scenario may arise. For example, Mr. Smith contributed \$400 to his Medical Expense FSA during Open Enrollment. Currently, he has not used any funds. Six months into the plan year, Mr. Smith's wife has a child. Because he realizes his medical expenses will increase, he adds \$200 to his original contribution. Now, there is \$600 in Mr. Smith's Medical Expense FSA since he has not submitted any expenses for reimbursement. While he is able to use this entire amount for expenses incurred after the date of his child's birth, Mr. Smith is prohibited from using the recently added \$200 for expenses that occurred before the Change in Status event (the birth of his child).



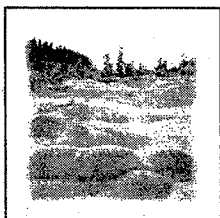
Changing Your Coverage *Continued*

What are the IRS Special Consistency Rules governing Changes in Status?

1. *Loss of Dependent Eligibility*— If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility for coverage due to: your divorce, or annulment from your spouse, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
2. *Gain of Coverage Eligibility Under Another Employer's Plan*— If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage in this plan if that individual gains coverage, or has coverage increased under the other employer's plan.
3. *Dependent Care Expenses*— You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.
4. *Disability Coverage*— For any valid CIS event, you may elect either to increase or decrease these types of coverage.

Changes in Status:

Marital Status	A change in marital status includes marriage, death of the spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee or the spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan includes attainment of legal age, or change in student, marital or employment status.
Change in Residence	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.* *Does not apply to a Medical Expense FSA plan.



Changing Your Coverage *Continued*

Some Other Permitted Changes:

Coverage and Cost Changes	Your employer's plans may permit election changes due to cost or coverage changes.* You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative. *Does not apply to a Medical Expense FSA plan.
Open Enrollment Under Other Employer's Plan	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if: • their employer's plan year is different from your employer's cafeteria plan, • they participate in their employer's plan and • their employer's plan permits mid-plan year election changes under this event. *Does not apply to a Medical Expense FSA plan.
Judgment/Decree/Order	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election* to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) cover the dependent child and provide coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage. *Does not apply to Dependent Care FSA plan.
Medicare/Medicaid	Gain or loss of Medicare/Medicaid eligibility and enrollment may trigger a permitted election change.* *Does not apply to a Dependent Care FSA plan.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: <i>birth, adoption or placement for adoption</i>. Note that a Healthcare FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.

COBRA and Retiree O&A

Can I continue coverage after I terminate?

If you are a covered employee who has lost group health plan coverage due to a qualifying event, you, your spouse and dependents are each entitled, under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), to continue the group health plans (including Medical Expense FSA coverage) that were in effect on the day prior to the qualifying event.

What are COBRA Qualifying Events?

As a general rule, there is a "COBRA-qualifying event" if eligibility for coverage is lost due to:

- a covered employee's termination of employment occurring for reasons other than gross misconduct.
- a reduction in a covered employee's hours of employment.
- the death of a covered employee.
- a covered employee becoming entitled to Medicare.
- the divorce or legal separation of a covered employee (legal separation is not recognized in all states).
- a child ceasing to qualify as a dependent under the terms of the plan.

How does HIPAA affect COBRA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives a person already on COBRA specific enrollment provisions to add dependents only if:

- such a person acquires a new dependent, or
- such a person's eligible dependent declines coverage because of alternative coverage, and later loses such coverage due to certain qualifying reasons.

A spouse and/or dependent added under this paragraph does not become a Qualified Beneficiary, and his/her coverage will end at the same time coverage ends for the person who elected COBRA and later added them.

How do I apply for COBRA?

Within 30 days of a COBRA-qualifying event, you may apply for continuation of your dental, vision and Medical Expense FSA through COBRA by contacting FBMC Customer Service at 1-800-342-8017, or by e-mail at webcustomerservice@fbmc-benefits.com.

What are my FSA Enrollment Rights?

Since your Medical Expense FSA is funded solely with employee contributions, as a qualified beneficiary, you have no Open Enrollment rights.

How does COBRA affect my Medical Expense FSA Plan?

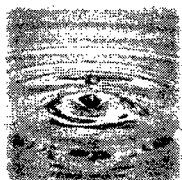
In accordance with COBRA, your employer offers COBRA continuation rights to qualified beneficiaries who have under spent their Medical Expense FSA accounts as of the date of the COBRA-qualifying event. Unless otherwise elected, the spouse and dependents of the person electing COBRA will be covered. Only qualified beneficiaries have election rights and may elect separate COBRA coverage with:

- a separate Medical Expense FSA at the elected annual limit in effect at the time of the COBRA-qualifying event and
- a separate COBRA premium through the end of the plan year in which the COBRA-qualifying event occurs.

Who are Qualified Beneficiaries?

Qualified Beneficiaries must be:

- a covered employee, the spouse of a covered employee or the dependent of a covered employee and
- covered by a group health plan immediately before the qualifying event occurs.



COBRA and Retiree Q&A *Continued*

How do I pay for continuation of coverage?

The monthly COBRA premium for coverage is the monthly premium you were paying via salary reductions before the date of the COBRA-qualifying event, and must be received by the appropriate party by the first of the month. Your first COBRA payment must include all retroactive payments back to your COBRA effective date. Under COBRA, your premium must be paid by check or by money order. Administration fees may apply.

COBRA laws allow for a 30-day grace period after the due date. If your full payments are not received by 30 days after the due date, your COBRA coverage will be cancelled retroactive to the first day of the month for which the full payment is due.

When must I make my initial COBRA elections?

A qualified beneficiary must elect COBRA coverage within 60 days after:

- the employee's loss of group health plan coverage or
- the date the Election Notice was mailed to the qualified beneficiary.

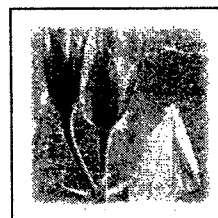
If a qualified beneficiary fails to meet this deadline, he or she will be deemed to have declined COBRA coverage.

What if I fail to make subsequent required payments?

Your full COBRA payments are due on the first of the month. COBRA laws allow for a 30-day grace period after the due date. If your full premium payments are not received by 30 days after the due date, your COBRA coverage will be cancelled retroactive to the first of the month for which the full premium payment is due.

What should I do when I retire?

During the 90 days prior to your anticipated retirement date, contact your Benefit Coordinator to schedule an appointment for retirement and continuation of group health/life plans and flexible benefits.



Beyond Your Benefits *Legal Notices*

Taxable Benefits

Disability Income Protection

If you suffer a disability, any disability payments you receive under the plan will be subject to federal income tax. You can elect to have federal income tax withheld by Standard Insurance Company just as it is withheld from your wages. Consult your personal tax advisor for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six (6) calendar months following the last calendar month in which you worked before becoming disabled. Thereafter, no FICA or Medicare tax will be withheld.

How Mountaineer Flexible Benefits Affects Other Benefits

Your contributions to MFB do not affect your pension benefits or your PEIA medical coverage in any way.

457 Plan Deferred Compensation and 403(b) Tax Deferred Annuity (TDA)

Participating in MFB may affect an employee's maximum contribution to the 457 plan by reducing includible compensation* from which this benefit is computed. Employees should contact their 457 plan provider about the specific effect of Mountaineer Flexible Benefits contributions.

Participation in the Flexible Benefits Plan will not affect an employee's maximum annual contribution to a 403(b) (TDA) plan.

*Includable compensation is the gross income shown on your W-2 form.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors', and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. As of January 2004, the maximum taxable annual wage for FICA is \$89,400. There is no maximum taxable annual wage for Medicare. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call FBMC Customer Service at 1-800-342-8017 for an approximation.

Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health insurance benefits will be provided, not by your Employer's Flexible Benefits Plan, but by the Health Insurance Plan(s). The types and amounts of health insurance benefits available under the Health Insurance Plan(s), the requirements for participating in the Health Insurance Plan(s), and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Health Insurance Plan(s). All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) and the rules, regulations, policies and procedures from time to time adopted.

Processing Claims for Debit Card Transactions

The IRS requires all FSA expenses be substantiated by an independent third party review of the required supporting documentation. Recent IRS guidance permits this review to be conducted electronically when certain expenses are paid with a debit card that is used in conjunction with an FSA. Generally, this applies to prescriptions, known co-payment amounts and recurring expenses. However, some expenses that fall into any of these categories may still require documentation be submitted for further review. All expenses that fall outside these categories require documentation be submitted to FBMC.

The IRS guidance requires FSA customers keep the required documentation for a minimum of one year and submit immediately to FBMC upon request. Any customer who refuses to comply with such request or who uses his/her card for unqualified expenses may experience any or all of the following actions:

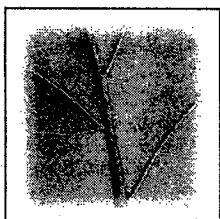
- suspension of card privileges
- offset to paper claim reimbursements (automatic substitution)
- salary deduction of unqualified or unsubstantiated expenses (as permitted by law)
- tax consequences at the end of the calendar year.

Automatic Substitution for Debit Card Receipts

The IRS requires documentation of all Flexible Spending Account transactions. FBMC will continue notifying you in writing that documentation is needed/required to validate your debit card transactions (e.g. original receipts, substitute receipts, medical needs letter or payments, etc.).

For your convenience, FBMC will apply approved paper claim requests to any outstanding debit card transactions. After receiving and processing approved debit card receipts, a payment will be made to you representing the difference between the approved paper claim(s) and any outstanding debit card transactions (if applicable).

Example: A debit card participant, John, has not submitted receipts for three (3) debit card transactions, each in the amount of \$10.00. Later, John submits a paper reimbursement request form for an eligible, out-of-pocket expense totaling \$120.00 and the entire amount is authorized for reimbursement. John will receive a reimbursement payment of \$90.00. The remaining \$30.00 of the \$120.00 reimbursement request will be used to offset the outstanding debit card transactions. After receiving and processing approved debit card receipts, a payment will be sent to John which represents the difference between the approved paper claim (\$120.00) and the outstanding debit card transactions (\$30.00).



Beyond Your Benefits^{Continued}

FBMC Privacy Notice

4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

- I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally vary depending on the products or services you request and may include:
 - Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status, and spousal and beneficiary information.
 - Responses from you and others such as information relating to your employment and insurance coverage.
 - Information about your relationships with us, such as products and services purchased, transaction history, claims history, and premiums.
 - Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.
- II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: www.fbmc-benefits.com. You have a right to a paper copy at any time. Contact FBMC Customer Service at 1-800-342-8017.
- III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena, or to prevent fraud.

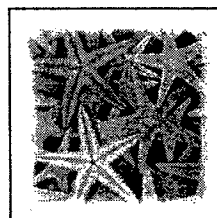
We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

NOTICE OF ADMINISTRATOR'S CAPACITY

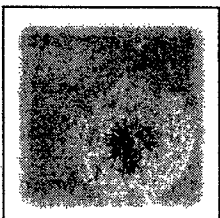
PLEASE READ: This notice advises insured persons of the identity and relationship among the contract administrator, the policyholder, and the insurer:

1. FBMC has been authorized by your employer to provide administrative services for your employer's insurance plans offered herein. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (but not limited to) marketing, underwriting, billing and collection of premiums, processing claims payments, and other services. FBMC is not the insurance company or the policyholder.
2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

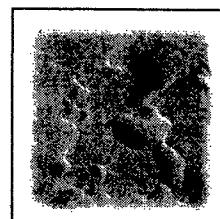
If FBMC is authorized to process claims for the insurance company, we will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.



Notes



Notes





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WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY PLAN DOCUMENT

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

Keith Huffman, General Counsel and Acting Co-Director
Jason Haught, Chief Financial Officer and Acting Co-Director
Gloria Long, Deputy Director of Insurance Programs and Services
and Acting Co-Director

July 1, 2005

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I: GENERAL INFORMATION

Introduction

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

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

Mission Statement

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

PEIA diligently works to achieve this by...

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

Organizational Overview

Director. The Director of the PEIA is appointed by the Governor with the advice and consent of the West Virginia Senate. He/she serves at the will and pleasure of the Governor and must have at least three years experience in health insurance

administration prior to appointment. The Director is responsible for the day-to-day administration and management of the PEIA, makes all rules and regulations, and enters into any contracts necessary to carry out the PEIA's mission.

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

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

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

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

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

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

Overview of Benefits

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

including:

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

Prescription Drug Plan. The Prescription Drug Plan benefits include:

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

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

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

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

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

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

Interpretation of Plan

The Director shall have ultimate authority to interpret the Plan for the PEIA. The

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

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

Amendments to Plan Document

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

Appendices

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

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

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

Definitions

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

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

Acordia - The Third-Party Administrator (TPA) responsible for claims processing, customer service, pre-authorizations and prior approval for out-of-network services for the PEIA PPB Plan. Acordia is also the TPA responsible for utilization management, including precertification, medical case management and any other utilization management functions for the PEIA PPB Plan.

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

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

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

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

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

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

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

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

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

Curascript - The exclusive specialty pharmacy vendor for the PEIA PPB Plan. Curascript provides mail order delivery of the Common Specialty Medications detailed in the Prescription Drug Benefits section of this Plan Document.

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

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

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

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

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

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

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

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

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

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

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

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

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 dystrophy; autism; multiple sclerosis and diabetes. The term "handicap" does not include excessive use or abuse of alcohol, drugs or tobacco.

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

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

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

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

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

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

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

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

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

Medicare Part B - The Medicare Supplementary Insurance Program (SMI); covers the costs of physician services, outpatient laboratory and X-ray tests, durable medical

equipment, outpatient hospital care, and certain other services. As a voluntary program, Part B requires payment of a monthly premium. Beneficiaries are responsible for a deductible and coinsurance payment for most covered services.

Medicare Part C – Medicare Part C is not offered through PEIA.

Medicare Part D – Medicare Part D is prescription drug coverage offered through Medicare and is not required by PEIA members.

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

Mountaineer Flexible Benefits - Flexible benefits plan offered by PEIA.

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

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

PEIA - The West Virginia Public Employees Insurance Agency

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

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

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

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

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

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

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

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

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

PEIA PPB Plan B - An optional PPB Plan available to members during open enrollment. Plan B offers lower premiums with higher deductibles, higher out-of-pocket maximums, and higher copayments for prescription drugs. The medical coverage is the same as in Plan A. The differences in deductibles, out-of-pocket maximums and drug copayments are noted in the benefit tables in the Medical Benefits section and the Prescription Drug section of the Summary Plan Description (SPD). This plan is referred to as PPB Plan B.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Specialty Medications – Specialty medications are high-cost injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of the patient's drug therapy. Specialty drugs generally have the following key characteristics:

- Need frequent dosage adjustments
- Cause more severe side effects than traditional drugs
- Need special storage, handling and/or administration
- Have a narrow therapeutic range
- Require periodic laboratory or diagnostic testing
- Often cost in excess of \$1,300 per 30-day supply

Under the PEIA PPB Plan, Specialty Medications are available only via mail order through Curascript, are subject to a \$50 copay for up a 34-day supply, and may not be purchased in 90-day supplies.

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

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

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

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

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

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

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

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

II: PARTICIPATION

Eligibility to Participate

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

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

Any eligible employer which is not mandated by State law to participate must enter a Participation Agreement with PEIA and agree to at least three years participation. PEIA may require such employers to pay all premiums one month in advance.

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

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

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

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

Retired Employees. Active employees who retire are eligible for PEIA health and life benefits, provided they meet the minimum eligibility requirements of the applicable state retirement system and, as of March 13, 1999, if their last employer immediately prior to retirement is a participating employer under the State retirement system. Active employees who are members of the Teacher's Defined Contribution Retirement plan must be either: fifty-five years of age and have twelve or more years of credited service; or be at least sixty years of age with five years of service; and their last employer immediately prior to retirement must be a participating employer under that, or the State retirement system to qualify to continue PEIA insurance benefits upon retirement. Employees who participate in non-State retirement systems (such as TIAA-CREF and similar plans) must, in the case of education employees, meet the minimum eligibility requirements of the State Teacher's Retirement System, and in all other cases meet the minimum eligibility requirements of the Public Employees Retirement Systems to be eligible for PEIA as a retiree.

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

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

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

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

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

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

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

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

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

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

Working Families Tax Relief Act (WFTRA) of 2004

As a result of the Working Families Tax Relief Act (WFTRA) of 2004, the federal IRS has changed the way it treats children under the tax code. This change may affect you if you pay your health and life insurance premiums pre-tax through a Section 125 premium conversion plan.

The IRS has developed a new definition for "qualified child" and "qualified relative." If you have dependents, they must meet one of these definitions to qualify for you to pay your premiums on a pre-tax basis. In nearly all circumstances, if your dependent meets PEIA eligibility criteria, they will also meet one of these federal definitions. The new definitions are as follows:

A "qualifying child" (QC) is a child who:

- has a specific, family-type relationship to the employee-taxpayer.
- Resides with the employee in his/her household for more than half of the tax year (with certain exemptions such as "temporary absences" if a full-time student).
- Is under age 19 and not a full-time student (under age 24 if a full-time student) as of the end of the calendar in which the employee's taxable year begins. There is no age requirement if a child is child is permanently and totally disabled.

A "qualifying relative" (QR) is a "too old" child or other individual who:

- has a specific, family-type relationship to the employee-taxpayer, or is someone (other than a spouse) who resides with the employee in his/her household for the employee's taxable year. A person will not be a member of the employee's household if at any time during the taxable year the relationship between the employee and the person violates local law.
- receives over half of his/her own support own support from the employee-taxpayer.
- is not anyone's "qualifying child."

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

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

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

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

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

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

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

Enrollment

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

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

When both spouses are eligible for PEIA coverage:

- 1) each may enroll as a policyholder in the PPB Plan;
- 2) each may enroll separately, with one being a policyholder in the PPB Plan and one being a policyholder in a managed care plan;
- 3) each may select a different managed care plan, although both spouses can't be policyholders in the same managed care plan; or,
- 4) they may enroll as a family unit for family coverage with one spouse as the policyholder in either the PPB Plan or a managed care plan, and the other spouse covered as a dependent carrying life insurance only.

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

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

Enrollment Periods.

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

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

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

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

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

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

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

Commencement of Coverage.

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

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

- perform the normal tasks of the job on a full-time basis for a full work day on the day coverage (or an increase in the coverage amount) is to begin; and
- perform the normal tasks at one of the normal places of business or at a location to which the employee must travel to do his/her job.

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

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

Retirees and their dependents who are Medicare eligible must enroll for Medicare Part A and B. The PEIA Plan will coordinate benefits as if the person has enrolled for both Part A and B coverage, regardless of whether the person has actually enrolled for such coverage. Beginning January 1, 2006, Medicare will offer a new program, Medicare Part D (prescription drug coverage). Please be aware that you **DO NOT** have to purchase Medicare Part D (prescription drug coverage) when it becomes available on January 1, 2006. PEIA will continue to provide prescription drug coverage to our Medicare members, and Medicare Part D will be of little or no use to you.

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

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

In the case of a newborn child of an employee covered by PEIA, the newborn must be enrolled by the employee in the calendar month the birth occurs or the

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

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

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

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

Termination of Coverage.

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

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

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

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

the full premium expense for the three months of extended coverage must be reimbursed by the employee through the respective payroll location.

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

A certificate of Creditable Coverage will be generated automatically upon termination of health coverage. You will need this certificate to verify your coverage under PEIA and avoid pre-existing conditions limitations if you are enrolling in another benefit plan. If additional certificates are needed, contact PEIA's Customer Service Unit.

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

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

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

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

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

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

Changes in Participation Status

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

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

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

Leaves of Absences

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

- the employee and employer continue to pay their proportionate shares of premium costs for the period of the medical leave, but not for a period greater than one year;
- if the medical leave extends beyond one year;
 - the employee may be required to pay the full premium costs;
 - the employer must intend that the employee return to work and must continuously hold a funded position open for the employee's return to work;

- during the period of the medical leave, the employee is required to submit to the employer, at least once a month, a statement from a qualified physician certifying that the employee is unable to return to work. The employer must retain the statements in the employees file and make them available for PEIA's review, upon request; and
- failure of the employer to hold open a vacant job position or to provide the physician statements, above, will result in loss of eligibility of the employee and action taken against the employer.

Medical Leave - Workers' Compensation. Any employee who is on a "workers' compensation" leave of absence due to injury or illness arising from employment and is receiving temporary total disability payments from the West Virginia Workers Compensation Fund is entitled to continue coverage until he/she can return to work. The employer is required to continue to pay its proportionate share of the medical insurance premium as long as the employer-employee relationship exists and the employee is receiving or actively seeking Workers' Compensation benefits. Once the temporary total disability claim has been settled, the employee is no longer eligible to continue under this provision.

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

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

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

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

work.

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

Extending Employer-Paid Coverage for Certain Retirees

West Virginia Code § 5-16-13 allows participating employees compelled or required by law to retire before age 65 or who voluntarily retire as provided by law to use accumulated sick and annual leave days to extend their employer-paid PEIA coverage. In order to participate in this benefit, the employee must retire from a participating employer and be drawing a pension from his/her respective retirement system. Policyholders who elect to defer retirement or who are not eligible for payment of retirement benefits at the time they leave active employment are not eligible for the extension of coverage. Eligible retired employees may not use this extension for part of a month. When both spouses are eligible for this benefit and are retired, they may request that PEIA coordinate their leave with their respective employers so as to effectively combine their sick and annual leave to extend their family coverage. If an employee dies before using all the extension of service credit, the benefit ceases and does not pass on to the spouse or dependents.

Employees hired on or after July 1, 2001, are not eligible for this benefit. **Please Note:** If you retire, and then return to active full-time employment with a participating agency, you will lose your right to use your sick and/or annual leave for extended employer-paid PEIA coverage. When you return to active employment and have PEIA benefits as an active employee, your new effective date of coverage with PEIA will be after July 1, 2001.

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

- For eligible employees continuously covered by the PEIA since before July 1, 1988, 2 days of sick or annual leave may be converted into the full premium for one month's single coverage and three days' sick or annual leave may be converted into one month's family coverage; and,
- For all other eligible employees, 2 days of accrued annual or sick leave may be converted into 50% of the premium for one month of single coverage and 3 days of sick or annual leave may be converted into 50% of the premium for one month of family coverage.

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

Continuation of Coverage After Termination.

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

Active Employees. Covered active employees who lose eligibility for coverage because of *i)* voluntary or involuntary termination (except for gross misconduct), *ii)* reduction in hours to part-time status, or *iii)* assignment to active duty military service may elect to continue medical coverage for themselves and their dependents at their own expense for up to 18 months from the date coverage would have terminated. It is the responsibility of the employer to report to PEIA any employees who are COBRA-eligible within 30 days of the date their coverage would ordinarily have terminated under the Plan. The PEIA will then notify the employee within 14 days of the right to continue coverage.

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

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

Dependent Children. An active employee or retired employee may continue coverage on a dependent child if the child no longer meets the definition of a covered dependent as defined in the Plan. Loss of eligibility may result from marriage, attainment of age 19, failure to maintain student status, etc. In such circumstances, coverage may be continued for up to 36 months following the date coverage would

have terminated. It will be the responsibility of the active employee or retired employee to notify the PEIA within 60 days of loss of a dependent's eligibility. The TPA – C will then notify the employee or retiree of the right to elect continued coverage on that dependent within 14 days.

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

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

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

- Continuation of coverage is optional on the part of the employee, retired employee, spouse, or dependent; and those for whom coverage is extended will be required to pay the full monthly group premium, which will include a 2 percent administrative fee, for the applicable coverage type.
- For disabled COBRA beneficiaries, PEIA may charge 150 percent of the applicable premium during the 19th through 29th months of coverage. There will be no contribution made from State or employer funds.
- All premiums must be remitted to TPA – C.
- PEIA is required by federal law to offer continuation of coverage for certain specified periods of time; however, failure to make prompt premium payments will constitute reason for termination of coverage prior to the expiration of the required extended coverage.
- PEIA may be required to offer continuation of coverage to a qualified beneficiary even if they are covered under another group health plan, if necessary for the beneficiary to avoid pre-existing condition limitations.

- After notification by TPA – C of the right to continue coverage, an insured who wishes to elect continued coverage must inform TPA – C, in writing, within 60 days. The insured will then have up to 45 days to pay the applicable premium to the TPA – C, retroactive to the date coverage would otherwise have terminated.
- During the period of continued coverage, medical benefits will be the same as those normally provided by PEIA. Should PEIA implement any changes in benefits or premium rates during the period of extension, the continuation coverage and cost will be affected accordingly.
- If continued coverage is elected, new dependents may be added during the period of continuation and cannot exceed the policyholder's duration of the original 18 months (employee) or 36 months (dependent) extension of coverage; however, they may be subject to the pre-existing condition limitations.
- The continuation option applies only to medical benefits. There are no extension provisions for employee, retired employee, or dependent life insurance other than the conversion options as addressed in this Plan.
- If an insured is enrolled in the PEIA and subject to the limitation for pre-existing conditions, this limitation will continue in effect under any continuation option until the expiration date of the 12-month pre-existing condition limitation period.
- An insured enrolled in an MCO will be offered continuation of coverage through the MCO Plan. Additionally, if the insured has elected to continue coverage, the insured will retain the right to change plan enrollment during the regular annual open enrollment period to be effective at the beginning of the next Fiscal Year.
- An insured enrolled in an MCO will be given the opportunity to elect either the PEIA's or the MCO's plan during open enrollment unless the insured moves outside of the MCO enrollment area.

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

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

one of the following circumstances:

- ~~– COBRA coverage was refused on the termination form; or~~
- no qualifying event has occurred (i.e., a dependent being voluntarily removed by the policyholder).

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

- At the end of the Period of Coverage specified by COBRA (e.g., 18, 29 or 36 month period);
- Upon the insured becoming covered as an employee under another group health plan that does not limit coverage for any pre-existing conditions;
- For a divorced spouse or dependent, who becomes covered under another group health plan that does not limit coverage for any pre-existing conditions;
- Failure of the insured to pay their premium within 30 days of the due date;
- The insured becoming entitled to Medicare after the election of COBRA; or,
- Upon a disabled employee no longer being considered disabled by Social Security.

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

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

Conversion

Life Insurance Conversion Coverage. The PEIA's contract with the carrier for the Basic and Optional Life and Accidental Death provides that the carrier must offer a conversion policy for insureds who are no longer eligible to participate through the PEIA. Prior to termination, the employee's benefit coordinator will notify the insured that the policy is being canceled because of loss of eligibility to participate under the PEIA Plan and will provide information on how the insured may convert the insurance to an individual policy.

III: PLAN ADMINISTRATION

Premium Accounts

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

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

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

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

In setting premium rates, the Finance Board may consider different levels of costs. For active employees, the levels may be based on the policyholder's ability to pay. For retired employees, the levels may be based on the retired employee's covered years of service on record with a State retirement system, ability to pay, or other relevant factors.

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

The PEIA Finance Board sets rates payable by employers who have retirees, dependents of retirees or surviving dependents participating in the Plan. The PEIA may

bill a non-participating employer a premium as established by the Finance Board to subsidize the cost of its retired employees, dependents of retired employees or surviving dependents that participate in the State Retirement Plan.

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

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

Tobacco-Free Discount. PEIA's premiums are based on the tobacco-use status of insureds. Tobacco-free insureds will receive the preferred monthly premium rate, which is \$15.00 lower for single coverage and \$30.00 lower for family coverage. Plan insureds must have been tobacco-free for six (6) months prior to the beginning of the Plan Year to qualify for the discount. Newly hired PPB Plan insureds must have been tobacco-free for six (6) months prior to their effective date of coverage to qualify for the discount.

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

If an individual fails to file a tobacco-free affidavit before the end of open enrollment, the insured may do so at a later date if they have been tobacco-free for six months. However, the insured will not receive the tobacco-free discount for the entire plan year. Upon receipt of a "late" tobacco-free affidavit, PEIA will process the affidavit within sixty days and the insured will receive the tobacco-free discount for the remainder of the plan year. PEIA will not apply the tobacco-free discount retroactively for late affidavits, regardless of the reason.

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

For active employees of State Agencies, and State Colleges and Universities, the State of West Virginia Auditor's Office shall collect the employer and employee premium for health and life insurance through the EPIC system and will remit those

funds to PEIA. For active employees of County Boards of Education, the employer shall collect the employee share through payroll deduction and shall pay to the PEIA the full premium amount monthly (employer and employee share).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

After July 1, 2001: Employees hired on or after July 1, 2001, are not eligible to use leave to extend coverage. Also, **Please Note:** If you retire then return to active employment with a participating agency, you will lose your right to use your sick and/or annual leave for extended employer-paid PEIA coverage. When you return to active employment and have PEIA benefits as an active employee, your new effective date of coverage in the PEIA plan will be after July 1, 2001, and therefore, you will be ineligible for the sick/annual leave benefit.

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

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

5 years of teaching service = 1 year of family coverage

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

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

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

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

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

Failure to Pay Premiums. Failure of an employer or policyholder to pay the monthly premium by the 5th of the month following the month for which the premium is invoiced will result in cancellation of the policyholder's participation in the Plan retroactive to the last day of the month for which the premium was received.

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

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

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

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

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

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

When all changes have been made, the current premium date should be recalculated and the correct amount forwarded by the 5th of the month following the month for which coverage was in invoiced.

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

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

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

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

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

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

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

Refund Timeframes. If the error was on the part of the employer or policyholder,

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

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

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

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

Contracts

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

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

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

any such fee paid by a prospective vendor must be related to actual services rendered or performed by the agent or agents.

TPAs. Awards of contracts for the PEIA's medical claims processing, prescription drug processing and utilization management services and other professional services shall be made by the Director on a competitive basis upon such criteria as the Director believes appropriate for the benefit of the PEIA plans.

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

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

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

Payments

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

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

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

- TPAs shall prepare, as requested by PEIA, a funding request for the total checks prepared for issuance by TPAs for the payment of claims, and shall deliver such voucher to the PEIA within twenty-four (24) hours after the request. Upon obtaining necessary approvals from the State Auditor and State Treasurer, the PEIA shall wire transfer to the PEIA Dedicated Daily Cash Investment Account's funds to pay all claims listed on the vouchers. Upon receipt of such funds by the bank, TPAs shall promptly mail the checks funded or electronically transfer the amount.
- TPAs shall include a statement on each check stating that such check shall be void if not cashed within one hundred eighty (180) days after issuance.
- Interest earned on the PEIA accounts shall belong to the PEIA. The PEIA shall be responsible for all bank charges associated with the PEIA accounts.
- TPAs shall maintain reasonable flexibility in their claims adjudication and payment process to enable the PEIA to make special requests for priority actions. For example, TPAs shall accommodate requests from the PEIA to process and pay or to hold all or a portion of outstanding claims for a particular insured or provider, for certain types of providers (e.g., hospitals), or for providers by geographic location (e.g., in-state versus out-of-state).
- TPAs shall be responsible for the administration of the respective PEIA Dedicated Daily Cash Investment Account and PEIA Dedicated Checking Accounts, and for the full and complete reconciliation of all deposits made and checks issued on the accounts, for as long as the accounts remain open, which shall be for at least one hundred eighty (180) days after the date of issuance of the last check. TPAs shall furnish the PEIA with monthly bank reconciliations for the PEIA Dedicated Cash Investment Account and PEIA Dedicated Checking Account within thirty (30) days after the end of each month.

Payment of Administrative Expenses

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

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

Payments to Managed Care Organizations. Payments to managed care

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

Audits

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

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

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

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

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

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

Agency. The PEIA will employ an independent accounting firm to perform an

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

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

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

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

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

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

MCO members are not eligible for the patient audit program.

Quarterly Reports

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

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

- A summary of funds accrued to the Plan by legislative appropriation, employer

and employee premiums and otherwise in the preceding calendar quarter for payment of health care claims;

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

- Expected claims costs for the next calendar year;
- Such other information as the Director deems appropriate; and
- Any other financial or other information as may be requested by the Committee.

Employer's Notification Responsibility

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

IV: SECTION 125 PLAN

ARTICLE I - INTRODUCTION

- 1.1 Purpose of Plan. The purpose of this Plan is to permit Participants to choose between cash and certain nontaxable health and welfare benefits provided by the Employer. In accordance with this purpose, the Plan provides Premium Conversion Benefits, which are non-taxable benefits provided automatically to Participants through payroll deductions upon the satisfaction of eligibility requirements (unless such benefits are declined for cash), and provides Mountaineer Flexible Benefits, which are non-taxable benefits provided to Participants only upon their election and agreement to payroll deductions.
- 1.2 Authorization. West Virginia Code Section 5-16-14 authorizes Director of the State of West Virginia Public Employees Insurance Agency to develop and implement deductible and employee premium programs which qualify for favorable income tax treatment under Section 125 of the Internal Revenue Code of 1986, as amended.
- 1.3 Cafeteria Plan Status. The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Code, and is to be interpreted in a manner consistent with the requirements of Section 125.
- 1.4 Effective Date. The Plan is amended and restated effective January 1, 1996.

ARTICLE II - DEFINITIONS

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

- 2.1 "Administrator" means PEIA and such other TPA as may be appointed from time to time by PEIA to supervise the administration of the Plan.
- 2.2 "Basic and Optional Life Insurance Program" means the group term life insurance plan offered by PEIA through a contractual arrangement with an insurance carrier of term life insurance under which benefits are excluded from the Employee's gross income pursuant to Section 79 of the Code.
- 2.3 "Benefit Election Form" means the form promulgated by the Administrator by which an eligible Employee makes his benefit election(s) as described in Section 4.1 of the Plan and in accordance with Article IV.
- 2.4 "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any Section or Subsection of the Code includes reference to any comparable or succeeding provision of any legislation, which amends, supplements or replaces such Section or Subsection.

- 2.5 "Compensation" means the total compensation for services paid or made ~~available by the Employer to an Employee including elective contributions or deferrals which would be included in the Employee's compensation except for the operation of Code Sections 125, 403(b), or 457.~~
- 2.6 "Contributions" means Employee contributions as described in Article IV used to purchase Premium Conversion Benefits and Mountaineer Flexible Benefits.
- 2.7 "Dental Benefit Plan" means the dental care plan, or plans, offered by PEIA under which benefits are excluded from the Employee's gross income pursuant to Section 105 of the Code.
- 2.8 "Dependent" means any person, which falls within the definition of dependent provided in Section 125 of the Code.
- 2.9 "Dependent Care Expenses" has the meaning specified in Article II of the Dependent Care Reimbursement Plan.
- 2.10 "Dependent Care Reimbursement Plan" means the State of West Virginia Public Employees Insurance Agency Dependent Care Reimbursement Plan.
- 2.11 "Director" means the Director of PEIA.
- 2.12 "Effective Date" means, with respect to this amendment and restatement, January 1, 1996.
- 2.13 "Eligible Employee" means any Employee who is eligible to participate in the Medical Benefit Plan.
- 2.14 "Employee" means any common law employee of the Employer.
- 2.15 "Employer" means the State of West Virginia, its boards, agencies, commissions, departments, institutions or spending units, or a county board of education which elects to participate in the Plan.
- 2.16 "Health Care Expenses" has the meaning specified in Article II of the Medical Reimbursement Plan.
- 2.17 "Highly Compensated Individual" means a Participant which is (a) an officer, (b) a shareholder owning more than 5 percent of the voting power or value of all classes of stock of the Employer, (c) highly compensated, or (d) a spouse or dependent (within the meaning of Section 152 of the Code) of an individual described in (a), (b), (c) above.
- 2.18 "Key Employee" means any person who is a key employee as defined in Section 416(i)(1) of the Code.

- 2.19 "Long-Term Disability Plan" means the long-term disability plan offered by PEIA ~~under which benefits are excluded from the Employee's gross income pursuant to Section 106 of the Code.~~
- 2.20 "Medical Benefit Plan" means the Employer's respective medical insurance plan(s) and any contract or contracts with health maintenance organizations or group plans in effect from time to time which provide for health care benefits.
- 2.21 "Medical Reimbursement Plan" means the State of West Virginia Public Employees Insurance Agency Medical Reimbursement Plan.
- 2.22 "Mountaineer Flexible Benefits" means, collectively, the Vision Benefit Plan, Dental Benefit Plan, Long-Term and Short-Term Disability Plan and the Dependent Care Reimbursement and Medical Reimbursement Plan, and related plans.
- 2.23 "Open Enrollment" means the period of time prior to or during a Plan Year which PEIA has designated and communicated to Eligible Employees as the period within which they may make elections to allocate Contributions under the Section 125 Plan. The Open Enrollment period may be changed from year to year by PEIA.
- 2.24 "Participant" means each Eligible Employee who elects to participate in the Plan in accordance with Article III.
- 2.25 "PEIA" means the State of West Virginia Public Employees Insurance Agency and any successor thereto.
- 2.26 "Period of Coverage" for the Premium Conversion Benefits means the period of time during the Plan Year in which a Participant is eligible to participate in the Plan under the terms of the Plan and pursuant to the laws of the State of West Virginia. In no event shall the Period of Coverage commence prior to, nor terminate after, the commencement and ending dates of the Plan Year.

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

- 2.27 "Plan" means the State of West Virginia Public Employee Insurance Agency Section 125 Plan as set forth herein, together with any and all amendments and supplements hereto.
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- 2.28 "Plan Year" means the twelve-month benefit period.
- 2.29 "Premium Conversion Benefits" means the Medical Benefit Plan and Basic and Optional Life Insurance Program.
- 2.30 "Spouse" means an Employee's legally married husband or wife.
- 2.31 "TPA" means the third-party administrator retained by PEIA to administer the Plan.
- 2.32 "Vision Benefit Plan" means the vision plan offered by PEIA under which benefits are excluded from the Employee's gross income pursuant to Section 105 of the Code.

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

ARTICLE III – PARTICIPATION

- 3.1 Commencement of Participation. All Eligible Employees may participate in and enter the Plan.
- (a) With respect to Premium Conversion Benefits, each Eligible Employee shall automatically become a Participant in this Plan for a Period of Coverage on the first day of the first month following enrollment in the Medical Benefits Plan, unless the employee properly files with the Administrator a Benefit Election Form to decline participating in the Plan in accordance with Section 4.5.
 - (b) With respect to the Mountaineer Flexible Benefits, participation begins when the Eligible Employee elects, pursuant to Section 4.5, to allocate the Contributions available under this Plan to pay for such benefits during an Open Enrollment period. An Eligible Employee is hired after Open Enrollment is not eligible to participate in the Plan until the next Open Enrollment.
 - (c) The effect of participation, in this Plan is that the Participant's Compensation will be reduced, pursuant to this Plan, by an amount equal to the amounts required as employee contributions for the benefits elected by the Participant.

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

- 3.2 Cessation of Participation. Except as provided in Article VIII, a Participant shall cease to be Participant as of the earlier of (a) the date on which the Plan terminates, (b) the date on which the employee ceases to be an Eligible Employee, or (c) the date on which he/she has elected to cancel the applicable benefit coverage(s) under Article IV.
- 3.3 Reinstatement of Former Participant. A Former Participant who is rehired shall become a Participant again in accordance with Section 3.1. However, in the case of a Participant who separates from service with the Employer during a Period of Coverage and elects to revoke existing benefit elections and terminates the receipt of benefits for the remaining portion of the Period of Coverage, upon return to service, such a Former Participant shall be prohibited from making new benefit elections for the remaining portion of the Period of Coverage.
- 3.4 Relation to Other Eligibility Requirements. Each of the optional benefits incorporated in this Plan, such as the Mountaineer Flexible Benefits and Premium Conversion Benefits, may have its own eligibility requirements for participation, which may differ from those set forth in this Plan. The eligibility requirements set forth in this Plan relate only to participation in this Plan and shall have no effect on such other eligibility requirements.

ARTICLE IV – BENEFIT OPTIONS

- 4.1 Benefit Elections. A Participant may elect under this Plan to receive full Compensation for any Period of Coverage in cash or have a portion of his/her Compensation contributed to the Plan by the Employer toward the cost of one or more of the following optional benefits:
- (1) Benefits available to the Participant as Premium Conversion Benefits, including, but not limited to, benefits available under the Medical Benefit Plan and Basic and Optional Life Insurance Program;
 - (2) Benefits available to the Participant as Mountaineer Flexible Benefits, including, but not limited to, the Vision Benefit Plan, Dental Benefit Plan and Long-Term Disability Plan, but excluding the Dependent Care Reimbursement and the Medical Reimbursement Plans;
 - (3) Benefits available to the Participant under the Dependent Care Reimbursement and the Medical Reimbursement Plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 4.11 Maximum Employer Contributions. The maximum amount of Employer contributions under the Plan for any Participant shall be the sum of (a) the maximum amounts which the Participant may receive in the form of dependent care reimbursement under the Dependent Care Reimbursement Plan and as health care reimbursements under the Medical Reimbursement Plan, as set forth in such plans, and (b) the costs from time to time of the most expensive Premium Conversion Benefits and Mountaineer Flexible Benefits available to the Participant (including the portion of such costs payable with non-elective Employer Contributions).
- 4.12 Effective Periods for Elections. Only Compensation earned after an Employee elects participation in the Plan may be used to purchase optional benefits described in Section 4.1 for a Participant. Participants may not carry over any overused contributions or benefits from one Period of Coverage to a subsequent Period of Coverage.
- 4.13 Nondiscrimination. Notwithstanding any provisions of insurance coverage provided for under this Plan and any other provisions of this Plan, this Plan shall not discriminate as to eligibility to participate, contributions or benefits in favor of Highly Compensated Individuals or Key Employees.

ARTICLE V – ADMINISTRATION OF PLAN

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

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

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

to act of another Employee of the Employer. Neither the Administrator nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

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

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

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

- (a) To prescribe such procedures as the Administrator deems necessary or proper to be followed by Participants in the filing of applications for benefits;
- (b) To construe and interpret the Plan, its construction and interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;
- (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;
- (d) To prepare and distribute, in such manner as the Administrator determines to be appropriate, information explaining the Plan;
- (e) To receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;
- (f) To furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate;

- (g) To receive, review and keep on file (as it deems convenient and proper) reports of benefit payments by the Employer and reports of disbursements for expenses directed by the Administrator;
- (h) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and,
- (i) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocations, delegation, or designation to be in writing.

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

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

- 5.4 Examination of Records. The Administrator shall make available to each Participant for examination (at reasonable times during normal business hours) such of the records under the Plan as pertain to such Participant. The Administrator shall be responsible for complying with all notice, reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 125 Plans.
- 5.5 Reliance on Tables, etc. In administering the Plan, the Administrator shall be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of the administrators of the plans described in Section 4.1 or by accountants, counsel (legal or otherwise), or other experts employed or engaged by the Administrator.
- 5.6 Rules and Decisions. The Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Administrator, whether discretionary or otherwise, shall be exercised in a uniform and consistent manner so that all persons similarly situated will receive substantially the same treatment. When making a determination or calculation, the Administrator shall be entitled to rely upon information by a Participant, the Employer, or the legal counsel of the Employer.
- 5.7 Procedures. The Administrator may act at a meeting or in writing without a meeting. The Administrator may adopt such bylaws and regulations as it deems necessary for the conduct of its affairs.

- 5.8 Authorization of Benefit Payments. The Administrator shall issue directions to the Employer concerning all benefits which are to be paid from the Employer's general assets pursuant to the provisions of the Plan, and warrants that all such directions are in accordance with the Plan.
- 5.9 Application and Forms for Benefits. The Administrator may require a Participant to complete and file with the Administrator an application for a benefit and all other forms approved by the Administrator, and to furnish all pertinent information requested by the Administrator. The Administrator may rely upon all such information so furnished it, including the Participant's current mailing address.
- 5.10 Facility of Payment. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a benefit or installment thereof hereunder is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such person or to the person's legal representative or to a relative of such person for such person's benefit, or the Administrator may direct the Employer to apply the payment for the benefit of such person in such manner as the Administrator considers advisable. Any payment of a benefit or installment thereof in accordance with the provisions of this Section 5.11 shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.
- 5.11 Indemnification of Administrator. The Employer agrees to indemnify and to defend to the fullest extent permitted by law, any individual serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against any and all liabilities, damages, costs and expenses (including reasonable attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or failure to act in connection with the Plan, if such act or failure to act is made in good faith pursuant to the provisions of the Plan.
- 5.12 Claims Procedure.
- (a) A claim for benefits under the Plan shall first be filed with the TPA. Notice of the decision shall be furnished to the claimant by the TPA within a reasonable period of time after receipt of the claim by the TPA. IF a Participant does not receive notice of denial of a claim for benefits under the Plan within 90 days of the filing of such claim, then the claim shall be deemed denied.
 - (b) A claimant may review all pertinent documents and may request a review by the TPA of any claim. Any such request must be filed in writing with the TPA within 90 days after the earlier of (i) receipt by the claimant of

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

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

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

ARTICLE VI – AMENDMENT AND TERMINATION OF PLAN

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

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

ARTICLE VII – MISCELLANEOUS PROVISIONS

- 7.1 Information to be Furnished. Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.
- 7.2 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or Administrator, except as provided herein. No Employer or Employee upon termination of employment or otherwise shall have additional rights or benefits under the Plan, except as provided from time to time under this Plan, and then only the extent of benefits payable under the Plan to such Employee or beneficiary. All payments of benefits as provided for in this Plan shall be made solely out of the assets of the Employer and the Administrator shall not be liable therefore in any manner.
- 7.3 Governing Law. This Plan shall be construed, administered and enforced according to the laws of the State of West Virginia.
- 7.4 Selection of Beneficiaries. In the case of any insurance policy which permits or requires the naming of a beneficiary, it shall be the responsibility of the Employee to see to it that this is done. The Employer shall not be liable for any loss or cost which may result from such failure. The Employer's responsibility shall be limited to joining in the execution of any documents as requested by an Employee or insurance carrier in order to carry out the purpose of this Plan.
- 7.5 Non-alienation of Benefits. Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable hereunder, shall be void. The Employer shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits hereunder.
- 7.6 Divestment of Benefits. Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to the benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.

- 7.7 Discontinuance of Contributions. In the event of a permanent discontinuance of contributions to the Plan, all Participants shall receive any and all benefits to which they were entitled as of the date the discontinuance of contributions occurred.
- 7.8 Non-guarantee of Employment. Neither the establishment or continuance of the Plan, nor any modification thereof, nor the establishment or continuance of any Medical Benefit Plan or any trust, nor the payment of any benefits, shall give any participating Employee, or other person whomsoever the right to be retained in the service of any Employer or PEIA, and all Participants and other Employees shall remain subject to discharge to the same extent as if the Plan had never been adopted.
- 7.9 Binding Effect. Subject to the other provisions of this Article VII, this Plan shall be binding upon PEIA and each Employer, their successors and assigns, and upon anyone participating in, or claiming benefits under, the Plan, including each Participant and each of the beneficiaries, heirs, executors, administrators, personal representatives, successors and assigns.
- 7.10 Severability. If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective, unless such action would then render the Plan inoperable relative to its original intent.
- 7.11 Construction of the Plan. The Director may construe any ambiguous provisions of the Plan, correct any defect, supply any omission, or reconcile any inconsistency, in such manner and to such extent as the Director in his discretion may determine; any such action of the Director shall be binding and conclusive upon all Participants.
- 7.12 Benefits Solely From Assets. The benefits provided hereunder will be paid solely from the assets of the Employer. The benefits provided by the Plan are given in exchange for the Participant's salary reduction agreement. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset for the Employer from which any payment under the Plan may be made.

ARTICLE VIII – CONTINUATION COVERAGE

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

V: MEDICAL BENEFITS PLAN

Introduction

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

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

Deductibles, Coinsurance, Copayments and Plan Maximums

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

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

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

Deductibles for the Medical Benefits Plan are based on the employee's annual salary, tier of coverage (Employee Only, Employee and Child(ren), Family, or Family with Employee Spouse), employment status, and whether the employee gets services within the PEIA network or outside the network. Medical expenses for an individual may apply to both the individual's deductible and the family deductible; however, an individual may not otherwise use the medical expenses of another individual to meet

the individual deductible. Once the family deductible has been met, then the deductible requirement will be satisfied for the Plan Year for each and every member of the family.

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

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

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

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

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

Copayments. A copayment is a flat dollar amount for which the insured is responsible upon receipt of medical services. Certain services are subject to a copayment under the Medical Benefits Plan, including all physician's office visits, except well child care visits. When seeking preventive care at a physician's office, the visit will be subject to a \$10 copayment. Office visits to treat an illness or injury or for

specialty care are subject to a \$15 copayment. Insureds do not have to meet the annual deductible in order for the office visit copayments to apply. However, these copayment amounts do not count toward the out-of-pocket maximum.

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

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

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

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

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

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

Benefit Maximum.

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

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

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

Providers

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

The Office of Inspector General (OIG) of the Federal Department of Health and Human Services, under Congressional mandate, has a program which may exclude individuals and entities from Medicare and other federally funded programs like Medicaid and CHIP. Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance Loans. The OIG maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities.

PEIA has adopted a policy to honor these exclusions. Providers on the OIG list will be removed from PEIA provider networks. Claims for services rendered by these non-network providers will be denied. Providers excluded by PEIA will be notified of the exclusion, in writing, and may appeal such exclusion to the Director within thirty (30) days of receipt of the notice.

Reimbursement Rates. Reimbursement rates for all providers are established by the PEIA and are not subject to review by the West Virginia Health Care Authority.

These rates represent the maximum amount the PEIA will pay for a covered service. PEIA will notify providers of changes to the reimbursement rates within thirty days, when possible.

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

West Virginia Facilities. Most West Virginia hospitals are paid for inpatient admissions in accordance with the Prospective Payment System (PPS) methodology. Outpatient RBRVS services performed at a facility are paid according to the RBRVS payment schedule. Facility admissions and services that are not covered under the PPS or RBRVS methodology will be paid on a discount-from-charges basis.

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

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

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

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

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

PEIA PPO. The PEIA Preferred Provider Organization (PPO) is made up of all West Virginia providers who accept PEIA's insureds as patients. This includes providers located within the State of West Virginia, as well as in the bordering counties

of the surrounding states, who participate in the Acordia/PEIA Provider Network. Care for covered services received from a provider in the PEIA PPO by a PEIA insured will be covered at the highest level of benefit and the services received do not require prior approval.

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

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

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

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

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

Covered Services

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

- consistent with the diagnosis and treatment of the injury or illness;

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

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

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

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

Allergy Services. Including testing and related treatment; in-network care covered at 20% coinsurance after in-network deductible is met. Allergy testing (for more than 70 tests) requires precertification.

Ambulance Services

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

- Air Ambulance Transportation: Expenses for air ambulance services are covered if the services are medically necessary and the services provide transportation to the nearest hospital able to provide the treatment.
- Transportation from hospital to home is not covered, unless approved by the TPA-UM.
- Except in the circumstances above, non-emergency and transportation is not covered.

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

- Tubal ligation;
- Vasectomy;
- Birth control pills: Birth control pills must be purchased at a drug store or through the mail order program and are covered under the Prescription Drug Plan;
- IUD and insertion;
- Birth control implants: covered expenses include the cost of the system and the charges for insertion and removal of the capsules one time every five years;
- Depo-provera injections: covered once every three (3) months. Office visits are not covered when the injection is the primary purpose of the visit.

The Plan does not cover:

- Reversal of a vasectomy or sterilization;
- Birth control pills for contraception purposes for dependent children. They are covered expenses under the Prescription Drug Plan if previously authorized and determined to be medically necessary for purposes other than contraception; or
- Birth control implant covered expenses do not include charges for reinsertion of capsules for the one-year period after the removal if the capsules must be removed due to medical conditions.

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

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

- Acute myocardial infarction (heart attack),
- Coronary by-pass surgery, or
- Stabilized angina pectoris.
- Cardiac rehabilitation for any other condition is not a covered expense.

Covered treatments may be provided at a clinic, a cardiac rehabilitation clinic, or the outpatient department of a hospital and are limited to three (3) sessions per week for 12 weeks or 36 sessions in a twelve-month period. Treatment must commence within twelve months of the cardiac event. Treatment is covered at 20% coinsurance after in-network deductible is met.

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

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

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

Chelation therapy treatment for the conditions listed above is not considered investigational. Chelation therapy is considered investigational, and is not covered for all other conditions including reversal or prevention of coronary artery disease. If covered, in-network therapy is covered at 80% after in-network deductible is met.

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

Childhood Immunizations. Immunizations for children through age 16 are covered at 100% of allowed charges, including the office visit. This benefit is not subject to deductible, coinsurance, or copayment.

Chiropractor. Covered chiropractic services include office treatment for neuromuscular-skeletal conditions, x-rays, and massage therapy when provided by a massage therapist or neuromuscular therapist and billed by the chiropractor. These services are included in the Outpatient Therapy Benefit (see below). Payments for the combined therapies are limited to a maximum of 20 visits per Plan Year, per insured. Office visits and x-rays billed by a chiropractor do not apply to the 20 visit maximum. Preauthorization is recommended for services for children under age 16.

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

- The treatment is for a demonstrable illness or injury;
- The Christian Science Sanitarium where the treatment is received is maintained and accredited by the Mother Church at the time of the service; The treatment is performed by a practitioner or nurse who is accredited by the Mother Church and who is listed in the Christian Science Journal's most recent issue at the time of the treatment; and,
- The individual receiving the treatment is not, at the same time, receiving medical treatment for the same condition.

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

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

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

Table: Preventive Care PPB Plan Benefits for PEIA

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

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

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

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

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

DEXA Scans. Bone mass measured by DEXA is limited to one scan every 24 months for members who meet one of the following criteria:

- 1) Member has received results from a peripheral osteoporosis screen indicating moderate or high risk for osteoporosis; OR
- 2) Member has documented clinical risk for osteoporosis.

Diagnostic testing is covered at 80% after deductible has been met. Routine screening scans are not covered. Complete details of the DEXA scan payment policy are available on the PEIA website at www.wvpeia.com.

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

Durable Medical Equipment (DME). Durable medical equipment is a covered expense. Precertification is required for all DME purchases of \$1,000, or more, or rentals of more than three months. If precertification is not obtained, a 30% penalty will be applied even if it is later determined that the DME was medically necessary. The

insured's provider must submit a letter of medical necessity or call the TPA-UM stating the length of time the equipment will be needed, its cost, and the reason the equipment is needed. The PEIA covers the item, in accordance with the fee schedule for DME and supplies, if purchased, and rental up to the purchase price, if it is rented.

Durable medical equipment coverage does not include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Expenses not covered include:

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

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

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

Home Health Care. Covered home health services include care in the patient's home from nurses, IV and infusion therapists, physical, speech, occupational, or respiratory therapists along with medical equipment and supplies. To be covered, services must be provided by licensed Home Health Agencies and prescribed by the patient's treating physician in place of inpatient care. Home health care must be precertified by the TPA-UM, and requires case management. If more than three (3) visits are necessary, precertification is required.

Home health care services are not covered for:

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

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

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

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

Covered expenses include:

- Room and board (semi-private);

- Cardiac and ICU care; and
- ~~Additional Services and supplies used for diagnosis or treatment while the insured is in the hospital.~~

The following services are not covered:

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

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

- One time between the ages of 20 and 30,
 - Once every 3 years between the ages of 31 and 39, and
 - Once every 2 years after age 40.
- More frequent screenings are not covered expenses.

Immunizations. All non-experimental immunizations are covered. Childhood immunizations for children through age 16 are payable at 100% and are not subject to a deductible, coinsurance or copayment (see Pediatric Care in this Section). All other

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

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

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

Massage Therapy. Massage therapy is included in the Outpatient Therapy Benefit (see below). Payments for the combined therapies are limited to a maximum of 20 visits per Plan Year, per insured. Treatment is covered at 20% coinsurance after the in-network deductible is met.

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

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

- The therapy begins more than 90 days after the onset of the condition;

- The frequency of the therapy is more than 5 times a week in the first week and more than 3 times a week in the following weeks;

-
- The duration of the therapy is greater than 90 days;

- The TPA-UM determines medical necessity.

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

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

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

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

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

- Hemoglobin/hematocrit;
- Blood types, RH factor, RH immunization;
- Urine culture;
- Rubella titer; and
- Chemistry profile

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

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

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

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

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

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

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

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

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

Consultations are covered when requested by the attending physician.

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

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

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

Inpatient and partial hospitalization day programs for mental health, chemical dependency and substance abuse services are limited to a maximum of 30 days per patient, per Plan Year. For outpatient partial/day programs, two (2) outpatient days will be counted as one (1) inpatient day when applying the 30-day maximum. Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment. Precertification is required.

These services are covered at 20% coinsurance after the in-network deductible is met. Unapproved out-of-network inpatient admissions are subject to a \$500 deductible per admission

Outpatient mental health, chemical dependency and substance abuse services are limited to a maximum of 20 visits per patient per Plan Year for short-term individual and/or group outpatient mental health and chemical dependency services. This benefit includes evaluation and referral, diagnostic, therapeutic, and crisis intervention services performed on an outpatient basis (includes a physician's office). Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment beyond the 20 visits.

This benefit is covered at 20% coinsurance after the in-network deductible is met.

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

- Individual, family, or group outpatient mental health and chemical dependency evaluation and referral services;
- Diagnostic, crisis intervention, and therapeutic services;
- Inpatient or partial hospitalization;
- Biofeedback for control of involuntary nervous system problems; and

- Psychological testing and neuropsychological assessment when specified tests are medically necessary.
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These services are not covered:

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

MRA. Magnetic Resonance Angiography services when performed on an outpatient basis are covered at 80% after the in-network deductible is met.

MRI. Magnetic Resonance imaging services when performed on an outpatient basis must be precertified by Acordia National and are covered at 80% after the in-network deductible.

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

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

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

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

reconstruction;

– Diagnosis of myofacial pain; and

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

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

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

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

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

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

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

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

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

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

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

In determining donor benefits, PEIA will cover the donor's charges on the recipient's medical claim history. Donor's room and board is limited to the day of donation. The donor's surgical charge will be paid separately as a second operative procedure charged to the recipient. Testing for persons other than the chosen donor is not covered.

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

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

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

Osteopathic Manipulations. Service of an osteopathic physician to eliminate or alleviate somatic dysfunction and related orders are covered at 80% after the in-network deductible is met, and are part of the Outpatient Therapy Benefits below.

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

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

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

- Allergy Services or Testing;
- Cardiac Rehabilitation;
- Christian Science Treatment;
- Colonoscopy (diagnostic only);
- Dexa Scans;
- Durable Medical Equipment (DME) if the cost is \$1,000 or more or rental more than 3 months;
- Home Health Services;
- Hospice Care;
- Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA);
- Neuromuscular Stimulators and Bone Growth Stimulators;
- Orthotics (if \$1,000 or more);
- Multidisciplinary Pain Management Services;
- PET (Positron Emission Topography) Scan; and
- Sclerotherapy.

Outpatient Therapy Benefit. The following outpatient therapy services have been combined into a single benefit: outpatient physical therapy, occupational,

massage, speech and vision therapy, acupuncture, osteopathic manipulations and chiropractic care. The combined benefit for all of these services is 20 visits per person per year. Additional services may be covered if approved in advance by the TPA-UM.

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

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

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

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

Periodic Physicals (for Adults). The PEIA PPB Plan covers a routine physical exam once every two years for adults age 18 and over. Routine physicals are subject to a \$10 copayment per visit. Exams may be provided more often if the patient's medical history indicates a need. This office visit, generally, includes, but is not limited to:

- height and weight measurement;
- blood pressure check;
- health risk and prevention counseling ; and
- physical examination.

Diagnostic testing, lab and x-rays, provided in conjunction with a period physical are covered, if medically necessary and are billed with a medical diagnosis. The deductible and 20% coinsurance will apply. Only the screenings specifically listed in this specified covered services section, will be covered as routine screenings.

Physical Therapy. This benefit is included in the Outpatient Therapy Benefit (see above) and coverage for the combined therapies is limited to \$1,000 per person per Plan Year. According to current state law, a physical therapist may practice only

when the patient is referred by a licensed physician, surgeon, dentist, osteopathic physician or surgeon. In order to be covered, physical therapy services must be performed by a provider practicing in accordance with the rules of the state board responsible for licensure of physical therapists and with state law.

Physician's Office Visits (treatment for illness, injury, or medical condition).

These visits are subject to a \$15 copayment for in-network services.

Prescription Drugs. Most prescription drugs are covered under the Prescription Drug Plan.

Professional Services of a physician or other licensed provider for treatment of an illness, injury or medical condition. Includes outpatient and inpatient services (such as surgery, anesthesia, radiology, and office visits). Office visits for preventive or specialty care are subject to the applicable copayment while other physician services are covered at 80% after the in-network deductible is met.

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

Prostheses and Implants. Covered expenses include:

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

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

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

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

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

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

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

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

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

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

- Medically necessary assistant surgeon fees.
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These surgical expenses are not covered:

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

Other special provisions

- If two or more surgical procedures are performed on the same day, the allowance for the second through fifth procedure is covered at 50% of the allowed amount. The sixth procedure requires special review by the TPA-UM.
- Certain outpatient surgeries require precertification by the TPA-UM. These include knee arthroscopy, cataract extraction, tonsillectomy, colonoscopy, septoplasty, and laparoscopy other than for sterilization.
- If an assistant surgeon is medically necessary, the allowance for the second surgeon is 16% of the allowed amount for the first procedure, and 8% after that.
- If a second surgical opinion is required by the TPA-UM, it will be covered at 100% of the PEIA fee schedule allowance after the annual deductible is met. If it is voluntary, it will be paid at the normal rate. Third surgical opinions are paid at the normal rate.

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

These therapies and supplies are not covered:

- Devices used in sports-related activities;
- Educational or cognitive medical rehabilitation;
- Therapy for a patient showing no progress;
- Daily living skills training;

- Stimulation therapy;
- Orientation therapy; and
- Aqua therapy.

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

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

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

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

- Nicotine withdrawal therapy is covered with a \$5 generic copayment for a month's supply.
- Zyban is covered with a \$15 preferred brand copayment for a month's supply.

Vision Therapy. Vision therapy is included in the Outpatient Therapy Benefit (see above) and is limited to a maximum of 20 visits per person per year for the combined benefit. Vision therapy is covered when it is ordered by a physician for correcting a covered medical condition. Preauthorization is recommended, but precertification is required beyond the 20 visit Outpatient Therapy Benefit amount. Coverage is at 20% coinsurance after the in-network deductible is met.

Weight Management Program.

PEIA offers a weight management program for PEIA PPB plan members who have a Body Mass Index (BMI) of 30 or greater or a BMI of 25 or greater with related conditions such as hypertension, diabetes, heart disease, or sleep apnea.

Currently, the program is available in Charleston, Huntington, Morgantown, Bluefield, Martinsburg and Clarksburg. We anticipate that more sites will become

available as the program develops.

~~The program includes comprehensive services from registered and licensed dietitians, degreed exercise physiologists and personal trainers at approved fitness centers.~~

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

- Immunizations and vaccinations, such as flu shots, are covered for insureds over age 16. For children through age 16, the plan covers routine office visits for preventive care as recommended by the American Academy of Pediatrics. These visits are covered at 100% of allowed charges and are not subject to copayments or coinsurance or deductible. This office visit, generally, includes, but is not limited to:
 - o height and measurements;
 - o blood pressure check;
 - o vision and hearing screening;
 - o developmental/behavioral assessment;
 - o physical examination.

There is a \$10 copayment for routine preventive care office visits for adolescents over the age of 16.

Well Child Care office visits are recommended by the American Academy of Pediatrics at the following ages:

- o Infancy: 1 month; 2 months; 3 months; 4 months; 6 months; 9 months; and 12 months
- High-Risk Birth Score Program: Infants determined to be at risk are eligible for six additional check-ups
- o Early Childhood: 15 months; 18 months; 24 months; 3 years and 4 years
- o Late Childhood: 5 years; 6 years; 8 years; 10 years; and 12 years
- o Adolescence: 14 years and 16 years
- Hypertension screening, including a detailed office visit, a blood pressure check, and a chemistry profile;
- Periodic physicals every two years, or more often if recommended by a

physician based on the patient's special needs;

- ~~– Tobacco Cessation Program, including prescription and non-prescription drugs and counseling services;~~
- Annual prostate examination for men over 50, including the office visit;
- Annual pap smears;
- Annual mammograms (the associated office visit is covered if the service is performed at the same time as the pap smear); and
- Colorectal Cancer Screenings.

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

1. Augmentative communication devices.
2. Aqua therapy.
3. Biofeedback, except in cases of mental health services.
4. Birth control drugs, devices, and services for dependent children.
5. Chemical dependency treatments when a patient leaves the hospital or facility against medical advice.
6. Coma stimulation.
7. Cosmetic or reconstructive surgery when not required as the result of accidental injury or disease, or unless the surgery is performed to correct birth defects.
8. Custodial care, intermediate care (such as residential treatment centers), domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living.
9. Dental services including dental implants, routine dental care, x-rays, treatment of cysts or abscesses associated with teeth, or any other dentistry and dental procedures.
10. Duplicate testing, interpretation or handling fees.

11. Educational equipment including augmentative communication devices. ~~Education, training, and/or cognitive services, unless specifically listed as a covered service.~~
12. Environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors.
13. Exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines.
14. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts.
15. Experimental, investigational or unproven services, unless pre-approved by the TPA-UM.
16. Foot care (routine) including: removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), hypertrophy (growth of tissue under the skin); Cutting, trimming, or partial removal of toenails; treatment of flat feet, fallen arches, or weak feet; and Strapping or taping of the feet.
17. Genetic testing.
18. Glucose monitoring devices, except Bayer Ascenia models covered under the prescription drug benefit.
19. Hearing aids, wigs or wig styling, vibrators or bathroom scales.
20. Homeopathic medicine.
21. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days; including unauthorized days prior to scheduled surgery.
22. Hygienic equipment such as bed baths, commodes, and toilet seats.
23. Hypnosis.
24. Incidental surgery performed during medically necessary surgery.
25. Infertility services or sterility services including in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, all methods of artificial insemination, and donor semen.

26. Mailing and handling charges.
27. ~~Maintenance-Chiropractic services.~~
28. Marriage counseling.
29. Medical equipment, appliances or supplies of the following types: equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs; recliners; contour chairs; or adjustable beds.
30. Nutritional supplements, food liquidizers or food processors.
31. Medical rehabilitation and any other services which are primarily educational or cognitive in nature.
32. Mental health services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning.
33. Optical services such as routine eye examinations, refractions, eye glasses, contact lenses and fittings.
34. Orthodontistia services.
35. Personal comfort and convenience items or services (whether on an inpatient or outpatient basis) such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician.
36. Physical conditioning. Expenses related to physical conditioning programs such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation.
37. Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered by the PEIA, when such services are: related to employment; to obtain or maintain insurance; needed for marriage or adoption proceedings; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; to obtain or maintain a license or official document of any type or for participation in athletics.
38. Pregnancy-related conditions for dependent children.
39. Professional medical equipment such as blood pressure kits or stethoscopes.

40. Radial keratotomy and other surgery to correct vision.

41. Reversal of sterilization and associated services and expenses.
42. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities.
43. Screenings, except those specifically listed as covered services.
44. Services rendered by a provider with the same legal residence as an insured, or who is a member of the insured's family. This includes spouse, brother, sister, parent, or child.
45. Services rendered outside the scope of a provider's license.
46. Sex transformation operations and associated services and expenses.
47. Supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags.
48. Take-home drugs provided at discharge from the hospital.
49. TMJ. Treatment of temporomandibular joint (TMJ) disorders: including intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for temporomandibular joint dysfunction not caused by documented organic disease or acute physical trauma.
50. The difference between private and semi-private room charges.
51. Therapy and related services for a patient showing no progress.
52. Transportation other than medically necessary ambulance services, or as approved by the TPA-UM.
53. War-related injuries. Treatment in a state or federal hospital for military or service-related injuries or disabilities.
54. Weight loss. Health services and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight control programs, weight control drugs, screening for weight control programs, and services of a similar nature, except those specific services provided through a pilot program by PEIA.
55. Whirlpool pumps or equipment.

56. Work-related injury or illness.

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

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

Utilization Management Program

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

Precertification/Notification Requirements.

Precertification of Inpatient (Admissions Mandatory). For providers participating in the PEIA Plan, precertification is the responsibility of the provider for both inpatient and outpatient services requiring precertification. The PEIA PPB Plan requires that certain services and/or types of services be reviewed to determine whether they are medically necessary and to evaluate the necessity for case management. Some services require "precertification," and other services require notification." Precertification is performed to determine if the admission/services is medically necessary and appropriate based on the patient's medical documentation. Notification to the TPA-UM is required to evaluate the admission/services in order to determine if the patient's medical condition will require case management, such as discharge planning for home health care services. Admissions for partial

hospitalizations and day programs also require prior approval. In addition, precertification is also required for organ transplant services and for the following outpatient services:

Precertification is required for the following:

Inpatient Admissions

1. hysterectomy,
2. laminectomy,
3. insertion of implantable devices (vascular access, pacemakers, implantable pumps, spinal cord stimulators, neuromuscular stimulators, bone growth stimulators,
4. uvulopalatopharyngoplasty,
5. Leforte osteotomy,
6. elective and cosmetic surgeries (breast reduction, blepharoplasty, admonioplasty, breast reconstruction, surgery for varicose venis),
7. bariatric surgery (gastric bypass, etc.),
8. transplants,
9. mental health, and
10. all admissions for out-of-state hospitals/facilities.

Outpatient Services.

1. allergy testing for more than 70 skin pricks and/or intradermal sticks,
2. home health care services for more than 3 days/visits,
3. partial/day mental health programs,
4. MRA (magnetic resonance angiography),
5. MRI (magnetic resonance imaging),
6. multidisciplinary pain management programs,
7. DEXA Scan,
8. durable medical equipment purchases and/or rentals of \$1,000 or more, and surgeries:
 - hysterectomy,
 - laminectomy,
 - implantable devices (vascular access, pacemakers, implantable pumps, spinal cord stimulators, neuromuscular stimulators, bone growth stimulators),

- uvulopalatopharyngoplasty,
- Leforte osteotomy,
- elective and cosmetic surgeries (breast reduction, blepharoplasty, abdominoplasty, breast reconstruction, treatment for varicose veins),
- bariatric surgery (gastric bypass, etc.), and
- transplants.

Notification to Acordia National is required for the following inpatient admissions to WV facilities:

1. medical (non-surgical),
2. surgical admissions (except those specifically listed as requiring precertification),
3. emergency (including chest pain and congestive heart failure, and other cardiac events), and
4. maternity and newborn.

Failure to precertify or notify Acordia National of an admission within the timeframes specified in the chart on the following page will result in a reduction of benefits under the PPB Plan of 30%. This 30% penalty will be the responsibility of network providers. For all non-network providers, this 30% penalty will be the responsibility of the insured in addition to any applicable copayment, coinsurance, deductible, and amounts that exceed PEIA's maximum allowance.

If the insured or provider feels that Acordia National inappropriately denied an admission or the extension of an admission, or that extenuating circumstances existed that prevented notification to Acordia National within the timeframes set forth, the insured or provider may file an appeal.

Exception: It is the patient's responsibility to precertify inpatient stays and outpatient procedures when these services are received out-of-network. If you do not precertify these out-of-network services, you must pay the 30% precertification penalty in addition to the out-of-network copayment, coinsurance, deductible and amounts that exceed PEIA's maximum allowance. Prior approval to use out-of-network providers does not Precertify services.

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

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

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

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

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

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

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

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

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

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

Failure to precertify an admission in accordance with the above timeframes will result in a thirty percent (30%) reduction of benefits under the Medical Benefits Plan.

This thirty percent penalty will be the obligation of the insured for non-participating providers and of the provider when the provider is participating. If the insured or provider feels that the TPA-UM inappropriately denied an admission or the extension of an admission, or that extenuating circumstances existed that prevented the insured from notifying the TPA-UM within the timeframes set forth in this Section, the insured or provider may appeal the decision in accordance with the procedures set forth herein.

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

Preauthorization is recommended for the following services:

- Chelation Therapy
- Chiropractic Services for Children Under 16
- Cosmetic and reconstructive surgery or procedures
- Massage Therapy
- Vision Therapy
- Accident-related Dental Services
- Orthotics

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

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

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

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

- Home health care for more than three (3) visits, including but not limited to skilled nursing visits, I.V. therapy in the home; physical, speech or occupational therapy done in the home, hospice care and medication provided or administered by a home health agency;
- Skilled nursing facility services;
- Durable medical equipment if \$1,000 or more for purchase and/or rental;
- Rehabilitation services;
- Physical, occupational or speech therapy in excess of the amount allowed under the Medical Benefits Plan;
- Mental health visits (outpatient) in excess of the amount allowed under the Medical Benefits Plan; and
- Insureds (employee and employee spouse) who are pregnant must contact the TPA-UM within the first trimester of pregnancy or as soon as pregnancy is confirmed.

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

Following this transition period or after treatment is complete, medical care must be provided by a network provider to be eligible for the higher in-network level of benefits. Not all conditions will qualify for the TOC program.

Medical conditions likely to qualify include:

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

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

- Allergies;
- arthritis;
- asthma;
- diabetes; and/or
- hypertension.

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

Claims

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

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

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

checks are not sufficient proof of payment. A HCFA 1500 or UB-92 signed by the provider and indicating the amount paid by the insured will also be acceptable.

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

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

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

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

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

Out-of-State Waiver Program. PPB Plan insureds who receive services out of state from a provider that does not participate in the Acordia/PEIA Network, may be subject to balance billing. In such circumstances, the insured may apply to PEIA requesting that the PEIA pay amounts exceeding the allowable charges under the Plan. The insured may request an Out-of-State Waiver form from the PEIA, complete the form and return it to the PEIA.

The Director, has sole discretion, to grant the out-of-state waiver under the following circumstances:

1. The PEIA is the primary payer;
2. The insured is billed for amounts that exceed the PEIA allowable charge;
3. It was necessary for the insured to receive the service for one of the following reasons:
 - * an emergency arises and out-of-state care can be reached more quickly;
 - * the insured lives or is traveling out of state; or
 - * the medically necessary service is not available in West Virginia; or
 - * is not available within a reasonable travel time in West Virginia; and
4. If the insured has secondary insurance, an EOB from the secondary insurance must be submitted with the request.

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

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

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

Assignment of Benefits. In accordance with W. Va. Code § 16-29D-4, any West Virginia provider who elects to see a PEIA insured must accept assignment of benefits. The provider may collect any copayment, coinsurance, or deductible that would be due under the Medical Benefits Plan at the time of service, if the provider knows the current allowed amount. Any provider who renders emergency medical

service necessary to treat a life threatening situation of a PEIA insured is not bound to accept assignment of benefits; however, once the patient is stabilized, any further services by the provider are subject to this provision. Providers who contract directly with the PEIA must accept assignment at all times.

Cost Controls

Coordination of Benefits (COB). In an effort to control health care costs, the PEIA has a coordination of benefits (COB) provision. Under this provision, when a PEIA insured also has coverage under another policy or policies, the rules described in Appendix G will determine how the PEIA will pay benefits. With respect to automobile medical payment policies, PEIA will pay as the primary plan and exercise its right of subrogation against the medical payment insurance coverage.

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

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

Subrogation applies, but it is not limited to, the following circumstances:

- Payments made directly by the person who is liable for the insured's sickness, injury, disease, or disability, or any insurance company which pays on behalf of that person, or any other payments on his/her behalf;
- Any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured medical payment policy on the insured's behalf; and
- Any payments from any source designed or intended to compensate the insured for medical treatment of the sickness, injury, disease, or disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.

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

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

- Notify the PEIA in writing of any injury, sickness, disease, or disability for which the PEIA has paid medical expenses on the insured's behalf that may be attributable to the wrongful or negligent acts of another person;
- Notify the PEIA in writing if the insured retains services of an attorney, and of any demand made or lawsuit filed on the insured's behalf, and on any offer, proposed settlement, accepted settlement, judgment, or arbitration award;
- the PEIA has the right to seek repayment of expenses from, among others, the party that caused the sickness, injury, disease or disability, his or her liability carrier or the insured's own auto insurance carrier in cases of uninsured, underinsured or medical payment coverage; and
- Promptly reimburse the PEIA for benefits paid on the insured's behalf attributable to the sickness, injury, disease, or disability, once the insured has obtained money through settlement, judgment, award, or other payment.

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

- PEIA's withholding payment of further benefits or recovery of payment from the provider; and
- The insured being obligated to pay attorney's fees and/or other expenses incurred by the PEIA in obtaining the required information or reimbursement.

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

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

Balance Billing. When PEIA is the primary payer, physicians, facilities, and other health care providers (with the exception of pharmacists and oral surgeons performing services on an outpatient basis) located within the State of West Virginia must accept as payment in full the maximum allowed amount established by the PEIA for covered services. This provision is not subject to waiver by the insured. Such providers are prohibited from billing members for any charges other than deductibles, coinsurance, copayments, and for services not covered by the Plan. Where the services are provided outside of the State of West Virginia or where PEIA is the

secondary payer, the above balance billing prohibition does not apply. In addition, the insured will not be balance billed if the service is provided by a participating Acordia/PEIA Network Provider.

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

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

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

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

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

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

Appeals

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

appropriate TPA to determine if the denial was an administrative error.

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

The written request should contain the following information:

1. Name of the insured and/or provider, address and telephone number;
2. Description of claim or service that was denied;
3. Date denial was received;
4. Reason given for the denial;

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

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

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

VI: PRESCRIPTION DRUG PLAN

Introduction

The PEIA Prescription Drug Plan works in coordination with the Medical Benefits Plan to assist in the payment of health care costs for PEIA insureds. The PEIA Prescription Drug Plan is available to all Participants in the PEIA PPB Plan. Participants in the PEIA PPB Plan B are subject to higher copayments and deductibles.

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

Deductibles, Copayments and Plan Maximums

Deductibles. Before the PEIA pays for the cost of covered prescription drugs, the insured must have met an annual deductible. This deductible is \$75 per person and \$125 per family for Plan A and \$150 per person and \$300 per family for Plan B for each Plan Year. Covered prescription drug purchases will be counted toward the annual deductible in the Plan Year of purchase, not the Plan Year they are billed to the PEIA. Only allowed expenses will be counted toward the deductible. Expenses that should be billed through the Medical Benefits Plan, including certain prescription drugs such as Hyalgan, Synvisc, immunizations and immune globulins will not be counted toward the Prescription Drug Plan deductible.

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

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

Copayments (Retiree Drug Copay Assistance)

Retired employees, whose total annual income is less than 250% of the current federal poverty level, may receive assistance in paying a portion of their drug copayments. Applicants must be enrolled in the PEIA PPB Plan A. Managed care members are not eligible for this program. Applications are mailed to all retired PPB Plan members annually. (See Appendix H.)

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

Brand vs. Generic

If an insured's doctor prescribes any generic drug, the copayment at a network drug store is \$5.00 for up to a 34-day supply. If the medication is a brand-name and is included on the Preferred Drug List (PDL), the copayment at a Network Pharmacy is \$15.00 (\$20.00 for PEIA PPB Plan B.) However, if the medication is a Non-Preferred brand-name drug, the copayment is \$30.00 (\$50.00 for PEIA PPB Plan B.) If an A-B rated generic drug is available, but the insured or the physician feel the brand-name drug is necessary, the insured will pay the \$5.00 generic copayment plus the difference in cost between the brand and the generic. If medical necessity of the multi-source brand-name product is documented by the physician, a prior authorization will be approved. However, the medication will be covered as a Non-Preferred brand-name drug.

Providers

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

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

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

Specialty medications must be purchased through Curascript (see information later in this section.)

Non-Network Providers. The PEIA will pay for prescriptions filled at a non-Network Pharmacy, however, a higher out-of-pocket expense will apply (see Appendix H). The insured must pay the full price of the non-Network claim at the time of the dispensing of the medication and seek reimbursement from PEIA for the covered amount (see **Filing Claims** in this section). The insured will be reimbursed PEIA's allowed amount for the drug, which is based on the Average Wholesale Price (AWP) less the PEIA discount, minus the dispensing fee, the insured's responsibility, and a \$3.00 processing fee.

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

Mail Order Service or Retail Maintenance Pharmacies

Through the current TPA-P, PEIA insureds have access to a prescription mail order service or retail maintenance pharmacies. Drugs prescribed by a physician that are included on the Maintenance Drug List can be filled by mail or at a participating retail maintenance pharmacy in a supply of up to 90 days for the price of two copayments (see **Maintenance Drug List** this section). The insured may check with local pharmacies to verify participation in the retail maintenance program.

If using the mail order service, the insured must submit a prescription from the physician written for a 90-day supply along with a completed Mail Service Pharmacy Order Form and payment to the TPA-P. The insured should notify the TPA-P of any changes in prescription information by submitting a new form. Refills of maintenance medications can be placed over the phone by contacting the TPA-P's customer service department. Any prescriptions submitted to the TPA-P that are not available by mail order will be returned to the insured.

Covered Prescriptions

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

- Aerochamber spacers;
- Ascensia Autodisc test strips
- Ascensia Elite test strips;
- Ascensia Microfill test strips;
- Compound medication of which at least one ingredient is a legend drug;
- Disposable needles/syringes;
- Glucose elevating agents;
- Inspirease spacers;
- Insulin;
- Lancets;
- Legend contraceptives, oral or other, except those listed below will be covered for policyholder and spouse only. Injectable contraceptives may be dispensed in up to a 90-day supply;
- Legend drugs. Exceptions: See Exclusion list in this Section; and

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

Preferred Drug List. The current TPA-P for PEIA offers a listing of brand-name and generic medications that have been proven to be safe, effective treatments and are available at a reduced cost. The copayments for drugs listed on the Preferred Drug List (PDL) are \$5.00 for generic and \$15.00 (\$20.00 for PEIA PPB Plan B) for brand-name drugs.

The PDL includes drugs to treat the following conditions:

- Asthma – beta agonist and corticosteroid inhalers, corticosteroid nasal sprays;
- Immunosuppressants – alkylating agents, antimetabolites, androgens, and hormones;
- Anxiety – anxiolytics;
- Arthritis – non-steroidal anti-inflammatory drugs (NSAIDs);
- Cardiovascular – ACE inhibitors, angiotensin II receptor blockers, alpha-1 blockers, beta blockers and calcium channel blockers for high blood pressure; HMG Co-A reductase inhibitors for high blood cholesterol;
- Central Nervous System – narcotic analgesics, anxiolytics, sedative/hypnotics, anticonvulsants, antivertigo antiemetics, antiparkinsonism agents, antipsychotic drugs, CNS stimulants;
- Depression – antidepressants;
- Dermatological/Topical – corticosteroids, anesthetics and acne;
- Diabetes – insulin, blood glucose strips, sulfonylureas;
- Gastrointestinal conditions – H₂ antagonists, proton pump inhibitors to treat ulcers and reflux;
- Glaucoma – alpha agonist, beta blockers, carbonic anhydrase inhibitors, prostaglandin;
- Infections – antibiotics, antifungals, and antivirals to treat common infections like bronchitis, ear infections, toenail and fingernail infections, herpes;
- Migraine – selective serotonin -1 receptor agonists;
- Topical – anesthetics, corticosteroids, anti-acne drugs, keratolytics, anti-psoriasis and anti-eczema drugs, drugs affecting the ear, nose, throat and mouth;
- Urological – anticholinergics, antispasmodics and benign prostatic hyperplasia therapy;
- Vitamins – prenatal and multi-vitamins; and

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

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

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

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

The medications listed below require prior authorization:

- becaplermin (Regranex)
- Botox **
- Brand-name medically necessary prescriptions. If the medication your doctor prescribes is a multi-source drug (that is, more than one manufacturer markets the drug), and there is an FDA-approved – or “A-B rated” – generic on the market, then PEIA will pay only for the generic version, unless your physician provides medical justification for coverage of the brand-name drug. If prior authorization is granted, these drugs will be covered as non-preferred brand-name drugs.
- ciclopirox (Penlac)
- erythroid stimulants (Epogen, Procrit, Aranesp) **
- fentanyl (Actiq and Duragesic)
- fluconazole (Diflucan)
- growth hormones **
- itraconazole (Sporanox)
- legend oral contraceptives for dependents (covered for treatment of medical conditions only)
- leuprolide (Lupron, Lupron Depot) **

- modafinil (Provigil) for adults*
- Myobloc **
- oxycodone hydrochloride (Oxycontin)

-
- tazarotene (Tazorac)
 - terbinafine (Lamisil)
 - teriparatide (Forteo) **
 - tretinoin cream (e.g. Retin-A) for individuals 27 years of age or older
 - topiramate (Topamax)
 - vacation supplies of medication for foreign travel (allow 7 days for processing)
 - voriconazole (VFEND)
 - zonisamide (Zonegran)

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

**These drugs must be purchased through the Common Specialty Medications Program (see information later in this section.)

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

Drugs with Special Limitations

Step Therapy. Step Therapy promotes appropriate utilization of first-line drugs and/or therapeutic categories. Step Therapy requires that participants receive one or more first-line drug(s), as defined by program criteria before prescriptions are covered for second-line drugs in defined cases where a step approach to drug therapy is clinically justified.

To promote use of cost-effective first-line therapy, PEIA has Step Therapy on the following:

- Angiotensin-Converting Enzyme (ACE) Inhibitors (Accuretic®, Accupril®, Aceon®, Altace®, Capoten®, Capozide®, Lexxel®, Lotesin/HCT®, Lotrel®, Mavik®, Monopril/HCT®, Prinivil®, Prinizide®, Tarka®, Uniretic®, Univasc®, Vasotec®, Vaseretic®)
- Angiotensin II Receptor Antagonists (Atacand/HCT®, Teveten/HCT®, Avapro®, Cozaar®, Benicar/HCT®, Micardis/HCT®, Diovan/HCT®, Avalide®, Hyzaar®)
- Disease-modifying Antirheumatic Drugs (e.g., Enbrel®, Kineret®, Humira®) [must be purchased through the Common Specialty Medication Program (see information later in this section.)]
- Inspra®
- Leukotriene Inhibitors (e.g., Accolate®, Singulair®)

- Non-Steroidal Anti-inflammatory Drugs (brand-name NSAID e.g., Celebrex®, Arthrotec®, Mobic®),
- Proton Pump Inhibitors (e.g., omeprazole, Prilosec®, Prevacid®, Nexium®, Aciphex®, Protonix®),
- Selective Serotonin Reuptake Inhibitors (e.g., Celexa®, Lexapro®, Luvox®, Paxil®, Paxil CR®, Prozac®, Prozac weekly®, Zoloft®),
- Strattera® and,
- Xopenex®

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

Quantity Limits

Under the PEIA PPB Plan Prescription Drug Program, certain drugs have preset coverage limitations (quantity limits). Quantity limits ensure that the quantity of units supplied in each prescription remains consistent with clinical dosing guidelines and PEIA's benefit design. Quantity limits encourage safe, effective and economic use of the drugs and ensure that members receive quality care. Select medications from the quantity limit list are provided below. Insureds taking one of the medications listed below who need to get more of the medication than the plan allows, must ask their pharmacist or doctor to call the Rational Drug Therapy Program to discuss Insured's refill options.

Anzemet, Emend, Kytril, Zofran.

Coverage Limitations:

- Anzemet is limited to 1 tablet per prescription;
- Emend 80 mg. is limited to 2 capsules per prescription;
- Emend 125 mg. is limited to 1 capsule per prescription;
- Emend Trifold Pack is limited 1 package per prescription;
- Kytril is limited to 2 tablets per prescription;
- Zofran 24 mg. is limited to 1 tablet per prescription;
- Zofran 4 mg. and 8 mg. are limited to 12 tablets per prescription;
- Zofran Solution is limited to 3 bottles per prescription;

Diflucan 150 mg. Coverage is limited to two tablets per prescription.

Migraine Medications. Coverage is limited to quantities listed on the following chart:

Generic Name	Brand Name	Quantity Limit Per	Total Quantity Limit within a 28-Day Period
Almotriptan tablets 6.25 mg, 12.5 mg	Axert® - Pharmacia	6 tablets	18 tablets
Dihydroergotamine nasal spray	Migranal® Novartis	4 Spray Devices	2 kits = 8 unit dose sprays
Eletriptan tablets 20 mg, 40 mg	Relpax® Pfizer	6 tablets	18 tablets
Frovatriptan tablets 2.5 mg	Frova® ELAN	9 tablets	27 tablets
Naratriptan tablets 1 mg, 2.5 mg	Amerge® GSK	9 tablets	18 tablets
Rizatriptan tablets 5 mg, 10 mg, orally disintegrating tablets	Maxalt MLT® - Merck	6 tablets	24 tablets
Rizatriptan tablets 5 mg., 10 mg.	Maxalt® Merck	6 tablets	24 tablets
Sumatriptan injection syringes	Imitrex® GSK	1 Kit (2 syringes)	8 kits = 16 injections
Sumatriptan injection vials	Imitrex® GSK	2 Vials	16 Vials
Sumatriptan nasal spray 20 mg	Imitrex® GSK	6 spray devices	3 boxes = 18 unit dose spray devices
Sumatriptan nasal spray 5 mg.	Imitrex® GSK	6 spray devices	6 boxes = 36 unit dose spray devices
Sumatriptan tablets 25 mg, 50 mg, 100 mg	Imitrex® GSK	9 tablets	18 tablets
Zolmitriptan tablets 2.5 mg and 5 mg, orally disintegrating	Zomig ZMT® Astra Zeneca	6 tablets for 2.5 mg 3 tablets for 5 mg	18 tablets
Zolmitriptan tablets 2.5 mg, 5 mg	Zomig® - AstraZeneca	6 tablets for 2.5 mg 3 tablets for 5 mg	18 tablets

New drugs approved by the FDA that have not yet been reviewed by Express Scripts' Pharmacy and Therapeutics Committee will have a non-preferred status. PEIA reserves the right to exclude a drug or technology from coverage until it has been proven effective.

Non-sedating antihistamines (Allegra, Clarinex, Zyrtec). PEIA will cover 34 days of therapy in a 180-day period. Therapy beyond 34 days requires prior authorization from Express Scripts.

Toradol. Coverage is limited to one course of treatment (5 days) per 90-day period.

Tamiflu and Relenza. Coverage is limited to one course of treatment within 180 days.

Exclusions. The following prescriptions are excluded from the Prescription Drug Plan:

- Amevive
- Amounts covered by Medicare for drugs covered by Medicare;
- Anorexients (any drug used for the purpose of weight loss);
- Anti-wrinkle agents (e.g., Renova);
- Birth control drugs for dependent children;
- Bleaching agents (Solaquin, Eldoquin Forte, Melanex, Nuquin, Eldopaque);
- RU-486;
- Butorphanol nasal spray (Stadol);
- Charges for the administration or injection of any drug;
- Codeine /APAP/Caffeine/Butalbital (Fioricet with Codeine)
- Codeine /ASA/Caffeine/Butalbital (Fiorinal with Codeine);
- Contraceptive devices and implants;
- Dermatologicals, hair growth stimulants;
- Drugs dispensed by a hospital, clinic, or physician's office;
- Drugs labeled "Caution—limited by federal law to investigational use," or experimental drugs not approved by the FDA, even though a charge is made to the individual;
- Drugs requiring a prescription by state law, but not by federal law (state controlled) are not covered;
- FDA unapproved uses of drugs requiring prior authorization;
- Fertility drugs;
- Hair growth stimulants;
- Homeopathic medications;
- Hyalgan;

- Immunization agents, blood or blood plasma, biologicals;
- Impotence medications;
- Medication which is to be taken by or administered to an individual, in whole, or in part, while a patient in a hospital, rest home, sanitarium, extended care facility, or convalescent hospital;
- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, or from any state or government agency or medication furnished by any other drug or medical service for which no charge is made to the member;
- Non-legend drugs other than those listed above, except when included in a compound with a legend drug;
- Pentazocine/Acetaminophen (Talacen);
- Prescription drug charges not filed within 6 months of the purchase date, if PEIA is the primary insurance, or within 6 months of the processing date on the Explanation of Benefits (EOB) from the other plan, if PEIA is secondary;
- Raptiva;
- Remicade;
- Replacement medication for lost or stolen drugs;
- Requests for more than a 34-day supply of an acute medication or more than a 90-day supply of maintenance medication;
- Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms, except when enrolled in the tobacco cessation program;
- Synagis;
- Synvisc;
- Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those listed above;
- Vacation supplies, unless leaving the country;
- Vaccines;
- Xolair.

In addition, the following drugs are not covered under the Prescription Drug Plan but are covered under the Medical Benefits Plan when approved by the TPA-UM:

- Amevive;
- Biological sera;
- Blood or blood products;
- Contraceptive devices and implants;
- Hyalgan;
- Immunizations;
- Raptiva;
- Remicade;
- Synagis;
- Synvisc;
- Vaccines;
- Xolair.

Dispensing Limits

Acute Medications. Reimbursement for medication taken for short periods to treat acute medical conditions will be limited to a 34-day supply when the prescription is filled, and each time it is refilled. If a larger supply is purchased, the insured will be responsible for the charge in excess of the cost of the 34-day supply.

Maintenance Medications. A maintenance drug is taken for a long-term condition such as high blood pressure or diabetes. A 3-month (90-day) supply of a maintenance medication can be purchased at a retail pharmacy for the price of three copayments. Maintenance medications can be purchased in a 90-day supply through the TPA-P's mail order service or participating retail maintenance pharmacies at the price of only two copayments. Any maintenance medication dispensed at less than a 90-day supply will be subject to the same copayment that would apply for an acute medication.

Maintenance Drug List:

- alendronate sodium (Fosamax®);
- antiarthritics;
- anticoagulants;

- anticonvulsants;
- antidementia drugs
- antihypertensives
- antiparkinsonism agents;
- antispasmodics: urinary tract;
- benign prostatic hypertrophy/micturation;
- bronchodilators;
- calcitonin (Miacalcin®);
- cardiovascular agents;
- cholinergic stimulants (urinary retention)
- corticosteroids, bronchial;
- cromolyn sodium (Intal®);
- diabetic therapies;
- digestants;
- disposable needles and syringes;
- diuretics;
- enzymes, systemic;
- estrogens and progestins;
- gastrointestinal, colitis;
- glaucoma agents;
- gout medications;
- hormones, misc.;
- immunosuppressive agents;
- legend vitamins (including legend hematinics, vitamin K);
- leukotriene receptor antagonists (asthma agents);
- lipotropics (cholesterol lowering agents);

- mucolytics (pulmonary agents);
- oral contraceptives;
- legend potassium;
- raloxifene (Evista®);
- risedronate (Actonel®);
- selective serotonin reuptake inhibitors (antidepressants in this class only)
- thyroid medications;
- tuberculosis medications;
- xanthines (asthma agents);

Prescription Drug Formulary

The PEIA maintains an open drug formulary to allow members access to most medications available. It follows a three-tier copayment schedule: a generic copayment, a brand-preferred copayment, and a brand non-preferred copayment. The TPA-P will publish and distribute a list of preferred medications, known as the Preferred Drug List (PDL). These medications are clinically appropriate alternatives while also being the most cost effective. Insureds are not limited to PDL medications, but may take advantage of the discounts available on the drugs that are included in the listing. The PDL will be sent to all insureds.

Common Specialty Medications

Beginning July 1, 2005, PEIA has selected CuraScript as the exclusive pharmacy for common Specialty Medications. This means you will only be able to purchase these specialty medications through CuraScript, and the medication will be mailed to either your home or physician's office. Most often these are self-administered injections.

After you have met your deductible, the copayment on these medications will be \$50 for any medications in this class.

Please refer to the list of the most "Common Specialty Medications" on the next page. These drugs are not available in 90-day supplies.

In addition to providing these specialty medications to our members, CuraScript offers:

- o A Patient Care Coordinator who serves as your personal advocate and point of contact.
- o Delivery of your specialty medications directly to your or your doctor.
- o Supplies to administer your medications – at no additional cost.
- o Care management programs to help you get the most from your medications.

If you are prescribed one of these common specialty medications, call CuraScript, toll free, at 1-866-413-4135 (8:00 a.m. – 9:00 p.m., Eastern Time, Monday – Friday and 9:00 a.m. – 1:00 p.m. Eastern Time, Saturday). A Patient Care Coordinator will contact your physician and work with you to schedule a delivery time for the medication.

COMMON SPECIALTY MEDICATIONS LIST

Drug Name	Category
Acthar	Multiple Sclerosis
Aldurazyme	Mucopolysaccharidosis
Aranesp [PA]	Anemia
Arixtra	Anti-Coagulant
Avonex	Multiple Sclerosis
Betaseron	Multiple Sclerosis
Bicillin C-R	Anti-Infectives
Botox [PA]	Migraine, Cerebral Palsy
Cerezyme	Gaucher Disease
Copaxone	Multiple Sclerosis
Copegus	Hepatitis C
Desferal	Diagnostic
Enbrel [ST]	Rheumatoid Arthritis
Epogen [PA]	Anemia
Fabrazyme	Fabry Disease
Fortaz	Anti-Infectives
Forteo [PA]	Osteoporosis
Fragmin	Anti-Coagulant
Fuzeon	HIV
Genotropin [PA]	Growth Hormone
Gleref [PA]	Growth Hormone
Imbruvic	Anti-Neoplastic
Humatrope [PA]	Growth Hormone
Humira [ST]	Rheumatoid Arthritis
Infergen	Hepatitis C
Innohep	Anti-Coagulant
Intron A	Interferons
Iressa	Anti-Neoplastic
Kineret [ST]	Rheumatoid Arthritis
Leukine	Hematopoietic
Leuprolide [PA]	Anti-Neoplastic
Lovenox	Anti-Coagulant

Drug Name	Category
Lupron [PA]	Anti-Neoplastic
Lupron Depot [PA]	Endometriosis, Anti-Neoplastic, Precocious Puberty
Myobloc [PA]	Neurologic
Neulasta	Neutropenia
Neumega	Hematopoietic
Neupogen	Neutropenia
Norditropin [PA]	Growth Hormone
Nutropin [PA]	Growth Hormone
Pegasys	Hepatitis C
Peg-Intron	Hepatitis C
Procrit [PA]	Anemia
Protopin [PA]	Growth Hormone
Pulmozyme	Cystic Fibrosis
Rebetol	Hepatitis C
Rebetron	Hepatitis C
Rebif	Multiple Sclerosis
Ribavirin	Hepatitis C
Rimso-50	Anti-Neoplastic
Rocephin	Anti-Infectives
Roferon-A	Anti-Neoplastic
Saizen [PA]	Growth Hormone
Sensipar	Hyperparathyroidism
Serostim [PA]	Growth Hormone
Tarceva	Anti-Neoplastic
Temodar	Anti-Neoplastic
Tev-Tropin [PA]	Growth Hormone
Thalomid	Anti-Neoplastic
Thyrogen Kit	Diagnostic
Tobi	Cystic Fibrosis
Xeloda	Anti-Neoplastic
Zavesca	Gaucher Disease
Zorbtive [PA]	Growth Hormone

[PA] – This drug requires Prior Authorization from RDT

[ST] – This drug requires Step Therapy

Bayer Glucoeter® Program

Diabetic PEIA PPB insureds have access to a free glucometer program made possible through PEIA and Bayer. Bayer provides the Ascensia® Dex2®, Ascensia Elite®, Ascensia Elite® XL, Ascensia Breeze®, and the Ascensia Contour® at no charge to insureds.

The Plan also covers Ascensia Elite®, Ascensia® Autodisc, or Ascensia, microfill test strips. PEIA insureds must have a current prescription for a glucometer on file at their participating pharmacy to receive their free glucometer. This program is for insureds who have the PEIA PPB plan as their primary insurance carrier. If another insurance is primary, including Medicare, then the blood glucose monitor expenses must be submitted to the primary insurance carrier.

Tobacco Cessation Program

PEIA has a tobacco cessation program that includes coverage for Zyban and nicotine withdrawal drugs. The drugs are covered under the PEIA PPB Plan prescription drug program after a call is made to the PEIA Quit Line: 1-877-966-8784. The program also includes phone coaching services and printed information.

Coverage

After the Quit Line is contacted, PEIA will cover prescription and over-the-counter (OTC) tobacco cessation products only if they are dispensed with a prescription. Coverage is limited to one twelve-week cycle per plan year, two cycles per lifetime. Zyban is available for the Brand-preferred copayment of \$15 (\$20 for PEIA PPB Plan B) for up to a 34-day supply. Nicotine withdrawal therapy is available for the generic copayment of \$5 for up to a 34-day supply.

From time-to-time, PEIA may offer special discounts on nicotine withdrawal therapy. Call the Quitline at 1- 877-966-8784 for details.

Who is Eligible?

PEIA PPB Plan insureds will be screened for eligibility and readiness. Pregnant women will be offered 100% coverage during any pregnancy.

Utilization Review

The TPA-P shall be responsible for the utilization review function of the Prescription Drug Plan. The purpose of utilization review is to ensure that medications prescribed for insureds are medically appropriate. When possible, the TPA-P will inform the dispensing pharmacy of a contraindicated drug before the drug is dispensed. While the TPA-P shall review prescriptions for over-utilization and contraindicated

prescriptions, neither the PEIA nor the TPA-P assumes any responsibility for the medical care or treatment of an insured. The insured should consult with his/her treating provider and the dispensing pharmacist concerning the medication that has been prescribed.

The utilization review program will focus on the following issues of prescription drug utilization:

- Over-utilization;
- Under-utilization;
- Duplicate claims;
- Excessive daily dose;
- Insufficient daily dose;
- Therapeutic duplication;
- Drug-to-drug interaction;
- Drug/age contraindication; and
- Drug/pregnancy contraindication.

By participation in the Prescription Drug Program, the insured has authorized the PEIA and the TPA-P to provide and receive information related to an insured's prescription from providers and pharmacies.

Filing Claims

The TPA-P is responsible for processing all prescription drug claims. In order to be paid under the Prescription Drug Program, the claim must be received by the TPA-P within six months of the date that the prescription was filled, if PEIA is the primary insurer, or within six months of the processing date on the Explanation of Benefits (EOB) from the other plan, if PEIA is secondary.

Network Pharmacies. Claims for prescriptions dispensed by a Network Pharmacy will be submitted electronically to the TPA-P. The prescription receipt must be attached to the form. Claims will be approved prior to dispensing. The insured will be responsible for any copayment, deductible amount, or ancillary charges at the time the prescription is dispensed.

Non-Network Pharmacies. Claims from non-Network pharmacies must be filed using the PEIA Prescription Drug Claim Form. This form, which can be obtained from the PEIA or the TPA-P, must be filled out by the dispensing pharmacist or the insured and forwarded by either the pharmacist or the insured to the TPA-P. When using a non-Network Pharmacy, the insured is responsible for paying the full amount at the time the prescription is dispensed, unless the insured and the pharmacy reach a different agreement.

Filing Claims for Court-Ordered Dependents. Prescription drug claims for court-ordered dependents will be processed using the Social Security number of the policyholder currently on file with PEIA.

Claims Incurred Outside the U.S. Claims for prescriptions filled outside the U.S. will be processed in the same manner as such claims are handled under the Medical Benefits Plan, except that prescription drug claims must be sent to the TPA-P and the PEIA prescription drug claim form must be completed, and accompanied by a receipt. (see Section V, Medical Benefits Plan, Claims).

Coordination of Benefits

If another insurance carrier is the primary insurer for a policyholder or a dependent, or if you are Medicare-eligible, PEIA will pursue coordination of benefits.

1. Commercial Insurance: As a secondary payor, PEIA will pay only if the other insurance plan's benefit is less than what PEIA would have provided as the primary insurer. If PEIA is the secondary insurer, you must submit the following documentation to Express Scripts to have the secondary claim processed:

- a. a completed Express Scripts claim form;
- b. the receipt from the pharmacy; and
- c. an Explanation of Benefits from the primary plan or a pharmacy printout that shows the amount paid by the primary plan.

You will usually be reimbursed within 21 days from receipt of your claim form. If you need claims forms, call Express Scripts' Member Services at 1-877-256-4680 or visit their website at www.express-scripts.com.

2. Medicare: If Medicare is the primary insurer, Medicare must be billed first for any drugs covered by Medicare. Your pharmacist should bill Medicare as the primary insurer. Acordia will receive the crossover claims from Medicare and pay the pharmacy directly. This will save the member money, since PEIA will pay the member responsibility for prescription drugs covered by Medicare. Members should not pay any deductible or co-insurance for Medicare-covered drugs. Members can find a listing of

pharmacies willing to bill Medicare and accept assignment on PEIA's web page at www.wvpeia.com or by calling PEIA's customer service unit at 1-800-654-4406. These classes of drugs are usually covered by Medicare:

- Immunosuppressants
- Oral chemotherapeutic medications
- Drugs for nausea associated with chemo meds
- Diabetic testing supplies
- Limited inhalation therapies

Medicare Part D

Beginning January 1, 2006, Medicare will offer a new program, Medicare Part D (prescription drug coverage.) Please be aware that you DO NOT have to purchase Medicare Part D (prescription drug coverage) when it becomes available. PEIA will continue to provide prescription drug coverage to our Medicare members, and Medicare Part D will be of little or no use to you.

Appeals

Appeals of decisions made by the TPA-P will be processed in the same manner as appeals filed in the Medical Benefits Program, except that the first level of the appeal is to the TPA-P (see **Section V, Medical Benefits Plan, Appeals**).

Appealing a Claim

If you think that an error has been made in processing your prescription drug claim or in a prescription benefit determination or denial, first call Express Scripts or RDT (depending on the nature of your complaint) to ask for details. If you are not satisfied with the outcome of your telephone inquiry, the second step is to appeal to Express Scripts or RDT, in writing. Please have your physician provide any additional relevant clinical information to support your request. Mail your request with the above information to:

Type of Error	Who to Call	Where to Write
Prior Authorization error or denial	RDT 1-800-847-4680	Regional Drug Therapy Program WV WVU School of Pharmacy P.O. Box 9511 HSCN Morgantown, WV 26506
Prescription Drug Claim Payment Error or Denial	Express Scripts 1-877-256-4680	Express Scripts, Inc. Clinical Appeals – (Client-WVA) BL0390 6625 W 78 th Street Bloomington, MN 55439

VII: MANAGED CARE PLANS

Introduction

The PEIA offers to certain policyholders and their dependents the option to participate in one of the managed care plans available through the PEIA.

PEIA will select and contract with qualified managed care plans to offer medical coverage to eligible PEIA insureds. While the managed care plans are non-governmental entities wholly separate and distinct from the PEIA, those members who select the managed care option are still regarded as Participants in the PEIA Plan.

Participation

Eligibility. All participating employers in the PEIA Plan must offer to their eligible employees the choice of selecting a PPB Plan or any PEIA-authorized managed care plan. Qualifications for participation in a PEIA-authorized MCO are the same as those requirements set forth in Section II of this Plan, except as specifically noted in this section. By selecting an MCO for medical coverage, the policyholder is agreeing that the insured and the insured's enrolled dependents will receive routine medical care in accordance with the guidelines established by the MCO. In addition to each plan's enrollment area, the Shopper's Guide contains a summary of each plan's benefit offerings, monthly premiums and copayment schedule.

All policyholders and their enrolled dependents are eligible to participate in a PEIA managed care option, unless the policyholder or an enrolled dependent is eligible to have Medicare as their primary insurer. Policyholders or any covered dependents who have Medicare as their primary insurer, may not select an MCO. Should Medicare become the primary insurer for the policyholder or one of the covered dependents during a Plan Year, the policyholder and dependents must enroll in the PPB Plan.

Dependents must participate in the same plan as their sponsoring policyholder. Dependents living outside the enrollment area of the MCO in which they are enrolled must receive all routine medical services through their PCP.

A Non-Medicare insured who becomes a policyholder as a surviving dependent or through COBRA eligibility may select either the PPB Plan or a managed care plan during open enrollment, but may not change plans during the Plan Year as a result of their achieving policyholder status.

Prior to each open enrollment period, PEIA produces the Shopper's Guide, a reference document developed to assist policyholders in the selection of a medical benefit plan.

Enrollment.

Open Enrollment Period. Eligible policyholders may select a PEIA-authorized managed care plan during the annual open enrollment period. The open enrollment period is held each year for approximately 30 days. The PEIA will provide policyholders with advance notice of the dates of the annual open enrollment, a copy of the Shopper's Guide, and a transfer form to use to make changes in coverage.

A policyholder already enrolled in a medical plan who does not wish to change coverage will be automatically re-enrolled in that plan for the next Plan Year, unless other instructions are communicated during Open Enrollment. It is not necessary to complete another enrollment form.

A policyholder who selects a managed care plan must remain in the Plan for the full Plan Year, unless there is a qualifying event to permit the policyholder to change coverage.

Changes in Coverage Outside Open Enrollment Period. A policyholder enrolled in a managed care plan may make changes outside of the open enrollment period only as a result of one of the following qualifying events:

Changes in Marital Status Including:

- Marriage or divorce of the employee;
- Death of the employee's spouse or child;
- Death of the employee's spouse or dependent;
- Annulment.

Change in Number of Dependents, Including:

- Birth, death or adoption of the employee's child;
- A dependent loses eligibility due to age or student status.

Changes in Employment Status Including:

- Commencement or termination of employment of the employee's spouse or dependent;
- A change from full-time to part-time employment status, or vice versa, by the employee or his or her spouse;

- An unpaid leave of absence taken by the employee or spouse;
- A significant change in the health coverage of the employee or spouse attributable to the spouse's employment;
- Change in the residence or work site of the employer, spouse, or dependent;
- Employment change due to strike or lock-out; or
- The employee's spouse changes coverage during open enrollment of the spouse's employer's plan, and the spouse's employer's plan permits the same type mid-year changes, and the spouse's employer's plan year is different than the PEIA Plan Year.

Additions outside of an open enrollment period must be made in the calendar month of or the two calendar months following a qualifying event. Coverage will be effective on the first day of the month following enrollment, or in the case of newborns, on the date of birth. Any additions not made within these time frames may not be made until the next open enrollment. All deletions must be made within 60 days of the qualifying event.

Any dependent added to a managed care plan as a result of a qualifying event will not be subject to pre-existing condition limitations.

While the PEIA authorizes policyholders to make changes under the above-listed circumstances, those policyholders who participate in an IRS Section 125 Plan must consult their Section 125 Plan and IRS regulations to determine whether such change would be permitted by the IRS.

A physician's departure from a managed care plan does not qualify a managed care plan member to change plans. The member will be offered the opportunity to choose another participating physician from the Plan's network. If the withdrawing physician is the member's primary care physician (PCP), and the member does not choose another PCP, the member will be assigned a PCP by the Plan.

Commencement of Coverage. Coverage for members enrolled during an open enrollment period will begin on the first day of the new Plan Year. Commencement of coverage for members enrolled outside the open enrollment period will be the first day of the calendar month following the enrollment. Coverage for newborns enrolled during the month of or the two calendar months following birth will begin on the date of birth.

Termination of Coverage. A policyholder and dependents must remain in the plan selected by the policyholder for the full Plan Year, unless there is a qualifying event that would allow the policyholder to terminate coverage.

Transfer Between Agencies. A member of a managed care plan who transfers from one participating state agency to another during a Plan Year must remain in the managed care plan for the balance of the Plan Year. The member can only change plans during the Plan Year if the transfer moves him or her out of the enrollment area of the Plan so that accessing care is unreasonable.

In certain extraordinary circumstances, the Director may allow the policyholder to terminate coverage with an MCO outside of an open enrollment period and without having a qualifying event as described in this section. A policyholder may apply to the Director in writing describing why it would create an undue and unreasonable hardship for him/her to remain in the managed care plan through the Plan Year. The decision to allow the policyholder to terminate coverage under this provision is solely at the discretion of the Director. The fact that a policyholder's or their dependent's primary care physician, specialist, or preferred facility voluntarily left the managed care network will not be considered a justifiable reason to terminate the policyholder's coverage with the MCO.

As previously stated, if the policyholder's premium is paid with pre-tax dollars, there are certain IRS restrictions that apply to termination or changes in coverage. A policyholder participating in an IRS Section 125 Plan should consult that Plan to determine whether he/she may terminate or change coverage.

Copayments, Deductibles and Plan Maximums.

Copayments due under an MCO plan are payable by the member at the time the service is provided. MCO plans typically do not have medical deductibles.

Premiums

State agencies, colleges, universities and county boards of education pay the same "employer" premiums for the same tiers of coverage whether the policyholder participates in the PEIA PPB Plan or a managed care plan. Cost differences among the plans are borne by the employees who participate in the plans. Except with respect for retirees, non-state agencies (local government entities) determine what portion of the premium will be paid by the employer, and what, if any, will be paid by the employee. Premiums are paid to PEIA which, in turn, pays a capitation amount to the MCO for each enrolled policyholder. Premiums are published in the Shopper's Guide each year prior to Open Enrollment.

Capitation Rates

A capitation rate is the amount that the PEIA will pay to an MCO for providing medical care and prescription drug coverage to a PEIA member. The Director will set capitation rates for each coverage tier allowed in the PPB Plan.

Administration

In order to administer the managed care offering, the PEIA, MCOs, employers and policyholders all must recognize and fulfill certain responsibilities. The following is not intended to be an exclusive list of those responsibilities. Further responsibilities may be contained in the managed care contracts and on enrollment forms.

Responsibilities of PEIA. The PEIA is responsible for the following:

- Disseminating information regarding managed care options, restrictions and limitations so that policyholders may make informed choices;
- Processing new enrollments, changes in enrollment, terminations of enrollment and verifying eligibility to enroll in a managed care plan;
- Furnishing eligibility data to managed care plans;
- Billing and receiving premiums from employers, retirement plans and individual policyholders, as appropriate; and,
- Paying MCOs those capitation rates as agreed upon in the managed care contracts.

Responsibilities of MCOs. MCOs offering benefits to PEIA members are responsible for the following:

- Providing to PEIA members those benefits set forth in the evidence of coverage;
- Maintaining adequate provider contracts to insure that PEIA members have appropriate access to services as required by the West Virginia Department of Insurance;
- Providing eligible policyholders with information concerning their plan;
- Providing enrolled members with an identification card and evidence of coverage prior to the commencement of coverage;
- Resolving member grievances in a timely and fair manner; and
- Performing other duties as outlined in the managed care contract.

Responsibilities of Employers. Employers shall be responsible for following:

- Knowing the managed care offerings in their geographic area so they may direct employees to the correct source of information;

- Communicating eligibility and enrollment data to the PEIA as soon as the information becomes available; and
- Collecting and paying to the PEIA by the 25th day of each month the employer and employee share of the premium.

Responsibilities of Policyholders. Policyholders who select one of the managed care plans authorized through the PEIA are responsible for the following:

- Making their selection of a health plan selection for the Plan Year during open enrollment;
- Reviewing and understanding managed care options, limitations and restrictions prior to selecting a plan; and
- Communicating eligibility/enrollment changes to the employer immediately as such information becomes available.

Benefits

The benefits package provided to PEIA must be an existing commercial benefit package offered to other clients and approved by the West Virginia Department of Insurance. Benefits, limitations and exclusions in an MCO plan must clearly be set out in the Plan description provided to members.

Solicitation

All solicitation material to be sent to PEIA insureds is subject to inspection and prior approval by the PEIA.

Communication

All communication materials to be mass-distributed to PEIA insureds are subject to inspection and prior approval by the PEIA.

Appeals

Managed care plan members who think that an error has been made in processing their claim, must call their managed care plan to discuss the matter.

If the claim has been denied, or if the insured disagrees with the determination made by the managed care plan, the second step is to appeal, in writing, within 60 days of the denial to the managed care plan. Instructions for filing that appeal are in the Evidence of Coverage provided by the managed care plan.

If the insured is not satisfied with the response from the managed care plan, they may appeal, in writing, to the Director of the PEIA. You, or your covered dependents, must request a review, in writing, within sixty (60) days of getting the decision from the managed care plan. Facts, issues, comments, letters, Explanation of Benefits (EOBs), and all pertinent information about the claim and review should be included. The appeal should be mailed to:

Director
Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, WV 25305-0710

When the request for review arrives, the PEIA will reconsider the entire case, taking into account any additional materials that have been provided. A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the insured or his or her authorized representative.

Insureds who disagree with the decision of the PEIA Director, you have one final level of appeal to the West Virginia Insurance Commissioner. Instructions for this appeal are also provided in your Evidence of Coverage from each managed care plan.

VIII: LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD & D)

Introduction

The PEIA contracts with a life insurance carrier ("Carrier") to offer term life insurance and AD&D plans to active employees and term life insurance to retired employees through a group life insurance policy. The current carrier is listed in Appendix A. Active and retired employees can choose basic life insurance, optional life insurance, and optional dependent life insurance. Each of these coverages is described below.

Basic Life and AD&D Insurance

Active employees may select basic life insurance. For active employees, this benefit plan also includes coverage for accidental death and dismemberment. Retired employees are eligible only for the basic life coverage, but not AD&D coverage.

Basic life and AD&D insurance is decreasing term coverage. The amount of benefits depends on the age and employment status of the insured as set forth below.

Basic Life Insurance Benefits

Amount of Benefits. Upon receipt of proof of death of an enrolled employee, the Plan will provide the following Basic Life Insurance benefits:

Active Employees:

	<u>Amount of Life Coverage</u>	<u>Amount of AD&D Coverage</u>
Under age 65	\$ 10,000	\$ 10,000
Between ages 65 and 70	\$ 6,500	\$ 6,500
Age 70 and older	\$ 5,000	\$ 5,000

Retired Employees:

	<u>Amount of Life Coverage</u>	<u>Amount of AD&D Coverage</u>
At retirement	\$ 5,000	\$ 0
At age 67 and older	\$ 2,500	\$ 0

Disabled Employees (Disabled Prior to Age 60):

	<u>Amount of Life Coverage</u>	<u>Amount of AD&D Coverage</u>
Under age 65	\$ 10,000	\$ 0
Age 65 but Under Age 70	\$ 5,000	\$ 0
Age 70 or older	\$ 2,500	\$ 0

Optional Life and Accidental Death and Dismemberment (AD&D) Insurance

Active employees can elect optional life and an equal amount of AD&D coverage. Retired employees can elect optional life insurance, but not the AD&D coverage. The employee can choose from eighteen levels of decreasing term coverage for active and ten levels of decreasing term coverage for retired employees, depending on the age and employment status of the employee as follows:

Active Employee -- Optional Life and AD&D

<u>Age</u>	<u>Plan I</u>	<u>Plan II</u>	<u>Plan III</u>	<u>Plan IV</u>	<u>Plan V</u>	<u>Plan VI</u>	<u>Plan VII</u>	<u>Plan VIII</u>	<u>Plan IX</u>	<u>Plan X</u>
Under 65	\$5,000	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$75,000	\$80,000	\$100,000
65-69	\$3,250	\$6,500	\$13,000	\$19,500	\$26,000	\$32,500	\$39,000	\$48,750	\$52,000	\$ 65,000
70 & over	\$2,250	\$4,500	\$9,000	\$13,500	\$18,000	\$22,500	\$29,000	\$33,750	\$36,000	\$ 45,000

<u>Age</u>	<u>Plan XI</u>	<u>Plan XII</u>	<u>Plan XIII</u>	<u>Plan XIV</u>	<u>Plan XV</u>	<u>Plan XVI</u>	<u>Plan XVII</u>	<u>Plan XVIII</u>
Under 65	\$150,000	\$200,000	\$250,000	\$300,000	\$350,000	\$400,000	\$450,000	\$500,000
65-69	\$ 97,500	\$130,000	\$162,500	\$195,000	\$227,500	\$260,000	\$292,500	\$325,000
70 & over	\$ 67,500	\$ 90,000	\$112,500	\$135,000	\$157,500	\$180,000	\$202,500	\$225,000

Retired Employee -- Optional Life with no AD&D

<u>Age</u>	<u>Plan I</u>	<u>Plan II</u>	<u>Plan III</u>	<u>Plan IV</u>	<u>Plan V</u>	<u>Plan VI</u>	<u>Plan VII</u>	<u>Plan VIII</u>	<u>Plan IX</u>	<u>Plan X</u>
Under 65	\$5,000	\$10,000	\$15,000	\$20,000	\$30,000	\$40,000	\$50,000	\$75,000	\$100,000	\$150,000
65-69	\$3,250	\$ 6,500	\$ 9,750	\$13,000	\$19,500	\$26,000	\$32,500	\$48,750	\$ 65,000	\$ 97,500
70 & over	\$2,500	\$ 5,000	\$ 7,500	\$10,000	\$15,000	\$20,000	\$25,000	\$37,500	\$ 50,000	\$ 75,000

Increasing the Optional Life Insurance Benefit. An employee who wants to increase the Optional Life Insurance benefit will be required to submit a statement of insurability form. A medical examination, paid for by the employee, may be required.

Continuation of Coverage During Leave of Absence. An employee on an approved leave of absence may continue Optional Life Insurance by paying the required premiums if coverage under Basic Life Insurance Plan is continued through the period of the leave of absence.

Optional Dependent Life and AD&D

In addition to the Optional Life AD&D coverages, active employees may elect Optional Life with AD&D Insurance for their dependents. Retirees may elect Optional Life Insurance without AD&D coverage for their dependents.

- If a retiree elects option II, the retiree must provide evidence of insurability for each dependent to be insured.
- Retirees may elect Dependent Life Insurance only during the calendar month of or the two calendar months following their date of retirement. After this time, no initial elections or increases will be permitted.

	<u>Plan I</u>	<u>Plan II</u>
Spouse	\$5,000 in Life Insurance \$5,000 in AD&D Coverage	\$10,000 in Life Insurance \$10,000 in AD&D Coverage
Each Child	\$2,000 in Life Insurance \$2,000 in AD&D Coverage	\$4,000 in Life Insurance \$4,000 in AD&D Coverage

A statement of insurability will be required if Optional Dependent Life is elected at any time after the enrollment period.

Dependent life insurance benefits will be available for newborns who die before discharge from the hospital when they are added to the policy within the allotted time frames for enrollment of dependents, and if they meet the guidelines of an eligible dependent. They cannot be enrolled for an amount greater than the amount for which the policyholder has previously elected.

Enrollment

Enrollment in Basic, Optional or Dependent Life and AD&D coverage is accomplished by completing enrollment forms obtained from the employee's place of employment or through the retirement system. Enrollment will authorize the employer or retirement system to deduct the premiums for the coverages from the employee's salary or pension.

New Employees. The enrollment period for new employees is the calendar month in which employment begins and the following two calendar months. No statement of health will be required during this time, for any amount not exceeding \$100,000. Coverage will become effective the first day of the month following enrollment, (or approval, if required).

In order for coverage to begin on the first day of the month following enrollment, the employee must be actively at work on the date the coverage would become effective. If the employee enrolls before he/she is actively at work, coverage will begin on the first day of the month following the employee's first day of active employment.

If the employee chooses to enroll in Basic, Optional, or Dependent Optional Life Insurance after the enrollment period, a statement of insurability will be required. Coverage will become effective the first day of the month following approval.

Basic Life coverage or an increase in the amount of Optional Life Insurance coverage will be effective on the date the policyholder becomes eligible provided the policyholder has completed:

- a) a full day of Active Work on that date; or
- b) a full day of Active Work on the last regularly scheduled work day and is able to work on the date he/she becomes eligible.

If the policyholder does not meet the requirements of (a) and (b) above, the coverage will become effective on the date the policyholder returns to Active Work.

Active Work and Actively at Work means: performing regular duties for a full work day for the Policyholder.

Retired Employees. The enrollment period for retired employees wishing to elect new, or continue or increase Optional Life Insurance is the calendar month of and the two calendar months following their retirement. A statement of insurability will be required for retirees wishing to elect new, increase their coverage, or who elect plan two. New or increased coverage will be effective the first day of the month following approval. The retired employee cannot elect to enroll in or increase Optional Life Insurance after this initial period. The retired employee cannot enroll for or continue AD&D insurance.

Benefits for Accidental Death and Dismemberment Insurance

For active employees, the amount of the AD&D coverage is equal to the amount of the basic and/or optional insurance coverage.

To qualify for an AD&D benefit payment, the death or dismemberment must be the result of an injury caused by external and purely accidental means. The accident must occur while the employee or dependent is insured, or the loss of life or body part must occur within 90 days after the accident. AD&D insurance is paid as follows:

- 100% – Accidental loss of life
- 100% – Accidental loss of both hands, both feet, the sight of both eyes, or one hand or one foot and the sight of one eye.
- 50% – The accidental loss of one hand, one foot, or the sight of one eye.

No more than the full amount of coverage will be paid for multiple injuries resulting from one accident.

No AD&D benefits will be paid for losses suffered due, directly or indirectly, to one of the following circumstances:

- Bodily or mental infirmity, or disease, whether it is a proximate or contributing cause of the loss, whether sane or not;
- An infection other than a burn-related infection or an infection of a cut or wound;
- Suicide or attempted suicide;
- Intentional self-inflicted injury;
- War or act of war;
- Taking part in a riot;
- Committing or trying to commit a crime;
- Any other kind of disease;
- Hernia, unless caused by accidental means; and
- Medical or surgical treatment (except surgical treatment required by the accident and performed within 90 days after the accident.)

Statement of Insurability

A statement of insurability will be required for any employee who does not elect Basic, Optional, or Dependent Optional Life Insurance during the enrollment period or who wishes to increase the coverage amount. The life insurance carrier may require a medical examination at the employee's expense, and will make the final determination of whether or not to issue coverage.

Designating and Changing Beneficiaries

Designation. The employee may indicate the individual, individuals, or entity to receive the proceeds of the benefits under the life insurance plan.

The employee may designate more than one person as the beneficiary, and may indicate the portion of the proceeds for each beneficiary by listing the beneficiary and the percentage of proceeds each beneficiary is to receive. If no percentage is listed, the proceeds will be divided equally among all beneficiaries. If a beneficiary has died, the remaining beneficiaries will share the portion that would have been paid to the deceased beneficiary.

Failure to Designate a Beneficiary. If the employee fails to designate a beneficiary or if the beneficiary does not survive the employee, benefits will be paid to the first surviving class of beneficiaries:

- widow or widower;
- surviving children;
- surviving parents;
- surviving brothers and sisters; and
- the employee's estate.

Minor beneficiary. If the beneficiary is a minor for whom no legal guardian has been appointed, the Plan will request that a guardian be appointed so that the entire benefit can be paid. The benefit will not be paid until the appointment, or the life insurance carrier will place the money into an interest-bearing account, in the minor's name, to be held until the minor turns age 18.

Multiple Beneficiaries. If more than one (1) beneficiary is named, the form should indicate the proportion to be paid to each beneficiary. If the share that each beneficiary is to receive is not stated on the designation form, the beneficiaries will be paid equal shares.

If one or more of the named beneficiaries dies before the employee, the remaining beneficiaries will share equally the amount which would have been distributed to the deceased beneficiary or beneficiaries. If only one beneficiary survives the employee, that beneficiary will receive the entire benefit.

Beneficiary for Optional Dependent Life Insurance. The employee will always be the beneficiary of Optional Dependent Life Insurance benefits.

Changing a Beneficiary. The employee may change the beneficiary of the Basic or Optional Life Insurance and AD&D coverage by completing a Change of Beneficiary form obtained from the employee's benefits coordinator or the retirement system.

Premiums

Basic Life Insurance Coverages. All costs of Basic Life Insurance coverage for employees and totally disabled employees are paid by the employer, except for non-state agencies. The premium rates are set forth in Appendix B.

Optional Life Insurance. The employee is responsible for paying the full applicable premium for Optional Life Insurance. The premium rates are set forth in Appendix B.

Optional Dependent Life Insurance. The employee is responsible for payment of all applicable premiums for Optional Dependent Life Insurance. The premium rates are set forth in Appendix B.

All premium rates are subject to change as determined by the WV PEIA's Life Insurance Carrier.

Basic Life Insurance For Disabled Employees (Waiver of Premium). If an active employee with Basic Life Insurance becomes totally disabled before reaching age 60, the Basic Life Insurance may be continued at no cost to the employee through a waiver of premium while the employee remains totally disabled. To qualify for this waiver of premium, the employee must furnish proof of total disability within one year after the date of disability, and, the employee must have been covered under Basic Life Insurance when the disability began. The date of disability is the employee's last day of active work.

"Total Disability" exists when the employee is completely unable, due to sickness or injury or both, to engage in any gainful occupation which the employee is reasonably capable of performing by education, training or experience. The employee will not be considered totally disabled while capable of working at any gainful occupation.

Application for waiver of premium is made through the employee's benefits coordinator. Proof of continuing disability will be required three months before each anniversary of the initial date of disability. The employee may be asked by the life insurance carrier to submit to periodic medical exams. AD&D coverage does not continue under the waiver of premium.

If the waiver of premium application is approved, the Basic Life Insurance will remain at \$10,000 with no premium cost to the employee. At age 65, the Basic Life Coverage will decrease to \$5,000, and further reduce to \$2,500 at age 67.

This coverage will end at the earliest of these events:

- the end of disability;
- the failure to provide proof of continued disability; or
- the failure to submit to a physical examination when required by the life insurance carrier.

Refund of Individual Policy Premiums. If the employee had converted his/her life insurance under the Group Policy to an individual policy while totally disabled, the employee must return the individual policy to the insurance company with the first proof of total disability for a refund of any premiums paid.

Medical Examinations. The insurance company has a right to have its medical representative examine the employee when necessary, but not more than one (1) time each year after the employee has been totally disabled for a period of two (2) years.

Optional Life Insurance for Disabled Employees (Direct Payment of Premiums). If an active employee who has Optional Life Insurance becomes totally disabled before reaching age 60, the same or lower level of Optional Life Insurance may be continued while the employee remains totally disabled if the employee pays the entire premium for the Optional Life Insurance directly to PEIA. To qualify for this benefit, the employee must furnish proof of total disability and, the employee must have been covered under Basic Life Insurance and Optional Life Insurance when the disability began. The date of the disability is the employee's last day of active work. The employee must meet the definition of "total disability" and qualify for "waiver of premium" of their Basic Life Insurance as more fully set out in the "Basic Life Insurance For Disabled Employees (Waiver of Premium) section immediately above. The employee must also qualify as totally disabled with the Public Employees Retirement System.

Conversion

Basic and Optional Life Insurance Coverage.

Termination of Employment. If an employee leaves employment, the life insurance protection will continue for thirty-one (31) days from the date of termination of employment. The Accidental Death and Dismemberment coverage will end on the date of termination of employment.

During the thirty-one (31) day period, the employee may elect to convert all or a part of the group life insurance coverage to an individual policy by making an application and paying the first premium during the thirty-one (31) day period. No medical examination or statement of health is required.

The employee may only choose a type of coverage available from the Carrier.

The amount which may be converted is an amount equal to or less than the prior level of coverage. The level of premium is based upon the age, occupation and type of policy selected. The policy will take effect at the end of the thirty-one (31) day period.

Conversion for Spouse or Dependent. If a dependent loses coverage due to attaining the age of nineteen (19) (or twenty-five (25) if a full-time student), the dependent may convert the Dependent Life Insurance into an individual policy. The application and payment of the first month's premium must be made within thirty-one (31) days after the termination of coverage.

If coverage on the spouse of the employee ends due to employee's loss of eligibility, the dependent may, within thirty-one (31) days after the insurance ends, apply to convert the coverage to an individual policy.

The spouse may elect term insurance for a period of not more than one (1) year before the conversion coverage. No medical exam is required. The converted policy will take effect thirty-one (31) days after the coverage under the group policy ends as long as proper application is made and the first monthly payment is paid in that period.

If the employee coverage on the spouse ends because the group policy has terminated or is amended, the employee may apply to convert the coverage to an individual policy in the manner described above. However, he/she must have been insured under the group policy for at least three (3) consecutive years and the group policy must have been in force at least five (5) consecutive years. The sum of coverage is reduced by any other group policy for which he/she is eligible within the thirty-one (31) day conversion period.

If a dependent's coverage under the Optional Dependent Life Insurance ends because the employee's class of employment is no longer classified as eligible and the dependent dies within thirty-one (31) days of that event, the benefit will be paid in the amount for which the dependent was last insured.

If a dependent dies within thirty-one (31) days after the insurance ends because the group policy is discontinued or amended, a benefit will be paid in the amount for which the dependent was last insured under the group policy. The employee must have been insured under the group policy for at least three (3) consecutive years and the group policy must have been in force for at least five (5) consecutive years. This amount will be reduced by any amount for which a person became insured under any other group policy within thirty-one (31) days after the coverage under this plan ended.

No payments will be made under the provisions of the last 2 paragraphs above if: (1) at the time of the dependent's death, he/she is eligible for insurance as an employee under the Plan; or (2) at a child's death, he/she is married or has reached the age limit.

Totally Disabled Employees. When the life insurance coverage for a totally disabled employee ends, the totally disabled employee will have the same rights to convert the group life insurance to an individual policy as apply to an employee. This right of conversion applies only if the totally disabled employee does not become insured again under the group policy.

Termination of Group Coverage or No Longer Eligible to Participate. If the group policy terminates or the employee is no longer employed in an eligible class of employees, the employee may convert coverage to an individual policy within the thirty-one (31) day period after coverage ends. For this right of conversion to exist, the employee must have been insured under the group policy for at least three (3) consecutive years. The amount which may be converted is reduced by any sum for which the employee was otherwise eligible under any other group policy in the thirty-one (31) days during which the election to convert may be made.

If an employee dies within thirty-one (31) days of the end of coverage, and the coverage ended because the group policy terminated or the employee was employed in a class of employees which is no longer eligible to participate, the employee's beneficiary will

be paid a benefit if the employee had been insured under the group policy for at least three (3) consecutive years and the group policy had been in force at least five (5) consecutive years.

The amount of the benefit will be the amount of life insurance for which the employee was last insured less any sum for which the employee became insured under any other group policy within thirty-one (31) days of the date the coverage ended under the group policy.

The individual policies for all life insurance policies are issued by PEIA's life insurance carrier. The individual policy is not the same as provided through PEIA, and may be substantially different. The employee may obtain a Life Insurance Conversion Application Form by calling the PEIA. The completed form is provided by PEIA's life insurance carrier which will explain the coverage options and costs to the employee.

Filing Claims

In General. Upon the death of the insured, the following steps are to be followed:

1. the insured's payroll location or retirement system should be notified by the family of the insured;
2. the payroll location or retirement system will initiate the process for the payment of the claim by completing the employer's statement on the notice of death form and sending it to PEIA;

3. PEIA will then notify the beneficiary by sending out a Proof of Death claim form and requesting a court-certified death certificate with a raised seal;
4. the beneficiary completes the Proof of Death claim form and returns these materials to:

Public Employee's Insurance Agency
Attn.: Life Insurance Specialist
State Capitol Complex
1900 Kanawha Boulevard
Building 5, Room 1001
Charleston, WV 25305-0710

5. upon receipt of these materials, PEIA completes the final preparation of the claim; and
6. PEIA forwards all materials to the Carrier for processing;
7. the proceeds will be paid to the beneficiary(ies).

Retired Employees. Retired employees using sick and/or annual leave to extend insurance coverage must contact their former employers to file life insurance claims. All other retired employees must file life insurance claims through their retirement system.

Accidental Death and Dismemberment Claims. Within ninety (90) days after the date of the loss for which a claim is being made, written notices of the event must be provided to the PEIA. Failure to provide notice within this ninety (90) day period will not invalidate or reduce the claim as long as it can be shown that it was not reasonably possible to provide notification within that time frame and that notice was provided as soon as reasonably possible.

Upon receipt of notice, the forms for filing a proof of claim will be provided by the PEIA. If the claimant does not receive the forms for filing a proof of claim from the PEIA within fifteen (15) days of providing notification, the claimant will be deemed to have complied with the proof of claim requirements. If the claimant submits written proof covering the occurrence and the character and extent of loss for which the claim is being made to the PEIA, this written statement must be received within ninety (90) days after the date of the loss unless it can be shown that it was not reasonably possible to furnish the proof within the required time, and that proof was provided as soon as reasonably possible.

Upon receipt of the proof of claim, the AD&D benefits will be paid to the employee, if living, or to the beneficiary.

Disputed Claims

All disputed claims for benefits under the Plan shall be submitted to PEIA, or its representative within 60 days of the receipt of the denial notice from Carrier. Written notice of the decision on each such claim shall be furnished within sixty (60) days of the decision of the Carrier to the claimant.

If the claim is wholly or partially denied, such written notice shall set forth an explanation of the specific findings and conclusions on which such denial is based. A claimant may review all pertinent documents and may request a review by the Carrier of such a decision denying the claim. Such a request shall be made in writing and filed with the Carrier, within 30 days after delivery to the claimant of written notice of decision. Such written request for review shall contain all additional information which the claimant wishes the Carrier to consider in rendering its decision, and the decision on review shall be made within ninety (90) days of the date all information is received by the Carrier.

Written notice of the decision of the Carrier, shall be furnished within sixty (60) days to the claimant and shall include specific reasons for such decision. For all purposes under the Plan, such decisions on claims (where no review is requested) and decisions on review (where review is requested) shall be final, binding, and conclusive on all interested persons as to participation and benefit eligibility and as to any other matter of fact or interpretation relating to the Plan.

Termination or Reduction of Coverage

Employee. Coverage ends when the employee is no longer eligible or when the group coverage terminates, whichever happens first. In the case of a voluntary termination of employment, the employee's coverage terminates immediately upon termination. If the termination of employment is involuntary but not due to gross misconduct, the employee may continue to be covered for three (3) months after the end of the month in which the employee is taken off the payroll.

Dependents. A dependent's coverage will end at the earlier of the following events:

- The dependent is no longer an eligible dependent;
- The employee retires and elects not to enroll for optional dependent life insurance;
- The employee dies;
- The employee elects not to participate; or
- The coverage under the group policy ends.

IX: VISION, DENTAL, AND LONG AND SHORT TERM DISABILITY PLANS

Introduction

In accordance with W. Va. Code § 5-16-15, the PEIA offers a vision, dental and long term disability plan to eligible insureds. These plans are offered as part of Mountaineer Flexible Benefits administered by a TPA with insurance coverage provided by a third-party. Eligible insureds may elect to participate in any one of these plans separately or in combination.

Eligibility

All active employees and their dependents eligible to participate in the Medical Benefits Plan may elect to participate in any of these plans. In the case of County Boards of Education, the board must participate for the employee to be eligible. Non-state (local government) agencies are not eligible to participate. All issues concerning eligibility will be determined by the Director.

Enrollment

Active employees may enroll in these plans during the PEIA annual open enrollment, or if a new employee, during the calendar month of or the calendar month following their employment. If the active employee enrolls in any of these plans and uses pre-tax dollars to pay premiums, the employee may not voluntarily terminate participation until an open enrollment period, effective the first day of the next Plan Year, unless the employee has a qualifying event as defined by PEIA's Section 125 Plan.

Premiums

All administrative and actuarial costs of these plans shall be borne by the premium payments of the Participants, or in the case of employees of county boards of education, pursuant to any agreement between the employee and the agency. Premiums will be determined by the company providing the insurance coverage.

Employers will collect premiums from employees participating in the plans and forward the premiums to the PEIA. Employees on a leave of absence will send premium payments directly to the PEIA. The PEIA will determine the dates premium payments are due at the Agency and provide appropriate notice. The PEIA will collect all premium payments and forward them to the TPA.

Administration

The Vision, Dental, and Long- and Short-Term Disability Plans are administered for the PEIA by the TPA listed in Appendix A.

The Director shall establish separate accounts for the deposit of dental premiums, vision premiums, and short- and long-term disability premiums.

The TPA shall provide to the PEIA such reports as requested by the PEIA and as set forth in the contract between the TPA and the PEIA.

Benefits

Each insured who elects coverage from one of these plans will be given a summary of benefits by the carrier describing the benefits covered, the providers participating in the benefit (if applicable) and how to file claims.

X: MEDICAL REIMBURSEMENT PLAN

ARTICLE I - INTRODUCTION

- 1.1 Purpose of Plan. The purpose of the Plan is to enable Participants to elect to receive payments or reimbursements of Health Care Expenses that are excludable from the Participant's gross income under §105(b) of the Code and that would be deductible expenses under §162 of the Code.
- 1.2 Qualification of Plan. This Plan is intended to qualify as an accident and health plan under §105(e) of the Code, as is to be interpreted in a manner consistent with the requirements of §105 (e).
- 1.3 Effective Date. The Plan is amended and restated effective January 1, 1999.

ARTICLE II – DEFINITIONS

The definitions in this Plan shall have the same meanings as set forth in the State of West Virginia Public Employees Insurance Agency Section 125 Plan, unless otherwise indicated below.

- 2.1 "Benefit" means any amount(s) paid to a Participant in the Plan as reimbursement for Health Care Expenses incurred by a Participant during a Plan Year by the Participant, Spouse or Dependents.
- 2.2 "Effective Date" means this amendment and restatement is effective July 1, 2000.
- 2.3 "Grace Period" means the 90-day period after the end of each Period of Coverage during which a Participant may submit claims for reimbursement from the Medical Reimbursement Account for claims incurred during the immediately preceding Period of Coverage.
- 2.4 "Health Care Expense" means health care expenses that are (a) deductible under Section 213 of the Code; (b) incurred by the Participant, Spouse, or Dependents during the Period of Coverage in which Contributions were credited to the Participant's Medical Reimbursement Account; (c) not incurred prior to the date the Employee's participation in the Plan commenced; and (d) not reimbursed by the Medical Plan or any other source. Health Care Expenses shall not include an expense incurred for the payment of premiums under a health insurance plan. For purposes of this Plan, expenses are incurred when the Participant or Beneficiary is furnished the health care or services giving rise to the claimed expense.

- 2.5 "Highly Compensated Individual" means a Participant who is (a) one of the 5 highest paid officers, (b) a shareholder owning more than 10 percent in value of the stock of the employer, or (c) among the highest paid 25 percent of all Participants as defined in §105(h)(5) of the Code.
- 2.6 "Open Enrollment" means the period of time prior to or during a Plan Year during which Eligible Employees may make elections to allocate Contributions under the Section 125 Plan. The Open Enrollment period shall be established from year to year by PEIA.
- 2.7 "Participant" means each Employee who elects to participate in the Plan in accordance with Article III.
- 2.8 "Period of Coverage" means the Plan Year. The Period of Coverage will generally be twelve (12) months, except the 1999 Plan Year, or for Periods of Coverage during which an Employee is a Participant for less than the entire Period of Coverage. A Period of Coverage shall not be for a duration which would enable a Participant to defer the receipt of Compensation or to obtain coverage under the Plan only for periods during which a Participant expects to incur Health Care Expenses.
- 2.9 "Plan" means The State of West Virginia Public Employees Insurance Agency Medical Reimbursement Plan as set forth herein, together with any and all amendments and supplements hereto, which is designed to operate in conjunction with the Section 125 Plan.
- 2.10 "Plan Year" means the twelve-month period beginning July 1 and ending June 30.
- 2.11 "Required Premium" means the amount of medical reimbursement coverage elected by the Participant for the Period of Coverage divided by the number of pay periods in such Period of Coverage.
- 2.12 "Section 125 Plan" means The State of West Virginia Public Employees Insurance Agency Section 125 Plan as amended from time to time.

The singular shall include the plural and vice-versa, whenever used herein, unless the context clearly indicates otherwise.

ARTICLE III - PARTICIPATION

- 3.1 Eligibility to Participate. All Eligible Employees may participate in and enter the Plan.
- 3.2 Commencement of Participation. An Eligible Employee may elect to become a Participant in the Plan by completing a Benefit Election Form and filing it with the Employer. Such an individual will become a Participant upon the effective date of an election to participate in the Plan as set forth in Article IV. In order to participate in the Plan during a particular Period of Coverage, an Employee must complete and file a Benefit Election Form during an Open Enrollment period designated by the Employer, which shall end prior to the first day of such Period of Coverage. If an Eligible Employee is hired after Open Enrollment, the employee must enroll during the month of hire or the following month.

On the Benefit Election Form, the Employee shall designate the amount of Compensation to be contributed to the Medical Reimbursement Plan, and thereby agrees to have his/her Compensation reduced by such amount.

- 3.3 Cessation of Participation. Except as provided in Article VII, a Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates, (b) the date on which the employee ceases to be an Eligible Employee, or (c) the date on which the election under the Section 125 Plan to receive Health Care Expense reimbursements expires or is terminated under the Section 125 Plan.
- 3.4 Reinstatement of Former Participant. A Former Participant will become a Participant again upon meeting the eligibility requirements of Section 3.1 and electing again under the Section 125 Plan to receive Health Care reimbursement under this Plan. However, in the case of a Participant who separates from service with the Employer during a Period of Coverage and elects to revoke existing benefit elections and terminates the receipt of benefits for the remaining portion of the Period of Coverage, if such Participant should return to service within the same Period of Coverage, the Participant will be prohibited from making new benefit elections for remaining portion of said Period of Coverage.
- 3.5 Participation of Spouses or Dependents. To the extent required by law, coverage under this Plan shall be made available to the Spouse or a Dependent of a Participant or Former Participant in lieu of (or in addition to) the Participant. In that event, such Spouse or Dependent shall be treated as a Participant under this Plan, but only to such extent and for such period as the law requires. No Benefit Election Form shall be required for such a Spouse or Dependent, but Required Premiums must be paid to the Employer on a monthly basis (or within such other time limit as may be provided for by law), and coverage shall cease upon nonpayment of any such Required Premium.

- 3.6 Salary Reduction. By participating in the Plan, each Participant agrees to have his/her annual Compensation reduced by the amount of money the Participant has elected to contribute to the Medical Reimbursement Account under the Section 125 Plan. No Participant shall be entitled to reduce Compensation for Health Care Expenses by more than the maximum amount of Benefits specified in Section 4.3.

ARTICLE IV – ELECTION TO RECEIVE HEALTH CARE REIMBURSEMENTS

- 4.1 Election Procedure. A Participant may elect to receive reimbursements of his Health Care Expenses under this Plan by filing a Benefit Election Form in accordance with Article IV of the Section 125 Plan. An election to receive reimbursements of Health Care Expenses shall be irrevocable and remain in effect until the end of the Period of Coverage, subject to a change in family status, as provided in the Section 125 Plan.
- 4.2 Minimum Reimbursement Election. The minimum amount, which the Participant may elect to receive in any Period of Coverage in the form of reimbursement for Health Care Expenses incurred during any Period of Coverage, is \$150.
- 4.3 Maximum Reimbursement. The maximum amount which the Participant may receive under this Plan in the form of payment or reimbursement for Health Care Expenses incurred in any Period of Coverage is \$3,000.
- 4.4 Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of Highly Compensated Individuals or Key Employees (as defined in Code §105(h)(5)) as to the eligibility to participate and/or benefits provided under the Plan, and is therefore intended to comply in this respect with the requirements of the Code.
- 4.5 Maximum Employer Contributions. The maximum amount of Employer Contributions under the Plan for any Participant shall be the maximum amount, which the Participant may elect to receive in the form of Health Care Expense reimbursement under the Plan described in Section 4.3.

ARTICLE V – MEDICAL REIMBURSEMENT ACCOUNTS

- 5.1 Establishment of Accounts. The Administrator will establish and maintain its own books on Medical Reimbursement Account for each Period of Coverage with respect to each Participant who has elected to receive reimbursement of Health Care Expenses incurred during the Period of Coverage.
- 5.2 Crediting of Accounts. There shall be credited to a Participant's Medical Reimbursement Account for each Period of Coverage as of each date Compensation is paid, for the Participant in such Period of Coverage, an amount

equal to reduction, if any, to be made in such Compensation in accordance with the Participant's Benefit Election Form under the Section 125 Plan. Contributions shall be credited to Medical Reimbursement Accounts in equal amounts over a period of time established by the Employer. All amounts credited to such Medical Reimbursement Account shall be the property of the Employer until paid out pursuant to Article VI.

{If an Employee's net pay is not sufficient to fully fund his requested salary reduction, the contribution cannot be made up in the future when the Participation has earned salary sufficient to fund such benefits election.}

- 5.3 Debiting of Accounts. A Participant's Medical Reimbursement Account for each Period of Coverage shall be debited from time to time as provided in Section 6.2 hereof in the amount of any payment under Article VI to or for the benefit of the Participant for Health Care Expenses incurred during such Period of Coverage. Amounts debited to each such Medical Reimbursement Account shall be treated as payments of the earliest amounts credited to the Account and not yet treated paid, under a "first-in, first-out" approach.
- 5.4 Limitation on Reimbursements or Payments with Respect to Certain Participants. Notwithstanding any other provision of this Plan, the Administrator may limit the amounts reimbursed or paid with respect to any Participant who is a Highly Compensated Individual (within the meaning of Code Section 105 (h)(5) or 125(e)) to the extent the Administrator deems such limitation to be advisable to assure compliance with any non-discrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section 5.5.
- 5.5 Forfeiture of Accounts. The amount credited to a Participant's Medical Reimbursement Account for any Period of Coverage shall be used only to reimburse the Participant for Health Care Expenses incurred during such Period of Coverage, and only if the Participant applies for reimbursement on or before the end of the Grace Period following the close of the Period of Coverage in which such expenses were incurred. If any balance remains in the Participant's Medical Reimbursement Account for a Period of Coverage after all reimbursements hereunder, such balance shall not be carried over to reimburse the Participant for Health Care Expenses incurred during a subsequent Period of Coverage, and shall be forfeited. (Forfeited amounts shall be used to pay the administrative expenses of the Plan).

ARTICLE VI - PAYMENT OF HEALTH CARE EXPENSE REIMBURSEMENTS

- 6.1 Claims for Reimbursement. A Participant may apply to the Employer for reimbursement of Health Care Expenses incurred by the Participant during the Period of Coverage by submitting a statement in writing to the Employer, in such form as the Employer may prescribe, setting forth:

- (a) The amount, date and nature of the expense with respect to which a payment or reimbursement is requested;
- (b) The name of the person, organization or entity to which the expense was or is to be paid;
- (c) The name of the person for whom the expense was incurred and, if such person is not the Participant, the relationship of such person to the Participant; and
- (d) Such other information as the Employer may from time to time require.

Such application shall be accompanied by statements showing the amounts of such expenses, together with any additional documentation, which the Administrator may request. Claims for reimbursement may be submitted at any time during the Period of Coverage or within the Grace Period.

Expenses shall be considered incurred when the health care is provided, not when the Participant is formally billed, charged for, or pays for the expense.

- 6.2 Reimbursement or Payment of Expenses. The Employer shall reimburse the Participant from the Participant's Medical Reimbursement Account for Health Care Expenses incurred during the Period of Coverage, for which the Participant submits a written application and documentation in accordance with Section 6.1. The Employer may, at its option, pay any such Health Care Expense directly to the person providing or supplying the health care in lieu of reimbursing the Participant. Notwithstanding anything herein to the contrary, a claim with respect to a Period of Coverage must be filed by the end of the Grace Period to be eligible for reimbursement.

Subject to Article VII, the amount available for reimbursement shall, at all times during the Period of Coverage, be equal to the amount of coverage purchased by the Participant (the amount the Participant elected to have contributed into his Medical Reimbursement Account for the Period of Coverage), less any previous reimbursements made for the Period of Coverage. In no event may the annual value of Benefits provided hereunder for any Participant pursuant to the Participant's election on his Benefit Election Form exceed the maximum reimbursement amount as described in Section 4.3.

ARTICLE VII - TERMINATION OF PARTICIPATION

- 7.1 **Termination of Participation.** (a) In the event that a Participant ceases to be a Participant in this Plan for any reason other than as provided by subsection (b) during a Period of Coverage, the Participant's Benefit Election Form relating to this Plan shall terminate. Except as provided in this Section 7.1 and Section 7.2, the Participant shall be entitled to reimbursement only for Health Care Expenses incurred up to the date of termination, but only if the Participant (or estate) applies for such reimbursement in accordance with Section 6.1. No such reimbursement shall exceed the remaining balance, if any, at the date of employment termination in the Participant's Medical Reimbursement Account for the Period of Coverage in which the expenses were incurred.
- (b) A Participant who terminates employment during a Period of Coverage due to disability or retirement shall be entitled to reimbursement for Health Care Expenses incurred within the same Plan Year as the termination until the Medical Reimbursement Account is exhausted, but only if the Participant (or the participant's estate) applies for such reimbursement in accordance with Section 6.1. No such reimbursement shall exceed the remaining balance, if any, in the Participant's Medical Reimbursement Account for the Period of Coverage in which the expenses were incurred, provided, however, that such Participant may be entitled to reimbursement up to the maximum amount which the Participant elected to receive in the form of Health Care Expense reimbursement for such Period of Coverage if the Participant continues to pay the Required Premium for such Period of Coverage subsequent to termination
- 7.2 **Continuation of Coverage.** If and to the extent required by law (including, without limitation, Sections 105, 125 and 4980N and regulations thereunder), in the event a Participant ceases to be an Employee and undertakes to pay Required Premium to the Employer on a monthly basis (or within such other time limit as may be provided for by law), coverage under the Plan shall continue so long as such Required Premiums are paid, but not beyond the end of the period for which such coverage is required by law. In addition, the former Participant shall be treated as a Participant under the Plan to such extent as is required by law, and shall be entitled to reimbursement for Health Care Expenses incurred during such period of continued coverage, subject to Section 7.3.
- 7.3 **Limits on Time and Amount of Reimbursements.** Reimbursements shall be made for any Period of Coverage under this Article VII only if the Participant applies for such reimbursement in accordance with Section 6.1 on or before the Grace Period following the close of the Period of Coverage. In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Article VII. No reimbursement under this

7.4 Article VII shall exceed the remaining balance, if any, in the Participant's Medical Reimbursement Account for the Period of Coverage in which the expenses were incurred.

ARTICLE VIII - ADMINISTRATION

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

The Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. Furthermore, the Administrator may rely upon any such direction, information or action of another Employee of the Employer as being proper under this Plan, and is not required under this Plan to inquire into the propriety of any such direction, information or action. It is intended under this Plan that the Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Administrator nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

All usual and reasonable expenses of the Administrator that are not properly chargeable to or payable by the Plan (including payment out of forfeitures pursuant to Section 5.5) shall be paid by the Employer, and any expenses not paid by the Employer shall not be the responsibility of the Administrator personally. The Administrator or any other designated representative of the Employer who is an Employee of the Employer shall not receive any compensation with respect to services hereunder except as such person may be entitled to Benefits under this Plan.

It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

The Administrator will have full power to administer the Plan in all of its details subject to applicable requirements of law.

- 8.2 Records and Reports. The Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants and the balances, if any, which are maintained under this Plan. The Administrator shall be responsible for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 105(b) plans.

- 8.3 Examination of Records. The Administrator will make available to each Participant such records as pertain to the participant, for examination at reasonable times during normal business hours.
- 8.4 Reliance on Tables, etc. In administering the Plan, the Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by the accountant, counsel or other expert who is employed or engaged by the Administrator.
- 8.5 Rules and Decisions. The Administrator may adopt such rules, as it deems necessary, desirable, or appropriate. All rules and decisions of the Administrator, whether directionally or otherwise, shall be exercised in a uniform and consistent manner so that all persons similarly situated will receive substantially the same treatment. When making a determination or calculation, the Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or the legal counsel of the Employer.
- 8.6 Facility of Payment. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a Benefit or installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such person or to the person's legal representative or to a relative of such person or such person's benefit, or the Administrator may direct the Employer to apply the payment for the Benefit of such person in such a manner as the Administrator considers advisable. Any payment of a Benefit or installment thereof in accordance with the provisions of this Section 8.6 shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.
- 8.7 Claims and Review Procedures.
- (a) A claim for benefits under the Plan shall first be filed with the TPA. Notice of the decision shall be furnished to the claimant by the TPA within a reasonable period of time after receipt of the claim by TPA. If a Participant does not receive notice of denial of a claim for benefits under the Plan within 90 days of the filing of such claim, then the claim shall be deemed denied.
 - (b) A claimant may review all pertinent documents and may request a review by the TPA of any claim. Any such request must be filed in writing with the TPA within 90 days after the earlier of (i) receipt by the claimant of written notice of the decision on the claim or (ii) 90 days after the initial filing of such claim. Such written request for review shall contain all additional information, which the claimant wishes the TPA to consider.

- (c) If such claim is denied by the TPA, a claimant may appeal in writing to PEIA. Such appeal must be filed with PEIA within 30 days of receipt of the TPA's decision denying such claim. All information relating to the denial, including a copy of the denial letter from the TPA, must be supplied to PEIA by the claimant. PEIA will, after reviewing the facts, make a final determination and notify the claimant of its decision. Such decision shall be final and binding.
- 8.8 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.
- 8.9 Indemnification of Administrator. PEIA agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by PEIA) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.
- 8.10 Appointment of Agent by Administrator. The Plan Administrator may delegate its duties to a TPA, and such TPA may perform all the duties of the Administrator as set forth in this Article VIII, subject to the terms of the Plan.

ARTICLE IX - AMENDMENT AND TERMINATION OF PLAN

- 9.1 Amendment of Plan. This Plan may be amended at any time by the PEIA to any extent and in any manner that it may deem advisable, by a written instrument signed by PEIA.
- 9.2 Termination of Plan. PEIA has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but PEIA will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time without liability. Upon termination or discontinuance of the Plan, all elections and reductions in compensation related to the Plan shall terminate, and reimbursements shall be made in accordance with Article VI and Article VII.

ARTICLE X - MISCELLANEOUS PROVISIONS

- 10.1 Communication to Employees. Promptly after the Plan is adopted, PEIA will notify all Employees of the availability and terms of the Plan.
- 10.2 Information to be Furnished. Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.
- 10.3 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Administrator or the Employer, except as expressly provided herein, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby.
- 10.4 Benefits Solely from General Assets. The Benefits provided hereunder will be paid solely from the general assets of the Employer. The Benefits provided by the Plan are given in exchange for the Participant's salary reduction agreement. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the Benefit of any Participant and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any payment under the Plan may be made.
- 10.5 Non-assignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his creditors by any process whatsoever, and any attempt to cause such rights to be

so subjected will not be recognized, except to such extent as may be required by law.

- 10.6 Non-alienation of Benefits. Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable hereunder shall be void. The Employer and PEIA shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits hereunder.
- 10.7 Divestment of Benefits. Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to the benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.
- 10.8 No Guarantee of Tax Consequences. Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under Article VI will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under Article VI is excludable from the Participant's gross income for Federal or state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.
- 10.9 Indemnification of Employer by Participants. If any Participant receives one or more payments or reimbursements under Article VI that are not for Health Care Expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal or state income tax or Social Security tax from such payment or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and state income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.
- 10.10 Governing Law. The Plan will be construed, administered and enforced according to the laws of the State of West Virginia.
- 10.11 Execution of Documents. Each Employee, family member or beneficiary, does, by the acceptance of potential benefits under this Plan, agree to execute any

documents, which may be necessary or proper in the carrying out of the purpose and intent of the Plan.

- 10.12 Election Not to Participate. Each eligible Participant shall have the right to elect not to participate in this Plan.
- 10.13 Not a Contract of Employment. This Plan shall not be deemed to constitute a contract between the Employer and the Participant or to be a consideration or an inducement for the employment of any Participant. Nothing contained in the Plan shall be deemed to give any Participant the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant at any time regardless of the effect which said discharge shall have upon the employee as a Participant of the Plan.
- 10.14 Severability. If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.
- 10.15 Construction of the Plan. PEIA and/or Administrator may construe any ambiguous provisions of the Plan, correct any defect, supply any omission, or reconcile any inconsistency, in such manner and to such extent as PEIA in its discretion may determine, any such action of PEIA shall be binding and conclusive upon all Participants.

ARTICLE XI - CONTINUATION COVERAGE

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

XI: DEPENDENT CARE REIMBURSEMENT PLAN

ARTICLE I- INTRODUCTION

- 1.1 Purpose of Plan. The purpose of the Plan is to enable Participants to elect to receive payments of reimbursements of their dependent care expenses that are excludable from the Participant's gross income under Section 129 of the Code.
- 1.2 Qualification of Plan. This Plan is intended to qualify as a dependent care assistance program under Section 129 of the Code, and is to be interpreted in a manner consistent with the requirements of Section 129.
- 1.3 Effective Date. The Plan is amended and restated effective January 1, 1999.

ARTICLE II - DEFINITIONS

The definitions in this Plan shall have the same meanings as set forth in the State of West Virginia Public Employees Insurance Agency Section 125 Plan, unless otherwise indicated below.

- 2.1 "Benefits" means any amount(s) paid to a Participant in the Plan as reimbursement for Dependent Care Expenses incurred by a Participant during a Period of Coverage by the Participant, Spouse, or Dependent.
- 2.2 "Dependent" means any individual who is (a) dependent (as defined in Code Section 152) of the Participant who is under the age of 13 and with respect to whom the Participant is entitled to an exemption under Section 151(c) of the Code, or (b) a dependent as defined in Code Section 152(c) or Spouse of the Participant who is physically or mentally incapable of caring for him or herself.
- 2.3 "Dependent Care Expenses" means expenses incurred by a Participant which (a) are incurred for the care of a Dependent of the Participant or for related household services, (b) are paid or payable to a Dependent Care Service Provider, and (c) are incurred to enable the Participant to be gainfully employed for any period of which there are one or more Dependents with respect to the Participant. "Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is described in Section 2.2(a) above or regularly spends at least eight (8) hours each day in the Participant's household.

Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses related are rendered.

- 2.4 "Dependent Care Reimbursement Account" means the account described in Article V hereof.

- 2.5 "Dependent Care Service Provider" means a person who provides care or other services described in Section 2.3 above, but shall not include (a) a dependent care center (as defined in Section 21(b)(2)(D) of the Code), unless the requirements of Code Section 21(b)(2)(C) are satisfied, or (b) a related individual described in Section 129(c) of the Code.
- 2.6 "Earned Income" means all income derived from wages, salaries, tips, self-employment and other employee compensation (such as disability benefits) but such term does not include any amounts received (i) under the Plan or any other Dependent Care program under Code Section 129, (ii) as pension or annuities; or (iii) as unemployment or Workers' Compensation.
- 2.7 "Effective Date" means this amendment and restatement is effective January 1, 1999.
- 2.8 "Eligible Expenses" means all Dependent Care Expenses incurred by a Participant or by his Spouse which are paid to a Dependent Care Service Provider.
- 2.9 "Grace Period" means the 90-day period immediately after the end of each Period of Coverage during which a Participant may submit claims for reimbursement from the Dependent Care Reimbursement Account for claims incurred during the immediately preceding Period of Coverage.
- 2.10 "Highly Compensated Individual" means a Participant who is (a) a 5 percent owner, (b) received compensation from the Employer in excess of \$75,000 (as adjusted), (c) received compensation from the Employer in excess of \$50,000 (as adjusted) and was in the top-paid group of Employees for such year, or (d) an officer who received compensation greater than 50 percent of the amount in effect under Section 415(b)(1)(A) of the Code for such year.
- 2.11 "Participant" means each Employee who elects to participate in the Plan in accordance with Article III.
- 2.12 "Period of Coverage" means the Plan Year. The Period of Coverage will be twelve (12) months, except for the periods of Coverage during which an Employee is a Participant for less than the entire Period of Coverage. A Period of Coverage shall not be for a duration which would enable a Participant to defer the receipt of Compensation or to obtain coverage under the Plan only for periods during which a Participant expects to incur Dependent Care Expenses.
- 2.13 "Plan" means The State of West Virginia Public Employees Insurance Agency Dependent Care Reimbursement Plan as set forth herein, together with any and all amendments and supplements hereto, which is designed to operate in conjunction with the Section 125 Plan.

2.14 "Plan Year" means the twelve-month period beginning July 1 and ending June 30.

2.15 "Section 125 Plan" means The State of West Virginia Public Employees Insurance Agency Section 125 Plan as amended from time to time.

The singular shall include the plural and vice-versa, whenever used herein, unless the context clearly indicates otherwise.

ARTICLE III - PARTICIPATION

3.1 Eligibility to Participate. All Eligible Employees may participate in and enter the Plan.

3.2 Commencement of Participation. An Eligible Employee may elect to become a Participant in the Plan by completing a Benefit Election Form and filing it with the Employer. Such an individual will become a Participant upon the effective date of an election to participate in the Plan as set forth in Article IV. In order to participate in the Plan during a particular Period of Coverage, an Employee must complete and file a Benefit Election Form during an Open Enrollment period designated by the Employer, which period shall end prior to the first day of such Period of Coverage. An Eligible Employee hired after Open Enrollment, must enroll during the month of hire or the following month.

On the Benefit Election Form, the Employee shall designate the amount of Compensation to be contributed to the Dependent Care Reimbursement Account, and thereby agrees to reduced Compensation by such amount.

3.3 Cessation of Participation. Except as provided in Article VII, a Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates, (b) the date on which the participant ceases to be an Eligible Employee, or (c) the date on which the election under the Section 125 Plan to receive Dependent Care Expense reimbursements expires or is terminated under the Section 125 Plan.

3.4 Reinstatement of Former Participant. A Former Participant who is eligible under Section 3.1 elects again under the Section 125 Plan to receive reimbursement of Dependent Care Expenses under this Plan, will again become a Participant in this Plan on the effective date of such election. However, in the case of a Participant who separates from service with the Employer during a Period of Coverage and elects to revoke existing benefit elections and terminates the receipt of Benefits for the remaining portion of the Period of Coverage, such a Participant who returns to service within the same Period of Coverage, will be prohibited from making new benefit elections for the remaining portion of such Period of Coverage.

- 3.5 Salary Reduction. By participating in the Plan, each Participant agrees to have annual Compensation reduced by the amount of money the participant has elected to contribute to his Dependent Care Reimbursement Account under the Section 125 Plan. No Participant shall be entitled to reduce Compensation for Dependent Care Benefits by more than the aggregate maximum amount of Benefits specified in Section 4.4.

ARTICLE IV - ELECTION TO RECEIVE DEPENDENT CARE REIMBURSEMENTS

- 4.1 Election Procedure. A Participant may elect to receive Dependent Care Expense Reimbursement under this Plan by filing a Benefit Election Form in accordance with the procedures set forth in the Section 125 Plan. An election to receive Dependent Care Expense Reimbursements shall be irrevocable and remain in effect until the end of the Period of Coverage, unless there is a change in family status, as provided in the Section 125 Plan.
- 4.2 Maximum Dependent Care Reimbursement. The maximum amount which the Participant may receive in any Period of Coverage in the form of Dependent Care Expense Reimbursement under this Plan shall be the lesser of (a) the Participant's Earned Income for the Period of Coverage (after all reductions in compensation including the reduction related to Dependent Care Reimbursement), (b) the actual or deemed Earned Income of the Participant's Spouse for the Period of Coverage, or (c) \$5,000 (\$2,500 where a separate return is filed by a married individual). In the case of a Spouse who is a full-time student at an education institution or is physically or mentally incapable of caring for him or herself, such spouse shall be deemed to have Earned Income of not less than \$200 per month if the Participant has one Dependent and \$400 per month if the Participant has two or more Dependents.
- 4.3 Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of Highly Compensated Individuals or Key Employees (as defined in Code Section 414(q)) as the eligibility to participate, contributions and/or benefits, and to comply in this respect with the requirements of the Code. If, in the judgment of the Plan Administrator, the operation of the Plan in any Period of Coverage would result in such discrimination, then such Plan Administrator shall select and exclude from coverage under the Plan such Highly Compensated or Key Participants and/or reduce contributions and or Benefits under the Plan for such Participants, as shall be necessary to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate.
- 4.4 Maximum Employer Contributions. The maximum amount of Employer contributions under the Plan for any Participant shall be the maximum amount,

which the Participant may receive in the form of Dependent Care Expense Reimbursement under the Plan.

ARTICLE V - DEPENDENT CARE REIMBURSEMENT ACCOUNTS

- 5.1 Establishment of Accounts. The Administrator will establish and maintain on its books a Dependent Care Reimbursement Account for each Period of Coverage with respect to each Participant who has elected to receive reimbursement of Dependent Care Expenses incurred during the Period of Coverage.
- 5.2 Crediting of Accounts. There shall be credited to a Participant's Dependent Care Reimbursement Account for each Period of Coverage as of each date Compensation is paid, for the Participant in such Period of Coverage, an amount equal to the reduction, if any, to be made in such Compensation in accordance with the Participant's Benefit Election Form under the Section 125 Plan. Contributions shall be credited to Dependent Care Reimbursement Accounts in equal amounts over a period of time established by the Employer. All amounts credited to such Dependent Care Reimbursement Account shall be the property of the Employer until paid out pursuant to Article VI.
- {If an Employee's net pay is not sufficient to fully fund the requested salary reduction, the contribution cannot be made up in the future when the Participant has earned salary sufficient to fund such benefit election}.
- 5.3 Debiting of Accounts. A Participant's Dependent Care Reimbursement Account for each Period of Coverage shall be debited from time to time as provided in Section 6.2 hereof in the amount of any payment under Article VI to or for the benefit of the Participant for Dependent Care Expenses incurred during such Period of Coverage. Amounts debited to each such Dependent Care Reimbursement Account shall be treated as payments of the earliest amounts credited to the Account and not yet treated as paid under this Section 5.3, under a "first-in, first-out" approach.
- 5.4.1 Forfeiture of Accounts. The amount credited to a Participant's Dependent Care Reimbursement Account for any Period of Coverage shall be used only to reimburse the Participant for Dependent Care Expenses incurred during such Period of Coverage, and only if the Participant applies for reimbursement on or before the end of the Grace Period following the Period of Coverage in which the expenses were incurred. If any balance remains in the Participant's Dependent Care Reimbursement Account for a Period of Coverage after all reimbursement hereunder, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Period of Coverage, but shall be forfeited. (Forfeited amounts shall be used to pay the administrative expenses of the Plan).

ARTICLE IV - PAYMENT OF DEPENDENT CARE EXPENSE REIMBURSEMENTS

- 6.1 Claims for Reimbursement. A Participant may apply to the Employer for reimbursement of Dependent Care Expenses incurred by the Participant during the Period of Coverage by submitting an application in writing to the Employer, in such form as the Employer may prescribe, setting forth.
- (a) The amount, date and nature of the expense with respect to which a payment or reimbursement is requested.
 - (b) The names, address and tax identification number of the person, organization, or entity to which the expense was or is to be paid.
 - (c) Such other information as the Employer may from time to time require.

Such application shall be accompanied by a receipt showing the amounts of such expenses, together with any additional documentation, which the Administrator may request. Claims for reimbursement may be made at any time during the Period of Coverage or within the grace period.

Expenses shall be considered incurred when the dependent care is provided, and not when the Participant is formally billed, charged for, or pays for the expense.

- 6.2 Reimbursement or Payment of Expenses. The Employer shall reimburse the Participant from the Participant's Dependent Care Reimbursement Account for Dependent Care Expenses incurred during the Period of Coverage, for which the Participant submits a written application and documentation in accordance with Section 6.1. No Reimbursement or payment shall at any time exceed the balance of the Participant's Dependent Care Reimbursement Account for the Period of Coverage at the time of the Reimbursement or Payment. The amount of Dependent Care Expense not reimbursed or paid as a result of the preceding sentence will be carried over and reimbursed if and when the balance in the Participant's Dependent Care Reimbursement Account permits such reimbursement or payment. Notwithstanding anything herein to the contrary, a claim with respect to a Period of Coverage must be filed by the end of the Grace Period to be eligible for reimbursement. In no event may the annual value of Benefits provided hereunder for any Participant pursuant to the Participant's election on his Benefit Election Form exceed the maximum reimbursement amount as described in Section 4.2.
- 6.3 Limitation on Amount of Benefits. The average Benefits provided to Non-Highly Compensated Individuals must be at least 55% of the average Benefits provided to Highly Compensated Individuals under all Dependent Care Reimbursement Plans of the Employer. For purposes of this limitation, in the case of any Benefits provided through a salary reduction agreement, the Plan may disregard

any Participant whose Compensation is less than \$25,000. For purposes of the above paragraph, there shall be excluded from consideration Employees who are described in Code Section 129(d)(9).

- 6.4 Principal Shareholders Limitation. Not more than 25 percent of the amounts paid or reimbursed by and Employer for Dependent Care Expenses incurred during a Period of Coverage may be provided for the class of Participants, each of whom (on any day of such Period of Coverage) owns more than 5 percent of the stock or of the capital or profits interest in such Employer. The ownership of stock in an Employer shall be determined in accordance with the rules provided under Section 1563(d) and (e) of the Code (without regard to Section 1563(e)(3)(C)). The Administrator shall reduce the Dependent Care Benefits for such Participants to the extent that it reasonably believes necessary to prevent this limitation from being exceeded.
- 6.5 Officers, Owners, and Highly Compensated Individuals. The Administrator shall also reduce the Dependent Care Benefits for Officers, Owner, and Highly Compensated Individuals and their Dependents, to the extent that absent such reduction, the Program would be discriminatory within the meaning of Section 129(d)(2) of the Code.
- 6.6 Verification of Information.
- (a) Limitations. Participants shall furnish to the Administrator such information as the Administrator shall reasonably require to satisfy itself that the limitations contained in Sections 6.3, 6.4 and 6.5 are not violated. The Administrator may, but shall not be required to, require verification of such information, and refuse to pay Benefits unless and until it is satisfied that none of the limitations contained in Article IV and VI would be violated by such payment.
- (b) Dependent Care Expenses. The Administrator may, but shall not be required to, require verification of Dependent Care Expenses for which Benefits are claimed and refuse to pay Benefits unless and until it is satisfied that such Benefits have been incurred. A Participant shall cooperate fully with such verification if the Administrator requires him to do so.
- (c) Service Provider Identifying Information. No amount paid or incurred by the Employer for Benefits provided to a Participant shall be excluded from the gross income of a Participant unless:
- (1) the name, address and taxpayer identification number of the facility or name, address, Social Security number and signature of the person performing the services are included on the Reimbursement Claim Form to which the exclusion relates; or

- (2) if such person is an organization described in Section 501(c)(3) of the Code and exempt from tax under Section 501(a), the name and address of such person are included on the Reimbursement Claim Form to which the exclusion relates.

The preceding sentence shall not apply if the Participant can show that due diligence was exercised in attempting to provide the required information in the case of a failure to provide such information.

- 6.7 Limitation on Dependent Care Benefits. Notwithstanding anything herein to the contrary, no benefit shall be paid under this Article VI to the extent otherwise reimbursed.

ARTICLE VII - TERMINATION OF PARTICIPATION

- 7.1 Termination of Participation. In the event that a Participant ceases to be a Participant in this Plan for any reason, the Participant's election with respect to the Dependent Care Reimbursement Plan shall terminate. However, the Participant (or estate) shall be entitled to reimbursement for Dependent Care Expenses incurred within the same Plan Year of termination until the Dependent Care Reimbursement Account is exhausted, but only if the Participant (or estate) applies for such reimbursement in accordance with Section 6.1. No such reimbursement shall exceed the remaining balance, if any, in the Participant's Dependent Care Reimbursement Account for the Period of Coverage in which the expenses were incurred.
- 7.2 Leave of Absence. Upon termination of employment, Participants may no longer contribute to their Dependent Care Reimbursement Accounts. However, Participants who take an unpaid leave during a Period of Coverage may continue to contribute to their Dependent Care Reimbursement Accounts using after-tax dollars.

ARTICLE VIII - ADMINISTRATION

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

The Administrator warrants that any directions given, information furnished, or action by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. Furthermore, the Administrator may rely upon such direction, information or action of another

Employee or Employer as being proper under this Plan, and is not required under this Plan to inquire into the propriety of any such direction, information or action. It is intended under this Plan that the Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Administrator nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

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

It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

The Administrator will have full power to administer the Plan in all of its details subject to applicable requirements of law.

- 8.2 Records and Reports. The Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants and the balances, if any, which are maintained under this Plan. The Administrator shall be responsible for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 129 Plans.
- 8.3 Examination of Records. The Administrator will make available to each Participant such records as pertain to the Participant, for examination at reasonable times during normal business hours.
- 8.4 Reliance on Tables, etc. In administering the Plan, the Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by any accountant, counsel or other expert who is employed or engaged by the Administrator.
- 8.5 Rules and Decisions. The Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Administrator, whether discretionary or otherwise, shall be exercised in a uniform and consistent manner so that all persons similarly situated will receive substantially

the same treatment. When making a determination or calculation, the Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or the legal counsel of the Employer.

8.6 Facility of Payment. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a Benefit or installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such person or to the person's legal representative or to a relative of such person for such person's benefit, or the Administrator may direct the Employer to apply the payment for the Benefit of such person in such manner as the Administrator considers advisable. Any payment of a Benefit or installment thereof in accordance with the provisions of this Section 8.6 shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

8.7 Claims and Review Procedures.

- (a) A claim for Benefits under the Plan shall first be filed with the TPA. Notice of the decision shall be furnished to the claimant by the TPA within a reasonable period of time after receipt of the claim by the TPA. If a Participant does not receive notice of denial of a claim for Benefits under the Plan within 90 days of the filing of such claim, then the claim shall be deemed denied.
- (b) A claimant may review all pertinent documents and may request a review by the TPA of any claim. Any such request must be filed in writing with the TPA within 90 days after the earlier of (i) receipt by the claimant of written notice of the decision on the claim or (ii) 90 days after the initial filing of such claim. Such written request for review shall contain all additional information, which the claimant wishes the TPA to consider. Notice of the decision on review shall be furnished in writing to the claimant within 90 days (unless special circumstances require an extension of up to 90 additional days) following the receipt of the request for review. The TPA's written decision shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan or of the Plan Documents on which the decision is based.
- (c) If such claim is denied by the TPA, a claimant may appeal in writing to PEIA. Such appeal must be filed with PEIA within 30 days of receipt of the TPA's decision denying such claim. All information relating to the denial, including a copy of the denial letter from the TPA, must be supplied to PEIA by the claimant. PEIA will, after reviewing the facts, make a final determination and notify the claimant of its decision. Such decision shall be final and binding.

- 8.8 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.
- 8.9 Indemnification of Administrator. PEIA agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by PEIA) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.
- 8.10 Appointment of Agency by Plan Administrator. The Plan Administrator may delegate its duties to a TPA, and such TPA may perform all of the duties of the Administrator as set forth in this Article VIII, subject to the terms of the Plan.

ARTICLE IX - AMENDMENT OR TERMINATION OF PLAN

- 9.1 Amendment of Plan. This Plan may be amended at any time by the PEIA to any extent and in any manner that it may deem advisable, by a written instrument signed by PEIA.
- 9.2 Termination of Plan. PEIA has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but PEIA will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time without liability. Upon termination or discontinuance of the Plan, all elections and reductions in Compensation related to the Plan shall terminate, and reimbursements shall be made in accordance with Article VI and Article VII.

ARTICLE X - MISCELLANEOUS PROVISIONS

- 10.1 Communication to Employees. Promptly after the Plan is adopted, PEIA will notify all Employees of the availability and terms of the Plan.
- 10.2 Information to be Furnished. Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

- 10.3 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Administrator or the Employer, except as expressly provided herein, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby.
- 10.4 Benefits Solely from General Assets. The Benefits provided hereunder will be paid solely from the general assets of the Employer. The Benefits provided by the Plan are given in exchange for the Participant's salary reduction agreement. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or the person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.
- 10.5 Non-assignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his creditors by any process whatsoever, and any attempt to cause such rights to be so subjected will not be recognized, except to such extent as may be required by law.
- 10.6 Non-alienation of Benefits. Benefits under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge garnishment, execution or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to Benefits payable hereunder, shall be void. The Employer and PEIA shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to Benefits hereunder.
- 10.7 Divestment of Benefits. Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to the benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.
- 10.8 Guarantee of Tax Consequences. Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under Article VI will be excludable from the Participant's gross income for Federal or State Income Tax purposes, or that any other Federal or State tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under Article VI is excludable from the Participant's gross income for Federal and state

income tax purposes, and to notify the Employer if the Participant has reason to believe any such payment is not so excludable.

- 10.9 Indemnification of Employer by Participants. If any Participant receives one or more payments or reimbursement under Article VI that are not for Dependent Care Expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal or State income tax or Social Security tax from such payment or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and State income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.
- 10.10 Governing Law. The Plan will be construed, administered and enforced according to the laws of the State of West Virginia.
- 10.11 Execution of Documents. Each Employee, family member or beneficiary, does, by his acceptance of potential Benefits under this Plan agree to execute any documents, which may be necessary or proper in the carrying out of the purpose and intent of the Plan.
- 10.12 Election Not to Participate. Each eligible Participant shall have the right to elect not to participate in this Plan.
- 10.13 Not a Contract of Employment. This Plan shall not be deemed to constitute a contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant. Nothing contained in this Program shall be deemed to give any Participant the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant at any time regardless of the effect which such discharge shall have upon him or her as a Participant of the Plan.
- 10.14 Severability. If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.
- 10.15 Construction of the Plan. PEIA and/or the Administrator may construe any ambiguous provisions of the Plan, correct any defect, supply any omission, or reconcile any inconsistency, in such manner and to such extent as PEIA in its discretion may determine, any such action of PEIA shall be binding and conclusive upon all Participants.

APPENDIX A: LISTING OF CURRENT TPAs

Third-Party Administrator for Medical Claims Processing and Customer Service

Acordia National
P. O. Box 2451
Charleston, WV 25329-2451
1-888-440-7342
1-304-353-7820

Third-Party Administrator for Medical Utilization Review

Acordia National
P. O. Box 2451
Charleston, WV 25329-2451
1-888-440-7342
1-304-353-7820

Third-Party Administrator for Prescription Drug Plan

Express Scripts
6625 West 78th Street
Bloomington, Minnesota 55439
1-877-256-4680

Specialty Medications - CuraScript

P.O. Box 628212
Orlando, FL 32862-9085
1-866-413-41

Administrator for Mountaineer Flexible Benefits

Fringe Benefits Management Company
P.O. Box 1878
Tallahassee, FL 32302
1-800-342-8017

Administrator for PEIA Basic and Optional Life Insurance and AD&D

Unum/Provident Life Insurance
2 Lakeside Commons, Suite 500
980 Hammond Drive
Atlanta, GA 30328
1-800-717-0590

Administrator for Nurse Line - WVU PEIA Nurseline

1-877-294-7342

Third-Party for Subrogation of Claims

Beacon Recovery
Beacon Recovery Group
205 Portland Street
Boston, MA 02114-1721
(617) 570-8000
Toll-free 1-800-874-0500

APPENDIX B: PREMIUMS (PPB, MANAGED CARE AND LIFE)

Open the Links Below to view the appendix:

PremiumTableCoverLetters.pdf

I:\Priscilla\Plandoc\Plan Document (Appendix B).doc

APPENDIX C: DEDUCTIBLES, COINSURANCE AND COPAYMENTS FOR MEDICAL BENEFITS PLAN

ANNUAL MEDICAL DEDUCTIBLES

PEIA PPB Plan A In-Network Deductibles				
Annual Salary (state agencies, colleges, universities and county boards of education)	Employee Only	Employee & Child(ren)	Family	Family with Employee Spouse*
\$ 0 - 20,000	\$100	\$200	\$200	\$200
\$20,001 - 30,000	\$150	\$300	\$300	\$300
\$30,001 - 36,000	\$200	\$400	\$400	\$400
\$36,001 - 42,000	\$225	\$450	\$450	\$450
\$42,001 - 50,000	\$250	\$500	\$500	\$500
\$50,001 - 62,501	\$375	\$750	\$750	\$750
\$62,501 - 75,000	\$400	\$800	\$800	\$800
\$75,001 - 100,000	\$425	\$850	\$850	\$850
\$100,001 - 125,000	\$500	\$1,000	\$1,000	\$1,000
\$125,001 +	\$600	\$1,200	\$1,200	\$1,200
Non-state Plan A	\$225	\$450	\$450	N/A
Non-Medicare Retirees	\$375	N/A	\$750	N/A
Medicare Retirees	\$150	N/A	\$300	N/A

PEIA PPB Plan B In-Network Deductibles				
Annual Salary (state agencies, colleges, universities and county boards of education)	Employee Only	Employee & Child(ren)	Family	Family with Employee Spouse*
\$ 0 - 20,000	\$500	\$1,000	\$1,000	\$1,000
\$20,001 - 30,000	\$500	\$1,000	\$1,000	\$1,000
\$30,001 - 36,000	\$500	\$1,000	\$1,000	\$1,000
\$36,001 - 42,000	\$500	\$1,000	\$1,000	\$1,000
\$42,001 - 50,000	\$1,000	\$1,500	\$1,500	\$1,500
\$50,001 - 62,501	\$1,000	\$1,500	\$1,500	\$1,500
\$62,501 - 75,000	\$1,000	\$1,500	\$1,500	\$1,500
\$75,001 - 100,000	\$1,000	\$1,500	\$1,500	\$1,500
\$100,001 - 125,000	\$1,000	\$1,500	\$1,500	\$1,500
\$125,001 +	\$1,000	\$1,500	\$1,500	\$1,500
Non-state Plan B	\$500	\$1,000	\$1,000	N/A

The out-of-network deductible is twice the in-network deductible listed above. The out-of-network deductible satisfies the in-network deductible, but the in-network deductible does not count toward the out-of-network deductible.

*Deductibles for Family with Employee Spouse coverage are based on the average of the two employee's salaries. Add the annual salaries together and divide by two to get the basis of the premium. This provision does not apply to local government agency or retired employees.

COINSURANCE FOR IN-NETWORK AND OUT-OF-NETWORK BENEFITS

	If you live in WV, you will pay:	If you live in a bordering county of a surrounding state, you will pay:	If you live out-of- state (beyond bordering counties), you will pay:
Access Care in WV or in a bordering county of a surrounding state using PPO providers	20% Coinsurance	20% Coinsurance	20% Coinsurance
Access care outside WV (beyond bordering counties) using PPO providers <u>with</u> prior approval	20% Coinsurance	20% Coinsurance	20% Coinsurance
Access care outside WV (beyond bordering counties) using non-PPO providers <u>with</u> prior approval	20% Coinsurance	20% Coinsurance	20% Coinsurance
Access care outside WV (beyond bordering counties) using PPO providers <u>without</u> prior approval	40% Coinsurance	40% Coinsurance	20% Coinsurance
Access care outside WV (beyond bordering counties) using non-PPO providers <u>without</u> prior approval	40% Coinsurance	40% Coinsurance	40% Coinsurance

SERVICES COVERED IN FULL

Type of Service	PPB Insured Responsibility
Routine Prenatal Care (Physician Services)	\$0; Covered in full*
Well Child Exams and Immunizations	\$0; Covered in full
High Risk Birth Score Program	\$0; Covered in full
Annual Screening Mammogram	\$0; Covered in full
Annual Pap Smear Test	\$0; Covered in full (\$10 preventive care office visit copay applies)
Colorectal Cancer Screening Test	\$0; Covered in full (\$10 preventive care office visit copay applies)
Prostate Cancer Screening Test	\$0; Covered in full (\$10 preventive care office visit copay applies)

*Deductible applies only if not met in hospital services.

SERVICES SUBJECT TO COPAYMENT ONLY

Type of Service	PPB Insured Responsibility
Physician Office Visits – preventive care	\$10 copayment/visit with no deductible
Physician Office Visits – treat illness or injury	\$15 copayment per visit with no deductible
Adult Routine Physical Exams	\$10 copayment per visit with no deductible
Second Surgical Options*	\$15 copayment/visit with no deductible

*No copayment if required by utilization management.

APPENDIX D: BENEFITS MAXIMUMS

Plan A

Out-of-Pocket Maximum Amounts – PEIA PPB Plan A			
Employee Status	Employee's Annual Salary	Annual In-Network Out-of-Pocket Maximum	Annual Out-of-Network Out-of-Pocket Maximum
Active State Agencies, Colleges and Universities, Boards of Education	\$ 0 - 20,000	\$800	\$1,600
	\$20,001 - 30,000	\$1,100	\$2,200
	\$30,001 - 36,000	\$1,250	\$2,500
	\$36,001 - 42,000	\$1,500	\$3,000
	\$42,001 - 50,000	\$1,750	\$3,500
	\$50,001 - 62,501	\$1,800	\$3,600
	\$62,501 - 75,000	\$1,850	\$3,700
	\$75,001 - 100,000	\$1,900	\$3,800
	\$100,001 - 125,000	\$2,000	\$4,000
	\$125,001 +	\$2,250	\$4,500
Non-State Plan A	Not applicable	\$1,500	\$3,000
Non-State Plan B	Not applicable	\$2,000/single; \$4,000/family	\$4,000/single; \$8,000/family
Retired, Non-Medicare	Not applicable	\$1,500	\$3,000
Retired, Medicare	Not applicable	\$1,000	\$1,000

Plan B

Out-of-Pocket Maximum Amounts – PEIA PPB Plan B			
Employee Status		Annual In-Network Out-of-Pocket Maximum	Annual Out-of-Network Out-of-Pocket Maximum
Active State Agencies, Colleges and Universities, Boards of Education and Non-State Plan B	All Salaries	Single \$2,000	\$4,000
	All Salaries	Employee with Children \$4,000	\$8,000
	All Salaries	Family \$4,000	\$8,000

ANNUAL BENEFIT MAXIMUMS

Annual Benefit Maximums	
Type of Service	Benefit Maximum (per member per plan year)
*Outpatient Mental Health/Chemical Dependency	20 visits
Christian Science Treatment	\$1,000
*Outpatient Therapy Services: This benefit includes outpatient physical, occupational, massage, speech, and vision therapies, acupuncture and chiropractic care.	\$1,000 □ (total amount allowed for all therapies combined)
Inpatient Rehabilitation	150 days
Skilled Nursing Facility	100 days

*Additional benefits may be recommended by Acordia when medically necessary and appropriate. Approval must be obtained before additional services are rendered.

APPENDIX E: MEDICAL EQUIPMENT NOT COVERED

Examples of Durable Medical Equipment that are not covered expenses:

Bath Paraffin (Unit)	Heat Lamps
Bathroom Equipment:	Heating Pad
toilet seat	Hydraulic Van or Car Lift
commode	Ice Bag
scale	Irrigating Kit
bathtub seat, bathtub lift	Language Master and other
rail or grab bar	vocabulary assistance devices
Bed Baths	Lift Chair
Bed Boards	Massage Devices, Vibrators
Breast Pump	Muscle Stimulators
Chair, Recliner or Autotilt	Orthopedic Mattress
	Orthopedic Shoes, unless
	attached to a brace
	Percussion Packs
Chair Tables	Professional Medical Equipment:
Child's Stroller	blood pressure kit
Contour Chair	stethoscope, etc.
Diapers (Adult or infant)	Pulse Tachometer
Diathermy Machines	Rollabout Chairs
Earplugs or Molds	Room Heater (Portable)
Electric Bed	Sauna Baths
Environmental Control Equipment:	Standing Tables
air cleaner	Telephone Arms
air filter	Thermometer
air conditioner	Trapeze Bar
dehumidifier	Treadmill, Jogger
dust extractor	Walking Cane with Seat
air freshener	Waterbed
humidifier	Whirlpool or Hydro Massage
sweeper	Equipment
Enuresis Unit	Wig, Wig Styling
Escalator, Elevator or Stair Lift	Transfer Bars or Benches
Exercise Bike, Stairmaster	Geri Chairs
Food Liquidizer/Food Processor	Special Adaptive Equipment
Hearing Aid	

Supplies such as tape, gauze, diapers, swabs, elastic bandages, and aspirin are not covered for any reason.

APPENDIX F: PEIA OUT-OF-STATE PPO PROGRAM

Preferred Provider Organizations

For services provided outside the State of West Virginia, the PEIA/Acordia National network principally utilizes three network relationships. In the State of Ohio, the network is Medical Mutual of Ohio's SuperMed Plus Network. In Maryland, Washington, D.C., and North Carolina, the network is the Alliance Network. For all other states, the network is Beech Street. These networks review their providers for quality standards such as licensing, background and treatment patterns. As part of their agreement with the network, the amount paid for services is a discounted amount. Remember, all services received out-of-state, other than services by a PPO provider in a county that borders West Virginia, must have prior approval in order to receive the highest level of benefit. However, if an insured is traveling out-of-state and has an emergency or accident, the insured should go directly to the nearest provider for treatment without calling for approval first. The PEIA PPB Plan medical identification card carries the logos for Alliance Network, Medical Mutual of Ohio's (MMO) SuperMed Plus Network and the Beech Street Network.

When receiving services, always follow these important steps:

1. Always carry the most current Identification Card.
2. When seeking services outside West Virginia and beyond the bordering counties, call Acordia National at (304) 353-7820 or (888) 440-7342 for prior approval to receive the highest level of benefits.
3. In an emergency or accident outside of West Virginia or a bordering county, prior approval is not necessary to receive the highest level of benefits. If the insured is admitted to the hospital, he/she or the provider must call Acordia within 48 hours of the admission.
4. If the out-of-state service is approved, please make sure the provider is a preferred provider with Alliance, MMO, or Beech Street.
5. Call Acordia National at (304) 353-7820 or (888) 440-7342 for network provider information.
6. At the doctor's office or hospital, the insured must present the PEIA PPB Plan Identification Card, and the doctor or hospital will verify membership and coverage information.
7. After receiving medical attention, the claim is routed to Acordia National.
8. All PPO providers are paid directly, relieving insureds of any hassle and

worry. Insureds will need to pay for out-of-pocket expenses (deductible, copayments, coinsurance and non-covered services). Acordia National will send insureds an Explanation of Benefits.

To locate providers in the PEIA/Acordia National Network, call Acordia National at (888) 440-7342.

APPENDIX G: COORDINATION OF PEIA'S BENEFITS WITH OTHER BENEFITS

I. APPLICABILITY

A. This Coordination of Benefits ("COB") provision applies to This Plan when an employee, retired employee or covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

- (1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
- (2) May be reduced when, under the order of benefit determination rules, another plan determines its benefits first. The above reduction is described in Section IV, "Effect on the Benefits of This Plan."

C. This Plan will never provide benefits as both a Primary Plan and a Secondary Plan for the same item of Allowable Expense incurred by the same person. No person may receive benefits for the same item of Allowable Expense from more than one PEIA-sponsored plan. "PEIA-sponsored plan" shall include both this Plan and any plan offered by an insurance company, health maintenance organization or other entity which has a contract with the PEIA to provide group medical benefits to PEIA-eligible employees and dependents.

D. This Plan will not coordinate benefits with any optional dental, vision or disability insurance offered through the PEIA-sponsored flexible benefits plan.

E. For any PEIA-insured person who is eligible for Medicare Parts A and B, This Plan will coordinate benefits as if the person has enrolled for both Part A and B coverage, regardless of whether or not the person has actually enrolled for such coverage.

II. DEFINITIONS

A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

- (1) Group insurance and group subscriber contracts;

- (2) Uninsured arrangements of group or group-type coverage;
- (3) Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;
- (4) Group-type contract. Group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description are included in the definition of "Plan" whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, "franchise" or "blanket");
- (5) The amount by which group or group-type hospital PPB benefits exceed \$100 per day. Hospital PPB benefits are benefits not related to expenses incurred;
- (6) The medical benefits coverage is group, group-type and individual automobile medical pay provisions; and
- (7) Coverage under a governmental plan, or coverage required or provided by law. This does not include a State plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time);
- (8) For purposes of Section III, Paragraph B (1)(b) only, "Plan" shall also include, for any person covered as a spouse or other dependent under This Plan (i.e., the PEIA Plan), individual hospital and surgical insurance coverage or individual major medical insurance coverage in which the spouse or dependent is the named insured or certificate holder and in which:
 - (a) The policy covers a specified disease, accident only, disability, or other limited benefits; and
 - (b) The policy is specifically designed, represented and sold as a supplement to other basic sickness and accident coverage; and
 - (c) The entire premium for the policy is paid by the insured or insured's family.

B. "This Plan" is the part of the PEIA group benefit plan that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Allowable Expenses under This Plan are calculated according to PEIA fee schedules, rates and payment policies.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because a covered person does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES

A. **General.** When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

- (1) The other plan has rules coordinating its benefits with those of This Plan; and

- (2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

- (1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, retired employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent under this Plan:
 - (a) Where two employees, both eligible to enroll for PEIA coverage in their own names, are married to each other and are covered under one PEIA family plan (one spouse is treated as the named policyholder and the other as a dependent for purposes of these rules;
 - (b) W.Va. Code §5-16-13(a) provides that when a person is covered as a spouse or other dependent under the PEIA Plan, then "such spouse and dependent coverage shall be limited to excess or secondary coverage for each spouse and dependent who has primary coverage from any other source. For purposes of this section, the term 'primary coverage' means individual or group hospital and surgical insurance coverage or individual or group major medical insurance coverage or group prescription drug coverage in which the spouse or dependent is the named insured or certificate holder." Accordingly, whenever a person is covered under This Plan (i.e., the PEIA Plan) as a spouse or other dependent, and such person also has other individual or group hospital and surgical coverage or individual or group major medical coverage or group prescription drug coverage in which the person is the named insured or certificate holder, then This Plan shall be the Secondary Plan and such other plan of coverage shall be the Primary Plan and determine its benefits first;
 - (c) Where a spouse would be subject to both Paragraphs B(1)(a) and (b) above, then only (a) shall apply;
 - (d) Exception to the rule stated in Paragraph B(1) above: for retirees covered by the PEIA PPB Plan and Medicare,

regardless of age, Medicare is primary and PEIA is secondary (this may not be applicable to Medicare End Stage Renal Disease benefits) and for PEIA PPB Plan active employees who are age 65 or older and eligible for Medicare PEIA PPB is usually primary;

- (e) Exception to the rule stated in Paragraph B(1) above: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is (i) Secondary to the Plan covering the person as a dependent, and (ii) Primary to the Plan covering the person as other than a dependent (e.g., a retired employee), then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent.

- (2) Dependent Child/Parents not Separated or Divorced. Except as stated in Paragraph B(3) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents;"

- (a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year (considering only the month and day, and not the year, of birth); but
- (b) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- (3) Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order;

- (a) First, the plan of the parent with custody of the child;

- (b) Then, the plan of the spouse of the parent with the custody of the child; and
- (c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that person has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. The plan of the spouse of the parent with custody of the child shall be the Tertiary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge. For purposes of this paragraph, the PEIA will not be deemed to have actual knowledge of a court decree until actual receipt of a copy of that decree by the PEIA.

- (4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III B(2).
- (5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as the employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.
- (6). Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (e.g., the Consolidated Omnibus Budget Reconciliation Act of 1987, as amended) or state law also as covered under another plan, the following shall be the order of benefit determination:
 - (a) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

(b) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- (7) Longer/Shorter Length of Coverage. If none of the above rules determines the order of the benefits, the benefits of the Plan which covered an employee, retired employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

IV. EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

- (1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of the COB provision; and
- (2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds either: (a) one hundred percent (100%) of the actual charges by providers to the insured in a Claim Determination Period, or (b) the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision, depending on the type of PEIA coverage (see C. below) under which the person is covered. In these cases, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than either: (a) those actual charges, or (b) the benefits that would be payable under This Plan in the absence of this COB provision, depending on the type of PEIA coverage under which the person is covered.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any application benefit limit of This Plan.

C. Methods of Coordination. When This Plan is a Secondary Plan, there are two methods of calculating the amount which This Plan will pay. The method which will be applied depends upon the PEIA coverage the person has:

- (1) **"Traditional" Method.** Under the traditional method of coordinating benefits, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than the actual charge.

The traditional method shall be used to coordinate benefits only for:

- (a) Retired employees or their dependents who are covered under PEIA "Basic Plan;"
- (b) Dependents of retired employees, for whom Medicare is the Primary Plan and who are covered under the PEIA "Basic Plan; and,
- (c) Active employees or their dependents for whom Medicare is the Primary Plan (e.g., persons who are eligible for Medicare because of End Stage Renal Disease).

- (2) **"Carve-out" Method.** Under the carve-out method of coordinating benefits, the benefits that would be payable under This Plan in the absence of this COB provision will be reduced by the benefits payable under the other plans. "Benefits payable under the other plans" shall include benefits that would have been payable had claim been duly made for those benefits.

The carve-out method shall be used to coordinate benefits for:

- (a) Active employees and their dependents who are not included in Paragraph C (1) above ("Traditional" Method);
- (b) Retired employees and their dependents who are enrolled in the PEIA "Basic Plan II," or PEIA "Catastrophic Plan," and
- (c) Retired employees who are enrolled in the PEIA "Basic Plan," and their dependents who are not included in Paragraph C (1)(b) above.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. PEIA has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person to the extent reasonably necessary to apply these rules. To the

extent permissible under existing law and to the extent reasonably required PEIA need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give PEIA any facts it reasonably needs to pay the claim.

VI. FACILITY OF PAYMENT

A payment made under another plan may include any amount which should have been paid under This Plan. If it does, PEIA may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. PEIA will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. RIGHT OF RECOVERY

If the amount of the payments made by PEIA is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- A. The persons it has paid or for whom it has paid;
- B. Insurance companies; or
- C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

PEIA shall have the right, after making reasonable attempts to collect from the person or entity to whom or for whom an overpayment has been made, to deduct the amount of the overpayment from other benefits or payments which are or may become payable to or on behalf of the person or entity to or for whom the overpayment was made.

Prescription Drug Copayments			
PEIA PPB Plan A			
	Up to 34-day supply	35- to 68-day supply *	69- to 90-day supply *
Generic Drug	\$ 5	\$ 10	\$ 15
Brand-name drug listed on the WV Preferred Drug List	\$ 15	\$ 30	\$ 45
Brand-name drug not listed on the WV Preferred Drug List	\$ 30	\$ 60	\$ 90
PEIA PPB Plan B			
Generic Drug	\$ 5	\$ 10	\$ 15
Brand-name drug listed on the WV Preferred Drug List	\$ 20	\$ 40	\$ 60
Brand-name drug not listed on the WV Preferred Drug List	\$ 50	\$100	\$150
* For maintenance medications only, See pages 77-78 for the maintenance drug list, You may not be able to *For maintenance medications only, see pages 119-120 for the maintenance drug list. You may be able to get a discount on your maintenance medications through a retail Maintenance Network Pharmacy or through Mail Service. Read on for details. you must pay the difference in price, plus the applicable generic copayment.			

APPENDIX H: ANNUAL PRESCRIPTION DRUG RATES

If a prescription is filled at a drug store that is not a part of the current TPA-P's network, the insured will be responsible for the entire cost at the time of purchase. The claim can be submitted to the TPA-P for reimbursement of PEIA's allowed amount for the drug, which is based on the Average Wholesale Price (AWP) less the PEIA discount, minus the dispensing fee, insured's responsibility and a \$3.00 processing fee.

COPAYMENTS (RETIREE DRUG COPAY ASSISTANCE)

PEIA members eligible for premium assistance (and their enrolled dependents) are also approved for prescription drug copayment assistance. This copayment assistance is available to retirees whose gross income is less than 250% of the Federal Poverty level.

Following is a chart listing the reduced copayments according to the years of service accrued.

Years of Active Service	Brand Preferred Copayment		Brand Non-Preferred Copayment	
	Retail (up to a 34-day supply)	Mail Order or Retail Maintenance Pharmacy (up to a 90-day supply of maintenance medication)	Retail (up to a 34-day supply)	Mail Order or Retail Maintenance Pharmacy (up to a 90-day supply of a maintenance Medication)
20 or More*	\$ 6	\$12	\$21	\$42
10 through 19*	\$ 9	\$18	\$29	\$58
5 through 9*	\$12	\$24	\$30	\$60
Less than 5**	\$15	\$30	\$30	\$60

*Generic copayment is \$3.00 retail, and \$6.00 mail order or retail maintenance pharmacy.

**Generic copayment is \$5.00 retail, and \$10.00 mail order or retail maintenance pharmacy.

Appendix I: Privacy and Security Amendment, Information from Health Plans To Plan Sponsor

1. The group health plans will not disclose protected health information to PEIA, in its capacity as the plan sponsor, unless the required provisions set forth in PEIA's policies and procedures for use and disclosure of protected health information are met.
2. Uses and disclosures of protected health information will be made to plan sponsor employees and the workforce of PEIA in order to administer and achieve the purposes of the group health plans as set out in this Plan Document and West Virginia Code §§5-16-1 et seq. all to be done consistent with: PEIA's policies and procedures for use of protected health information; PEIA's Notice of Privacy Practices and Procedures (Appendix J), and applicable law.
3. The plan sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that it creates, receives, maintains or transmits on behalf of the group health plan.
4. The plan sponsor will not use or further disclose PHI received from the group health plans other than as permitted or required by the plan documents or as required by law.
5. The plan sponsor will ensure that any agents, including any subcontractor, to whom it provides protected health information received from the group health plans, agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information. This includes, but is not limited to, the implementation of reasonable and appropriate security measures.
6. The plan sponsor will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.
7. The plan sponsor will report to the group health plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the plan documents of which it becomes aware. The plan sponsor will further report to the group health plan any security incident of which it becomes aware.
8. The plan sponsor will permit individuals to have access to any PHI which it has received from the group health plan , in accordance with PEIA's RIGHT OF ACCESS TO PROTECTED HEALTH INFORMATION policy.
9. The plan sponsor will make available protected health information for amendment and incorporate any amendments to protected health information in accordance with PEIA's INDIVIDUAL REQUESTS TO AMEND HEALTH INFORMATION policy.

10. The plan sponsor will make available the information required to provide an accounting of disclosures in accordance with PEIA's ACCOUNTING OF DISCLOSURES OF HEALTH INFORMATION policy.
11. The plan sponsor will make its internal practices, books, and records relating to the use and disclosure of protected health information received from the group health plans available to the Secretary, Department of Health and Human Services, for purposes of determining compliance by the group health plan with federal privacy regulations regarding PHI (specifically, 45 CFR Parts 160 and 164).
12. The plan sponsor will, if feasible, return or destroy all protected health information received from the group health plans that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
13. In order to provide adequate separation between the plan sponsor and the group health plans, only the following employees or classes of employees or other persons under the control of the plan sponsor will be given access to the protected health information to be disclosed. This will include any employee or person who receives protected health information relating to payment, *health care operations*, or other matters pertaining to the group health plans in the ordinary course of business. The following categories of employees and other members of the workforce will be given access to protected health information.
 - 13.1. Those who are assigned to the administration of the group health plans . This includes claim processing, maintenance of enrollment, payroll and premium, and eligibility records, analysis of payment and utilization data, and other matters pertaining to the ordinary course of business of the group health plan; and,
 - 13.2. Others who are authorized to have access to PHI on behalf of PEIA in its role as the plan sponsor, for purposes permitted by the Plan Document, including, but not limited to, benefit coordinators, payroll clerks, and personnel officers.
 - 13.3. The plan sponsor will ensure that the adequate separation is supported by reasonable and appropriate security measures.
14. The plan sponsor will restrict the access to and use of PHI received from the group health plan by members of its workforce (as listed in item 12, above) to the plan administration functions that the plan sponsor performs for the group health plan.

15. Employees and others in the workforce will be subject to discipline, including suspension or termination, in the event any member of the workforce who is authorized to have access to the group health plan's PHI violates any of the provisions of the Plan Documents as set forth in this policy.

REFERENCE: 45 CFR 164.504(f) & 164.314 (b)

APPENDIX J: NOTICE OF PRIVACY PRACTICES

**West Virginia Public Employees Insurance Agency (PEIA)
Capitol Complex, Building 5, Room 1001, 1900 Kanawha Boulevard, East
Charleston, WV 25305-0710 •(304)558-7850**

Effective date of this notice: April 14, 2003. If you have questions about this notice, please contact the person listed under Whom to Contact" at the end of this notice.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE

USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary

In order to provide you with benefits, PEIA will receive personal information about your health, from you, your physicians, hospitals, and others who provide you with health care services. We are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

Occasionally, we may use members' information when providing treatment. We use members' health information to provide benefits, including making claims payments and providing customer service. We disclose members' information to health care providers to assist them to provide you with treatment or to help them receive payment, we may disclose information to other insurance companies as necessary to receive payment, we may use the information within our organization to evaluate quality and improve health care operations, and we may make other uses and disclosures of members' information as required by law or as permitted by PEIA policies.

Kinds Of Information That This Notice Applies To

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you.

Who Must Abide by This Notice

- PEIA
- All employees, staff, students, volunteers and other personnel whose work is under the direct control of PEIA.

The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

Our Legal Duties

- We are required by law to maintain the privacy of your health information
- We are required to provide this notice of our privacy practices and legal duties regarding health information to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.

How We May Use or Disclose Your Health Information

We may use your health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. Treatment. We may use your health information to provide you with medical care and services. This means that our employees, staff, students, volunteers and others whose work is under our direct control, may read your health information to learn about your medical condition and use it to help you make decisions about your care. For instance, a health plan nurse may take your blood pressure at a health fair. We will also disclose your information to others to provide you with options for medical treatment or services. For instance, we may use health information to identify members with certain chronic illnesses, and send information to them or to their doctors regarding treatment alternatives.

2. Payment. We will use your health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our customer service department or at our claims processing administrator may use your health information to help pay your claims. And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the subscriber and each dependent who are enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information confidentially: see the "Confidential Communication" section in this notice. We may also disclose some of your health information to companies with whom we contract for payment-related services. For instance, if you owe us money, we may give information about you to a collection company that we contract with to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.

3. Health Care Operations. We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may also provide health information to students who are authorized to receive training here. We may disclose your health information as necessary to others who we contract with to provide administrative services or health care coverage. This includes our third-party administrators, available managed care plans, lawyers, auditors, accreditation services, and consultants, for instance.

4. Legal Requirement to Disclose Information. We will disclose your information

when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the state health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by state auditors. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.

5. Public Health Activities. We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.

6. To Report Abuse. We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

7. Law Enforcement. We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations.

8. Specialized Purposes. We may disclose the health information of members of the armed forces as authorized by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, and protection of the president. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution.

9. To Avert a Serious Threat. We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

10. Family and Friends. We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.

11. Research. We may disclose your health information in connection with medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.

12. Information to Members. We may use your health information to provide you with additional information. This may include sending newsletters or other information to your address. This may also include giving you information about treatment options, alternative settings for care, or other health-related options that we cover.

13. Health Benefits Information. If your enrollment in PEIA's health plan is offered through your employer, your employer may receive limited information, as necessary, for the administration of their health benefit program. The employers will not receive any additional information unless it has been de-identified or you have authorized its release.

Your Rights

1. Authorization. We may use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. If you authorize us to use or disclose your health information, in additional circumstances you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the person listed under "Whom to Contact" at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

2. Request Restrictions. You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

3. Confidential Communication. If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your health information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will agree to any reasonable request.

4. Inspect And Receive a Copy of Health Information. You have a right to inspect the

health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under "Whom to Contact" at the end of this notice. We will respond to your request within 30 days. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

5. Amend Health Information. You have the right to ask us to amend health information about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

6. Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. We cannot include disclosures made before April 14, 2003. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.

7. Paper Copy of this Privacy Notice. You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Whom to Contact" at the end of this notice.

8. Complaints. You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the:

Region III, Office for Civil Rights
U.S. Department of Health and Human Services
150 South Independence Mall West
Suite 372, Public Ledger Building

Philadelphia, PA 19106-9111.

All complaints must be in writing.

We will not take any retaliation against you if you file a complaint.

Our Right to Change This Notice

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all subscribers within 60 days of the effective date.

Whom to Contact

Contact the person listed below:

- For more information about this notice, or
- For more information about our privacy policies, or
- If you want to exercise any of your rights, as listed on this notice, or
- If you want to request a copy of our current notice of privacy practices.

Privacy Officer
West Virginia Public Employees Insurance Agency
Building 5, Room 1001,
1900 Kanawha Blvd. E.
Charleston, WV 25305-0710
304-558-7850 or 1-888-680-7342

Copies of this notice are also available at the reception desk of the PEIA office at the address above. This notice is also available by e-mail. Send an e-mail to:
peia@peia.state.wv.us

