WEST VIRGINIA SECRETARY OF STATE

MAC WARNER

ADMINISTRATIVE LAW DIVISION

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Office of West Virginia
Secretary Of State

NOTICE OF FINAL FILING AND ADOPTION OF A LEGISLATIVE EXEMPT, INTERPRETIVE OR PROCEDURAL RULE

AGENCY: Public Employees Insurance Agency

TITLE-SERIES: 151-01

RULE TYPE:	Legislative Exempt	Amendment to Existing Rule:	Yes	Repeal of existing rule:	No

RULE NAME: Plan Document

CITE STATUTORY AUTHORITY: W. Va. Code 5-16-1 and 5-16-24

This rule is filed with the Secretary of State. This rule becomes effective on the following date:

July 1, 2019

BY CHOOSING 'YES', I ATTEST THAT THE PREVIOUS STATEMENT IS TRUE AND CORRECT.

Yes

Ted Cheatham -- By my signature, I certify that I am the person authorized to file legislative rules, in accordance with West Virginia Code §29A-3-11 and §39A-3-2.

151CSR1

TITLE 151
LEGISLATIVE RULES
PUBLIC EMPLOYEES INSURANCE AGENCY

SERIES 1
LEGISLATIVE (EXEMPT) RULES PERTAINING TO THE GENERAL ADMINISTRATION OF THE WEST VIRGINIA INSURANCE PLAN

§151-1-1. General

1.1. Scope. – These legislative (exempt) rules implement the provisions of W. Va. Code §5-16-1 et seq. pertaining to the general administration of the West Virginia Public Employees Insurance Plan.

1.2. Authority. – W.Va. Code §5-16-1 et seq., W.Va. Code §5-16-24.

1.3. Filing Date. – June 26, 2019

1.4. Effective Date. – July 1, 2019

1.5. Repeal of former rule. – This legislative exempt rule repeals and replaces the former rule of the same Title filed June 26, 2018 and effective July 1, 2018.

§151-1-2. Governance of the Plan.

2.1 The insurance plans offered by the West Virginia Public Employees Insurance Agency shall be governed by:

2.1.a. The "West Virginia Public Employees Insurance Agency Plan Document" dated July 1, 2019, which is herein incorporated by reference and which is attached to this rule ("Plan Document"); and

2.1.b. The "State of West Virginia Public Employees Insurance Agency (PEIA) 2020 Summary Plan Description which is herein incorporated by reference and which is attached to this rule ("SPD Plans ABD").

2.1.c The "State of West Virginia Public Employees Insurance Agency (PEIA) 2020 Summary Plan Description Plan C which is herein incorporated by reference and which is attached to this rule ("SPD Plan C").

2.2 In the event of any direct conflict between the provisions of the Plan Document, and SPD Plans ABD or SPD Plan C to this rule, the provisions of the Plan Document shall prevail. Otherwise, the provisions of the Plan Document, SPD Plans ABD and SPD Plan C shall be construed together.



WEST VIRGINIA
PUBLIC EMPLOYEES INSURANCE AGENCY

PLAN DOCUMENT

601 57th Street, SE, Suite 2
Charleston, WV 25304-2345

Ted Cheatham, Director

July 1, 2019

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I: GENERAL INFORMATION

I.1. 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. As of July 1, 2007, retirees and their dependents are administered by PEIA on behalf of the West Virginia Retiree Health Benefits Trust Fund (RHBT).

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

I.2. 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.
- complying with applicable rules, regulations, and standards as they relate to ensuring the privacy, confidentiality, security, and integrity of the individually identifiable health information of our policyholders and dependents.

I.3. 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 Department Secretary and eight 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.

The Finance Board is responsible for approving the Agency's and Retiree Health Benefit Trust'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 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.

Technology. The Director or his/her designee(s) may employ or contract certain technologies, applications or systems to improve plan operations, allow employer and/or member access to management of their account(s), monitor health care trend(s), analyze data, or otherwise facilitate the safe and secure operation(s) of the Plan.

System(s) Access. Only authorized Users shall be allowed to access PEIA applications, platforms, and/or systems. PEIA Employee, member, Employer, Contractor, and/or vendor access to PEIA applications, platforms, and/or systems is a privilege and may be revoked if certain security provisions and/or procedures are violated, bypassed, tampered with, and/or otherwise compromised. PEIA reserves the right to conduct User and/or Access audits to authenticate users and verify compliance with security provisions and/or procedures.

Compliance. PEIA strives for compliance with any and/or all applicable State and/or federal laws, rules, and/or regulations that relate to the operations of the Plan. PEIA shall conduct an ongoing review of its operations, systems, applications, and processes to ensure said compliance.

I.4. Overview of Benefits

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

- Medically necessary services and supplies;

- Pre-admission review and case management;

- Wellness benefits; and

- An organ transplant network.

Medicare-primary Members. For PEIA's Medicare-eligible retired employees and Medicare-eligible dependents of retired employees, the specific major medical and drug benefits described in this Plan Document do not apply, however, the eligibility, administrative, and fringe benefits (cafeteria plan) sections do apply. PEIA has contracted with Humana to provide the Medicare Advantage Prescription Drug Plan (MAPD). This plan provides both medical and prescription drug coverage for those Medicare-primary members. Information in this Plan Document regarding the MAPD plan is very limited. Each eligible member has received detailed information about the plan from Humana and PEIA.

Prescription Drug Plan – PEIA PPB. The Prescription Drug Plan benefits generally 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;
- 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 generally 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 generally includes the following:

- Dental, Vision, hearing, Short- and Long- Term Disability Insurance;
- A Medical Flexible Spending Account;
- A Dependent Care Flexible Spending Account; 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.

I.5. 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.

In administering a medical and drug benefits plan it is necessary to follow certain medical and drug policies, procedures and protocols in determining whether a service, condition, treatment or item is medically necessary or otherwise appropriate and subject to coverage. It is not possible to include all these in this document. PEIA reserves the right to rely upon these in application to particular claims and or appeals.

I.6. 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 or the Director's designee shall have sole authority to approve amendments to the Plan Document. The Plan Document, the Summary Plan Description, and all approved amendments will be filed with the State of West Virginia Secretary of State's Office.

I.7. Documentation

PEIA may require documentation from employers, employees, or retired employees to verify eligibility of insureds, eligibility events, or other relevant facts.

PEIA may require documentation from providers to verify the service(s) provided to its insureds and ensure the accuracy and validity of services provided and billed to the Plan.

PEIA may require documentation from its Business Associates, contractors and/or subcontractors to substantiate and verify that they have provided products, goods, and/or services in accordance with the terms, conditions and scope of their agreements and/or contract(s).

I.8. Appendices

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

I.9. 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.

I.10. 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.

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

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.

Annual Deductible - The amount an insured must pay each year before the Plan pays any portion of the cost.

Appeal - A formal request under defined procedures for the health insurance company or the Plan Sponsor to review a decision that denies a benefit or payment

Audit - A review of the insured's status and/or claims records to determine the eligibility for and validity of the service(s) paid for the coverage(s) furnished.

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

Breach - Means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under 45 CFR 164.402, subpart E which compromises the security or privacy of the protected health information.

Case Management: A program from UMR to identify catastrophic and complex illnesses, transplants, and trauma cases, and work with members to maximize their benefits.

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.

Common Specialty Medications: Self-administered specialty drugs that are provided through CVS Specialty Pharmacy. All Specialty medications require prior authorization.

Comprehensive Care Partnership (CCP) Program: This program promotes the use of services to keep the patient well, identify health problems early, maintain control of chronic conditions and to promote efficient utilization of healthcare resources. The CCP provider is responsible for preventative services, routine sick care, and coordination of care with specialists when needed. Members who enroll in the CCP program pay less for specified services at their CCP provider. Any time a CCP member uses any provider outside the CCP, including another primary care provider, the copayment for the office visit will be $40. Insureds enrolled in PEIA PPB Plan C or who have Medicare as their primary coverage are not eligible for CCP enrollment.

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

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.

CVS Caremark - PEIA's prescription drug benefit manager (PBM). CVS Caremark processes and pays prescription drug claims and helps manage the prescription drug benefit.

Deductible - A specified amount of money that the insured must pay before the insurance company will pay a claim.

De-identified data – Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual in accordance with the HIPAA Privacy Rule 45 CFR 164.514.

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.

Disease Management: A program from UMR to identify individuals who have certain chronic diseases and would benefit from working with specially trained nurses to manage those chronic diseases and maintain quality of life.

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

Durable Medical Equipment (DME) - 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 the Plan are calculated according to PEIA fee schedules, rates and payments policies in effect at the time of services.

Emergency - A condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of a bodily part or organ.

Employee - An active or retired employee as applicable.

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

Experimental, Investigational, or Unproven Procedures - Medical, surgical, diagnostic, psychiatric, substance abuse or the 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 Services, 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 is 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 it is proposed. Phase 2 and 3 Clinical Trials for terminal cancer and other life-threatening conditions and which meet certain statutory criteria will be covered despite being experimental.

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.

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

GDPR – The General Data Protection Regulation - Designed to unify data privacy requirements across the European Union (EU). The regulation applies to entities who market to or process the information of EU Data Subjects – which include end users, customers and employees. Although PEIA may provide certain coverage(s) to members and/or their dependents who are citizens of the European Union, enrollment in a PEIA plan shall constitute a waiver of protection(s) under GDPR rule(s) and/or regulation(s). PEIA shall strive for full compliance with any and/or all applicable Federal and/or State of West Virginia law(s) rule(s) and/or regulation(s) as they relate to the privacy, security, confidentiality, and integrity of data that is created, used, stored, maintained, and/or transmitted by the Agency.

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 impairments" 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) - 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 that 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.

Health Savings Account (HSA): A health savings account (HSA) is a tax-exempt trust or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you incur. The HSA works in conjunction with a High Deductible Health Plan.

HealtheNotes: UMR provides targeted mailings to members and providers. HealtheNotes provide useful, personalized information to help members manage their health.

High Deductible Health Plan (HDHP) - A High Deductible Health Plan (HDHP) is a plan that includes a higher annual deductible than typical health plans, and an out-of-pocket maximum that includes amounts paid toward the annual deductible and any coinsurance that you must pay for covered expenses. The HDHP deductible includes both medical services and prescription drugs under a single deductible. Out-of-pocket expenses include copayments and other amounts, but do not include premiums.

HIPAA – the Health Insurance Portability and Accountability Act of 1996. This includes both the Privacy Rule(s) [45 CFR §164. Subpart E extends from §164.500 through §164.534] and the Security Rule(s) [45 CFR §164.302 through §164.318]

HITECH – the Health Information Technology for Economic and Clinical Health Act of 2009, enacted as part of the American Recovery and Reinvestment Act (ARRA)

IIHI - Protected Health Information as defined in Section 1171 of Part C of Subtitle F of Public Law 104-191 (August 21, 1996): Health Insurance Portability and Accountability Act of 1996: Administrative Simplification. These statutory definitions are of health information and individually identifiable health information. Also referred to as PHI.

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.

Legal Guardianship: A legal relationship created when a person or institution is named by the Court to take care of minor children. Eligibility for guardianship requires an Order from a Court of record. Notarized documents signed by parents assigning "guardianship" are not sufficient to establish eligibility. The term "guardian" may also refer to someone who is Court-appointed to care for and/or handle the affairs of a person who is incompetent or incapable of administering his/her affairs. Sometimes a separate person is appointed to handle the financial matters of the child(ren) or the adult and that relationship is called a conservatorship.

Life Insurance Carrier - The life insurance company with which PEIA contracts to provide life insurance benefits to PEIA members.

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

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

Maternity Management: A program from UMR that provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term.

Medicare Advantage and Prescription Drug (MAPD) Plan - A type of Medicare benefit that combines Medicare Parts A, B and D into one comprehensive benefit package. PEIA provides

benefits to Medicare-eligible retired employees and Medicare-eligible dependents of retired employees almost exclusively through the Humana MAPD plan offered by PEIA.

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 D (drug coverage) IS NOT required for members of the PEIA 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 to most individuals 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 test, 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. PEIA Plan Medicare eligible retirees must participate in Part B.

Medicare Part D - Medicare Part D is prescription drug coverage offered through Medicare or a Medicare approved plan.

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

Mountaineer Flexible Benefits - Flexible benefits plan offered by PEIA.

Non-Resident PPB Plan Participants - PEIA PPB Plan participants who reside outside West Virginia and beyond the bordering counties.

Notification: The required process for reporting an inpatient stay to UMR. This process is performed to screen for care planning, discharge planning, follow-up care and ancillary service requirements.

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

OOSINNA - Out-of-state (beyond the contiguous counties), in-network, not approved. Services of an out-of-state, in-network provider, not approved in advance by UMR are covered at 60%. The patient is also responsible for double the in-network deductible and double the in-network out-of-pocket maximum. OOSINNA does not apply to non-resident PPB Plan participants.

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 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. Plan B offers lower premiums with higher deductibles, higher out-of-pocket maximums, increased coinsurance, and higher copayments for prescription drugs. The medical coverage is the same as in Plan A. the differences in deductibles, out-of-pocket maximums, coinsurance, and drug copayments are noted in the tables in the "What You Pay with the PEIA PPB Plans, A, B and D" section and the "Prescription Drug Benefit" section of the Summary Plan Description (SPD). This plan is referred to as PPB Plan B.

PEIA PPB Plan C - The IRS-qualified High Deductible Health plan (HDHP) offered by PEIA. The plan offers lower premiums, but a high deductible that must be met before the plan begins to pay. The plan is designed to work with either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). The benefits are described in full in the section of the Summary Plan Description devoted to PEIA PPB plan C.

PEIA PPB Plan D - PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-network coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

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 all properly licensed WV providers who provide health care services or supplies to any PEIA participant, as well as most out-of-state providers in UnitedHealthCare Choice Plus Preferred Provider Organization. For services provided outside of the State, contact UMR to find a network provider.

Pharmacy Benefits Manager (PBM): A company with which PEIA has a contract to administer the prescription drug benefit component of PEIA PPB plans. The PBM processes and pays prescription drug claims and helps manage the prescription drug benefit.

PHI – Protected Health Information as defined in Section 1171 of Part C of Subtitle F of Public Law 104-191 (August 21, 1996): Health Insurance Portability and Accountability Act of 1996: Administrative Simplification. These statutory definitions are of health information and individually identifiable health information.

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 for active PEIA participants. January 1 to December 31 for participants in the Special Medicare Plan.

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 contact UMR in advance of a procedure to verify that the service is a covered benefit and medically necessary.

Precertification - The required process of reporting any out-of-state inpatient admission, any mental health inpatient admission, in-state admissions for certain procedures, and certain outpatient procedures in advance to UMR to obtain approval for the admission or service.

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. As of July 1, 2010, PEIA no longer has a pre-existing condition limitation. Pre-existing conditions are covered as of the effective date of coverage in the PEIA 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, PEIA PPB Plan C, & PEIA PPB Plan D 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.

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

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

Primary Care Provider (PCP) - A general practice doctor, family practice doctor, internist, pediatrician, geriatrician, OB/GYN, nurse practitioner, or physician assistant working in collaboration with such a physician, who, generally, provides basic diagnosis and non-surgical treatment of common illnesses and medical conditions.

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

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

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 Employee 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 the MCOs that are offered to public employees.

Qualifying Event - A qualifying event is a personal change in status which may allow you to change your benefit elections. Examples of qualifying events include, but are not limited to, the following:

1. Change in legal marital status – marriage or divorce of policyholder or dependent;
2. Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship;
3. Change in employment status of the employee's spouse or employee's dependent – switching from part-time to full-time employment status or from full-time to part-time, termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in employee/dependent becoming ineligible for coverage; and
4. Dependent satisfies or ceases to satisfy eligibility requirement. **Qualifying events which end eligibility, such as divorce, must be reported to PEIA immediately.**

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

Reasonable and Customary - The usual, customary, and reasonable amount determined by the plan for a geographic 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.

Resident PPB Plan Participants - PEIA PPB plan participants who live in West Virginia or a bordering county of a surrounding state.

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.

Retiree Health Benefits Trust fund (RHBT) - Entity created by WV Chapter 15, article 16D to administer the WV Other Post Employment Benefit plan (OPEB).

Retired Employee - An insured who qualifies for PEIA as a retired employee pursuant to W.Va. Code §5-16-2.

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.

Special Medicare Plan - The plan created by PEIA to provide benefits to retirees unable to access providers in the Medicare Advantage plan and those retirees who became eligible for

Medicare benefits during a plan year. Medical claims under this plan are paid by Medicare first, then by UMR and prescription claims are paid by CVS Caremark. The medical benefits are identical to those provided to members of the Humana MAPD plan, including a plan year that runs from January through December.

Specialty Injectable Drugs: These are prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring. The PEIA PPB Plans cover specialty injectable drugs through a program managed by UMR.

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. Some specialty medications are covered under the medical benefit and are managed by UMR, and some are covered under the prescription drug benefit and administered by CVS Specialty Pharmacy. Those covered under the prescription drug benefit, have a two-tier copay; after meeting your deductible, preferred specialty drugs have a $100 copay, non-preferred specialty drugs have $150 copay. Specialty Injectable drugs managed by UMR require 20% coinsurance after deductible. All specialty medications covered under the prescription benefit (oral and self-injectable) require prior authorization through CVS Caremark. PEIA will allow a one-time initial fill of the medication at a retail pharmacy.

Subrogation - The right of the PEIA or a PEIA contracted insurer or MCO to succeed to an insured's right of recovery against a third-party who is, or may be, legally liable and to receive full reimbursement and recovery.

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.

Tobacco Free – A person who has not used tobacco products (including cigarettes, e-cigarettes, cigars, pipes, and chewing and/or smokeless tobacco) in the last six months and will not use tobacco products for the next year.

TPA (Third-Party Administrator) - A company with which 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.

UMR: The third-party administrator that handles medical claim processing, case management, utilization management, precertification, prior approval, and customer service for the PEIA PPB Plans.

UnitedHealthCare Choice Plus PPO: PEIA's out-of-state Preferred Provider Network. Not all providers in the UnitedHealthCare Choice Plus PPO network may participate with PEIA. Kings Daughters Medical Center and Our Lady of Bellefonte hospitals in Kentucky remain out-of-network for PEIA, regardless of their network status with the PPO network. Also, PEIA does not use the PPO network in Washington County, Ohio (including Marietta Memorial Hospital), or in Boyd County, Kentucky. PEIA reserves the right to remove providers from the network, so not all providers listed in the network may be available to you.

Unsecured Protected Health Information - Means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Pub. L. 111-5.

Utilization Management - A process by which PEIA controls health costs and saves money for plan members. 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 UMR.

Waiver of Premium - If an insured becomes disabled before the insured is age 60 and while insured, basic life insurance coverage will continue if 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.

Wellness Program – Any program or initiative designed and intended to improve the quality of life and/or overall health and wellness of the insureds. Such programs may be all-encompassing or they may target or address specific metabolic, health and/or wellness conditions such as obesity, hyperlipidemia, diabetes, tobacco use, exercise, hypertension, stress management, substance use/abuse, mental health, care utilization, or other health matters.

II: PARTICIPATION

II.1. 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;
- Members of the W.Va. Board of Education;
- County Boards of education, including elected members of the boards of education;
- Certain permanent full-time substitute education employees on a 30-day or more contract;
- 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.

You and Your Spouse Are Both Public Employees. Two active public employees who are married to each other, and 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.

Beginning January 1, 2007, to qualify for the Family with Employee Spouse premium, both employees MUST have a basic life insurance. During the life insurance, open enrollment in fall 2006, couples who were already subject to the Family with Employee Spouse premium, but who do not both have life insurance will be required to apply for the coverage. If the life insurer will not issue the basic life insurance for medical reasons, then PEIA permits existing Family with Employee Spouse couples to continue to receive the premium discount, even if both do not have basic life insurance. For new plan members on and after July 1, 2006, the Family with Employees Spouse premium discount will not be granted unless both employees are basic life insurance policyholders in the plan.

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.

Disability Retirement. A member who is granted disability retirement by a state retirement system or who receives Social Security disability benefits is eligible to continue coverage in the PEIA Plan as a retired employee, provided that the member meets the minimum years of service requirement of the applicable state retirement system. Members in this category continuously covered since before July 1, 2010, pay the same premiums as those with 25 or more years of service. Those hired on or after July 1, 2010, may continue coverage, but will pay the full, unsubsidized premium for that coverage. If you receive Social Security Disability benefits, please send a copy of your Disability Award letter to PEIA. Generally, those awarded Social Security disability benefits will receive Medicare benefits after a two-year waiting period. When you receive your Medicare ID card, you must provide a copy of that card to PEIA immediately. Disability retirees may be eligible for a life insurance waiver of premium.

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 unsubsidized retiree coverage (W. Va. Code §5-16-13(l)). However, the employee must elect such coverage within two years of separation from employment with a participating agency.

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 if their last employer immediately prior to retirement: is a participating employer under Consolidated Public Retirement Board and, as of July 1, 2008, forward, is a participating employer with PEIA. Active Employees who as of July 1, 2008, have ten years or more of credited service in the CPRB and whose employer at the time of their retirement does participate with CPRB, but does not participate with PEIA will be eligible for PEIA retiree coverage; provided: they otherwise meet all criteria under this heading. PEIA may require as a prerequisite to providing coverage to the retiree that their employer agree, in writing, upon a form prescribed by PEIA that the employer will pay to PEIA the non-participating retiree premium on behalf of the retiree or retirees. 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 services; 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 CPRB system to qualify to continue PEIA insurance benefits upon retirement. Employees who participate in non-State retirement systems, but which are CPRB system affiliated, contracted, or approved (such as TIAA-CREF and similar plans), or are approved, in writing, by the PEIA Director must, in the case of education employees, meet the minimum eligibility requirements of the Public Employees Retirement System to be eligible for PEIA as a retiree. Eligible retirees not participating with PEIA immediately before their retirement or retirees who enroll with PEIA after the expiration of the calendar month of their retirement and the following two (2) calendar months may only enroll during open enrollment or upon the occurrence of a qualifying event. If your life insurance lapses after retirement for any reason, for example, for non-payment of premiums, you will not be permitted to reinstate that coverage; you will need to seek life insurance from another source.

Certain non-state agencies that participate in the PEIA health and life insurance plans for active employees have "opted out" of offering their employees PEIA's retiree insurance coverage, called the WV OPEB plan. If an employer opts out of the WV OPEB plan or is ineligible to participate in the WV OPEB plan due to retirement system participation, they are opting out of retiree eligibility for PEIA health and life coverage. Other post-employment benefits (OPEB) refers to the benefits, other than pensions, that a state or local government employee receives as part of his or her package of retirement benefits. **Please be aware that, regardless of previous employment, previous or current coverage through PEIA and years of service, if an employee transfers to an opt-out agency immediately prior to retirement, the employee <u>will not</u> be eligible for retirement health or life insurance benefits through PEIA.**

Deferred Retirement. If you separate from employment before your retirement from a participating employer under the State retirement plan, you may not enroll in PEIA as a retiree if you have other earned income just prior to retirement. If you are self-employed or have earned income from any other source, you will not be permitted to enroll as a retiree. To be eligible to enroll in PEIA, your last employer immediately prior to retirement must have been a public entity that participates in the CPRB retirement system or a CPRB affiliated retirement plan (effective March 13, 1999) and in PEIA (effective July 1, 2008).

Emergency Medical Services retirement – Age 50-55. An individual between the ages of fifty and fifty-five years, inclusive, who is eligible to and retires under the Emergency Medical Services Retirement System shall be eligible for insurance coverage under PEIA. The premium cost for such coverage shall be borne entirely by the retired individual. The premium amounts for such coverage shall be set and adjusted as necessary, by the Public Employees Insurance Agency, shall reflect the total cost to provide such coverage and shall not be subsidized by any, or any portion of any other program, fund, group or other entity subject to or administered under the West Virginia Public Employees Insurance Act. Such individuals may not use accrued annual leave or sick leave to purchase health insurance hereunder until reaching age fifty-five.

State police Retirement System – Age 50-55. An individual between the ages of fifty and fifty-five years, inclusive, who is eligible to and retires under the State Police Retirement System shall be eligible for insurance coverage under PEIA. The premium cost for such coverage shall be borne entirely by the retired individual. The premium amounts for such coverage shall be set and adjusted as necessary, by the Public Employees Insurance Agency, shall reflect the total cost to provide such coverage and shall not be subsidized by any, or any portion of any other program, fund, group or other entity subject to or administered under the West Virginia Public Employees Insurance Act. Such individuals may not use accrued annual leave or sick leave to purchase health insurance.

Deputy Sheriff Retirement – Age 50-55. On or after January 1, 2000, an individual between the ages of fifty and fifty-five years, inclusive, who is eligible to and retires under the West Virginia Deputy Sheriff's retirement System shall be eligible for insurance coverage under PEIA. The premium cost for such coverage shall be borne entirely by the retired individual. The premium amounts for such coverage shall be set and adjusted as necessary, by the Public Employees Insurance Agency, shall reflect the total cost to provide such coverage and shall not be subsidized by any portion of any other program, fund, group or other entity subject to or administered under the west Virginia Public Employees Insurance Act. Such individuals may not use accrued annual leave or sick leave to purchase health insurance.

Dependents. The term "dependents" include:

- the policyholder's legal spouse;
- the policyholder's biological children, or legally adopted children, stepchildren; and
- other children for whom you are the court-appointed guardian under age 18.

From time-to-time PEIA may conduct eligibility audits to verify that policyholders and dependents in the plan qualify for coverage. If policyholders are audited, they may have to produce documentation for the dependent(s) in question, including, but not limited to: marriage

certificates, birth certificates, and/or their most recent Federal tax return showing that they have claimed the dependent on their taxes. If the policyholder cannot prove that the dependent qualifies for coverage, coverage will be terminated, and PEIA will pursue reimbursement of any medical or prescription drug claims paid during the time the dependent(s) was/were ineligible. In the event that an ineligible dependent is removed from the plans as the result of a review or audit, PEIA will not refund the Employee and/or Employer share of the difference(s) in premiums to the Participating Agency and/or Entity and/or the employee as the failure to report and/or otherwise disclose the ineligibility in a timely manner is/was an error of commission and/or omission solely on part of the employee member, and through no fault of the State of West Virginia and/or PEIA.

Legally 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. Financial responsibility usually begins on the date of placement by a legal authority having jurisdiction for adoptions as assigned by the sovereign State. Informal agreements to care for a child do not qualify as an adoption. All foreign adoptions require documentation from the United States Department of State and/or the United States Department of Homeland security that the adoption has been conducted in accordance with the provisions of The Hague Convention on the Protection of Children and Co-operation in respect of Intercountry Adoption (Convention) entered into force for United States on April 1, 2008.

Any and/or all eligibility documents submitted to PEIA from a foreign country must be translated into English by an independent third party. Such translations must represent a true and correct statement of the contents of the original document and must include the following:

a. The date of the translation
b. The printed name and signature of the person(s) doing the translation
c. A notarized statement validating the authenticity of the translation

With regard to adoptions. any claim(s) related to the birth mother are not payable under this Plan, unless she is PEIA-eligible in her own right.

Coverage for a divorced spouse and any step-children the policyholder has not legally adopted shall terminate on the last day of the month in which the final decree of divorce is entered. **The final divorce must be reported to PEIA immediately by the policyholder.** Coverage for a child shall terminate at the end of the month in which the child turns age 26, unless the child qualifies for continued coverage as described above in this Plan Document.

Disabled Child. Your dependent child may continue to be covered after reaching age 26 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 26
- the child must have been covered by PEIA upon age 26; and
- the child must be incapable of self-sustaining employment and chiefly dependent on you for support and maintenance

To continue this coverage, the WV PEIA Disabled Dependent Disability Application must be obtained from PEIA, completed by a licensed physician, and returned to PEIA with all

supporting medical records, between 2-3 months prior to the dependent's 26th birthday, to prevent a potential lapse in coverage.

Surviving Dependents. The PEIA Medical Benefits Plan is available to the surviving spouse and dependents of a decreased active or retired employee who were enrolled and covered as dependents under the deceased employee's medical 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. If such a surviving dependent is eligible for PEIA coverage in their own status as an employee or retired employee/retired employee. They may not maintain more than one status.

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, otherwise, they may not enroll until open enrollment or a qualifying event. Also, surviving dependents must enroll in the same plan in which they were covered at the time of the policyholder's death. During the next open enrollment, they may select any plan for which they are eligible. 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 re-marriage. If a divorce occurs after the re-marriage, re-enrollment as a surviving dependent is not allowed. The surviving spouse must immediately notify PEIA if they re-marry.

If you enroll as a surviving dependent before July 1, 2015, premiums will be based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium with 25 or more years of service, but the surviving dependent is not eligible for life insurance. If you enroll after July 1, 2015, the premiums will be based on the number of years of service of deceased employee policyholder.

Ineligibility based on custodial status. PEIA shall not be responsible for any and/or all medical and/or pharmaceutical claims incurred while a policyholder or covered dependent is in the legal custody of the state and/or federal government. Persons shall be deemed immediately not eligible for participation in the Plan(s) if they are in the legal custody and/or are in the care and/or control of a state and/or federal government based on a writ, Order, or decree. Such examples of ineligible custodial status include, but are not necessarily limited to: pretrial and/or pre-adjudication detention and/or incarceration(s); incarceration(s) in a juvenile or adult correctional facility; involuntary hospitalization(s) by Order of a Court of competent jurisdiction; and/or legal custodial status exerted by a child protective services agency or an adult protective services agency.

II.2. Enrollment

Procedures. Active employees and retirees may enroll in the PEIA Plan at their place of employment. 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 unless they are non-Medicare-eligible dependents of a Medicare-eligible retiree or a Medicare-eligible dependent of a non-Medicare-eligible retiree.

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 PEIA of any change in their address, marital status, Medicare eligibility, their eligibility status, or status of their dependent(s).

When both active employee 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.

If alive, the spouse of a deceased employee will be considered the policyholder for all other dependents of the deceased employee. If a surviving minor child is the survivor policyholder, a guardian must be appointed to contract for premium payment responsibility.

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 only during open enrollment or upon the occurrence of a qualifying event. 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. All employees must enroll when changing to retired status in order to maintain continuous coverage. Retirees electing coverage after the calendar month of or the two following calendar months following retirement may enroll later only during open enrollment or upon the occurrence of a qualifying event. 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 two calendar months. 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 (e.g., 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 otherwise added to the PPB Plan only in the calendar month of or two calendar months following a qualifying event or during open enrollment. Dependents of an active employee may be added to life insurance during open enrollment. Dependent of an active employee may be added to life insurance during open enrollment, but if at any time other than when the policyholder initially enrolls the dependents must submit a statement of health. 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.) Dependents who lose their eligibility, such as through a divorce, may be removed from the Plan at any time throughout the plan year.

Surviving Dependents. In the event of the death of an active or retired employee, dependents that were covered as a dependent under the medical coverage of the employee at the time of death are eligible to enroll for health coverage as surviving dependents during the month of the death and two following calendar months. Surviving dependents are not eligible for life insurance. In the event of the death of the employee spouse who is the policyholder in the PEIA Plan, when the surviving dependent is also an active or retired public employee who is benefit-eligible in his or her own right, the surviving dependent must choose their eligibility status. He or she must choose whether to enroll in the PEIA Plan as a surviving dependent of the policyholder, or as an active or retired employee. The surviving spouse may not enroll in both statuses. Surviving dependent children may continue coverage to age 26.

Open Enrollment 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. Medicare-eligible retirees are limited to the MA and the PD Plans, except under very limited circumstances.

Medical Identification Cards. Policyholders will usually 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.

II.3. 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. Employees must enroll for coverage during their "initial enrollment period", which is the calendar month of their employment and the two following calendar months. Employees not enrolling during this period, must wait until the next open enrollment or a qualifying event. 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 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.

Medicare for Active Employees - For PEIA PPB plan active employees who are age 65 or older and eligible for Medicare, as long as the policyholder is an active employee, PEIA will be their primary insurer, except in a few rare cases. As long as the policyholder is an active employee, they do not need to sign up for Medicare Part B. When the policyholder prepares to retire, they must enroll for Medicare Part B. If they do not enroll in Medicare Part B, they will be ineligible for coverage by the MAPD Plan or PEIA, as applicable and their coverage may be terminated. The MAPD Plan is the ***only*** plan available to Medicare-eligible retirees and Medicare-eligible dependents of retired employees (except under very limited circumstances, the Special Medicare Plan).

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.

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 enrollment may only be done during open enrollment or upon the occurrence of a qualifying event. Retirees may not enroll for life insurance at a later date.

Retirees and their dependents who are Medicare eligible must enroll for Medicare Part A and B. The PEIA Plan will not cover Medicare-eligible retirees and their Medicare-eligible dependents that have not enrolled for both Part A and B coverage. Enrollment in a plan other than PEIA's MAPD Plan will make the Medicare beneficiary ineligible for PEIA's medical or prescription drug benefits.

When a retired employee or a dependent of a retired employee, becomes an eligible beneficiary of Medicare, they must enroll in Medicare Part A and Medicare Part B.

Generally, all Medicare-eligible retired employees and Medicare-eligible dependents of retired employees have coverage through Humana's Medicare Advantage (MA) and Prescription Drug (PD) Plans (MAPD). This plan provides both medical and prescription drug coverage for those Medicare-primary members. To be eligible for the MA and PD plans, the member must enroll for Medicare parts A and B. If you do not enroll in Medicare Parts A and B and pay the monthly premium, you will not be eligible for the MA and PD plans, which is the only coverage offered to retire, Medicare-eligible members and Medicare-eligible dependents of retired employees.

If you become eligible for Medicare prior to age 65, you should send 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.

Retired Employees hired on or after July 1, 2010: No Subsidy. The PEIA Finance Board has voted that employees hired on or after July 1, 2010 will receive no premium subsidy when they retire and participate in PEIA as retired employees. Such retired employees must pay the full cost of their participation in the Plan.

Retirees from non-state entities which employer joined PEIA on or after July 1, 2010 will also receive no premium subsidy and must pay full cost of their participation in the Plan. Such non-state retirees will be assigned a "hire date" in the PEIA system(s) which is the same as the date they enroll in PEIA as an active employee.

With respect to active employees who have a break in service or retired employees who become re-employed and go back to active employee status, the following rules apply to determine their date of hire for premium subsidy purposes:

1. Active employees hired before July 1, 2010 who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2010) hire date.
2. Retired employees who had an original hire date prior to July 1, 2010, may return to active employment and retain their pre-July 1, 2010, original hire gate for purposes of determining their eligibility for premium subsidy.

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 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. Coverage is not automatic. The employee must enroll the dependent.

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. In that event the employee's PEIA premium will be adjusted retroactively to the month of the newborn's birth. If the newborn is not enrolled in the month of birth or the following two calendar months, the newborn may not

be enrolled until the next open enrollment or upon the occurrence of a qualifying event. A statement of health will also be required for optional dependent life insurance.

Legally adopted children may also be enrolled effective from their date of adoption if enrolled during the calendar month of adoption or the following two calendar months if legal documentation is provided stating that the PEIA policyholder become financially responsible for claims incurred by the adopted child on the date of adoption. In that event the employee's PEIA premium will be adjusted retroactively to the month of adoption. Informal agreements to care for a child do not qualify as adoption. All foreign adoptions require documentation from the United States Department of State and/or the United States Department of Homeland Security that the adoption has been conducted in accordance with the provisions of The Hague Convention on the Protection of Children and Co-operation in Respect of Intercountry Adoption (Convention) entered into force for the United States on April 1, 2008.

If a retired employee enrolls dependents already in the plan 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 not enrolled at that time, they may not be enrolled until the next open enrollment or until a qualifying event.

PEIA requires documentation to support the eligibility of any and/or all dependent(s). Such documentation may include, but not be limited to: marriage certificates, birth certificates, National Child Support Orders, copies of adoption paperwork (e.g. Court Orders, adoption decrees, etc.), social security numbers, and/or other legal documents validating the dependent's eligibility. Coverage(s) may be pended for the dependent(s) until all of the required documentation is submitted to PEIA. Coverage(s) may be termed for failure to submit required documentation.

Surviving Dependents. Surviving dependents of an active or retired public employee, that were insured by PEIA under the employee's comprehensive health coverage (either in the PEIA PPB Plan, the Special Medicare plan, or in a managed care plan) at the time of the employee's death, may elect to continue the same coverage as a policyholder in your own right under that health plan. If you are also eligible for PEIA coverage due to your status as an active employee or a retired employee, you must elect between surviving dependent status and status as an active or retired employee. To do so, you will need to complete a Surviving Dependent enrollment form available from PEIA. If you are a surviving spouse and you choose not to enroll immediately for coverage, you may elect PEIA coverage in the future, Medicare-eligible dependents of deceased retirees will be covered by the MA and PD plans. Dependent children may elect surviving dependent coverage until the age of 26.

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 does not enroll during that period, they may not enroll until the next open enrollment or until a qualifying event.

If you are a surviving spouse and you choose not to enroll immediately for coverage, you may elect PEIA coverage in the future during open enrollment, if you have not remarried.

The surviving spouse's eligibility for PEIA coverage terminates upon remarriage. If a divorce occurs after the remarriage, re-enrollment as a surviving dependent is not allowed. The

surviving spouse must immediately notify PEIA if they remarry. Any surviving spouse who becomes ineligible due to re-marriage, and fails to immediately report that re-marriage, shall be responsible for repaying PEIA for any and/or all claims incurred during their period of ineligibility.

Dependents, who were covered at the time of the policyholder's death, are also eligible to enroll. See the earlier section on dependents to determine what persons are eligible.

II.4. 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.

For employees on delayed payroll, coverage will terminate at the end of the month in which their employment terminates, although they may continue to receive paychecks due to their delayed payroll status.

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. The employer continues to be liable for premiums of such employee until proper termination notification is received by PEIA and such premiums will not be refunded outside of the PEIA Refund policy even though no coverage is in force.

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 may 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 last day of preceding month if the monthly premium is not paid by the 5th day of the following month of coverage, with the exception of Medicare MA or PDP members, which requires PEIA to comply with CMS termination procedures.

In the event an active employee or covered dependent violates the terms and conditions of the plan(s), and PEIA conducts an administrative proceeding pursuant to West Virginia Code §5-16-12, PEIA shall terminate coverage(s) and set off any payment of any benefits or other payment due to that/those person(s) until any overpayment is recovered.

Retired Employees. Coverage for retired employees in the PEIA PPB plan or a managed care plan terminates at the end of the month in which the retired employee terminates coverage or fails to pay the premium.

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 30 days following the due date, all coverage may be suspended. If payment is not received within 45 days following the due date, health and life insurance coverage will be cancelled, and all medical and prescription drug claims incurred will be your personal responsibility. Canceled life insurance cannot be reinstated, even if past-due premiums are paid. The cancellation is permanent, and you will need to seek life insurance from another provider. PEIA will also submit premiums over-due by 45 days to a collection agency.

Direct Pay

For non-Medicare policyholders who pay premiums directly to PEIA, if is not received by PEIA within 30 days following the due date, a termination notice containing the termination date will be mailed to the policy-holder. All claims incurred following the termination date will be the policyholder's personal responsibility. The policyholder has the right to appeal the termination in writing within 60 days following the termination date.

1) If terminated policyholder appeals the termination in writing within 60 days from the date of termination, he or she must pay the past-due premiums, apply to pay premiums by direct draft from a bank account, and may be granted uninterrupted medical and prescription coverage at PEIA's discretion. Life Insurance cannot be reinstated.
2) If the terminated policyholder appeals the termination in writing more than 60 days following the date of termination, PEIA may only allow re-enrollment for health coverage if the policyholder enrolls as a new enrollee and agrees to pay premiums by direct draft from a bank account. In this case, there may be a break in the period of coverage. Two terminations for failure to pay within a 12-month period may result in permanent disqualification from coverage under the PEIA plan.

If extenuating circumstances prevent the policyholder from appealing within 60 days of the termination, the policyholder may send a written request and the PEIA director may grant a waiver of the 60-day requirement, at his or her discretion.

For Medicare policyholders who pay premium directly to PEIA, failure to pay premiums will result in termination from the plan consistent with applicable Medicare rules.

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 of the spouse and any step-children the policyholder has not legally adopted is effective at the end of the month in which the divorce is final, and policyholder must immediately report the divorce to PEIA) whether or not the decree requires the policyholder to provide health benefits to ex-spouse and/or step-children;

- the dependent child reaches age 26;

- the dependent is voluntarily removed from the Plan by the policyholder;

- dependent child over the age of 26 ceases to be deemed handicapped;

- dependent child over whom the policyholder is court-appointed guardian reaches age 18.

The policyholder may voluntarily terminate coverage for dependents only during open enrollment or with a qualifying event by completing the appropriate forms.

Surviving Dependents. Coverage for surviving dependents terminates at the end of the month in which the surviving dependents no longer elects to participate, fails to pay the premium, or becomes ineligible due to age or marriage. Re-marriage must be reported immediately in writing to PEIA by surviving dependent. Any surviving spouse who becomes ineligible due to re-marriage, and fails to report that re-marriage, shall be responsible for repaying PEIA for any and/or all claims incurred during their period of ineligibility.

Confined Insured. An insured who is confined to a hospital or other (non-penal) medical facility rendering medical care on the date coverage would otherwise terminate will remain covered through the date of discharge (for facility charges only). PEIA shall not be responsible for any and/or all medical and/or pharmaceutical claims incurred while a policyholder or covered dependent is in the legal custody of the state and/or federal government. Persons shall be deemed immediately not eligible for participation in the Plan(s) if they are in the legal custody and/or are in the care and/or control of a state and/or federal government based on a writ, Order, or decree. Such examples of ineligible custodial status include, but are not necessarily limited to: pretrial and/or pre-adjudication detention and/or incarceration(s); incarceration(s) in a juvenile or adult correctional facility; involuntary hospitalization(s) by Order of a Court of competent jurisdiction; and/or legal custodial status exerted by a child protective services agency or an adult protective services agency.

Local Government Agencies and other Non-Mandatory Participants. Coverage 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 eligible retiree or a dependent of an eligible retiree and eligible to enroll by virtue of their eligible retiree status.

II.5. Changes in Participation Status

Elections at open enrollment. Employees must make their annual elections (i.e., plan choices) during open enrollment and may not change their annual elections absent a "qualifying

event" which changes their participation status. It is policyholder's responsibility to keep PEIA enrollment records up to date. The policyholder must notify their benefit coordinator or PEIA immediately of any changes in participation status or in family situation, and make the appropriate change to keep PEIA coverage up to date. Examples of such changes include retirement or disability retirement, a change of address, a change in marital status, or a dependent child no longer qualifying for coverage.

If the policyholder fails to notify their benefit coordinator or PEIA promptly of changes in participation family status, the employing agency may look to the policyholder for reimbursement of premiums the employer paid in error, and PEIA or the Plan may adjust claims paid for ineligible enrollees.

Dependents Status to Member Status. An employee (other than a spouse) who is covered as a dependent under a family medical plan of another eligible employee 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 there will be no coverage during that lapse.

Transfer 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 or vice versa will, for purposes of exchanging leave for PEIA coverage upon retirement, be treated as a new hire unless other arrangements are agreed to by PEIA and the new employer. For purposes of coverage change, deductible, out-of-pocket maximum, the individual will be considered a transfer.

If the policyholder transferring from one State agency to another wish to add a spouse or other dependent the policyholder must wait until open enrollment, unless there is a qualifying event. Also, the policyholder may not add dependents to coverage if covered by a managed care plan until open enrollment, unless there is a qualifying event.

II.6. Leaves of Absence

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 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 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 insurance 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. original hire date, 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 may be restored to the same PEIA benefits to which that employee had at the time of the approved leave of absence.

II.7. Extending Employer–Paid Coverage for Certain Retirees

West Virginia Code § 5-16-13, under certain conditions, allow participating employees compelled or require 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 (in PEIA and CPRB) employer and be drawing a pension from his/her respective retirement system. The leave must be used immediately at the time of retirement. 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 to effectively combine their sick and annual leave to extend their family coverage. If an employee dies before using all their respective extension of service credit, the benefit ceases and does not pass on to the spouse or dependents.

If the retired employee changes his/her plan from single to family or vice versa, PEIA will then recalculate the amount of remining earned extended insurance coverage.

If an employee changes from single to family, such change may be made only at open enrollment or upon a qualifying event.

The death of an employee with or without the family plan terminates any and all of their remaining earned extended insurance coverage. From the date of the employee's death, the dependents shall be entitled to continue their participation coverage and completion of surviving dependent enrollment forms.

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 you will be treated as a new hire and your new effective date of coverage with PEIA will be after July 1, 2001. Two exceptions will be made to this rule:

1. Active employees hired before July 1, 2001, who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2001) hire date.
2. Retired employees who had an original hire date prior to July 1, 2001, may return to active employment and retain their pre-July 1, 2001, original hire date for purposes of determining their eligibility for this benefit, but may only use leave earned after they return to active employee status.

Participating Employee (Other than Certain Higher Education Faculty). Retiring 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 hired by their employer and who have been 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 hired by their employer and who entered PEIA after July 1, 1988 and before July 1, 2001, 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; and

- Employees hired on or after July 1, 2001 are not eligible.

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 only if the employee was hired before July 1, 2009.

II.8. 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 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 dependent child if the child no longer meets the definition of covered dependent as defined in the Plan. Loss of eligibility may result from attainment of age 26. 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 immediately of 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 of 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 29 the 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 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.

- An election to continue coverage under COBRA must be made within 60 days starting from the latest of:
  (1) the date on which the qualifying event occurs;
  (2) the date on which you lose (or would lose) coverage under the plan due to the qualifying event; or
  (3) the date on which you are informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and procedures for doing so.
  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,

- 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 ad addressed in this Plan.

- An insured enrolled in a MCO will be offered continuation 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 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.

II.9. 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

III.1. Premium Accounts

Premium Accounts Section. The PEIA will 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 will 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
- Non-Medicare/Medicare
- Retiree with Family Coverage

-Retiree with Family Coverage

- Policyholder with non-Medicare Dependents
- Policyholder with Medicare Dependents

-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, including but not limited to Medicare eligibility.

The Finance Board may allocate a portion of the premium costs to participating employers and employees 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 (not participating in PEIA as an active group) employer a premium as established by the Finance Board to subsidize the cost of 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 active 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 premium are based on the tobacco-use status of insureds. Tobacco- free insureds will receive the preferred monthly premium rate, which is $25.00 lower for single coverage and $50.00 lower for family coverage. Plan insureds must be tobacco-free for six (6) months 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 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. Once filed, a tobacco-free affidavit will remain effective until amended unless PEIA in any subsequent Plan Year requires that a new affidavit be submitted. PEIA reserves the right to review medical records to check for tobacco use. PEIA offers a tobacco cessation benefit. Tobacco-Free means a person who has not used tobacco products (Includes cigarettes, cigars, pipes, and chewing and/or smokeless tobacco; including e-cigarettes and/or vaping oils) in the last six months and will not use tobacco or similar products for the next year.

It shall be considered a violation of West Virginia Code §5-16-12 for a person to knowingly and/or willingly submit false information on a PEIA Tobacco affidavit.

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.

PEIA reserves the right to perform audits to verify policyholder and/or dependent tobacco status. If a member or dependent is found to be a tobacco user, but has been reported as "tobacco free", PEIA will immediately change the member and/or dependent's status to that of a tobacco user.

If your doctor certifies on a form provided by the PEIA, that it is unreasonably difficult due to a medical condition for you to become tobacco-free or it is medically inadvisable for you to become tobacco free, PEIA will work with you for an alternative way to qualify for the tobacco-

free discount. Send all such doctors' certifications and requests for alternative ways to receive the discount to: PEIA Discount Alternatives, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345.

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 5th day of the following month for which coverage is in effect (i.e., for coverage for February, payment must be made by March 5th).

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 or electronic fund transfer via the automated clearinghouse process (ACH) 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 first of that month.

For retirees participating in one of the Consolidated Public Retirement Board systems, their share of the premium will 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 paid by their last employer from which they retired and must be submitted by State Agencies and State Colleges and Universities by intergovernmental transfer (IGT). This premium is not collected through the EPIC system.

Furthermore, and annual administrative fees must also be remitted through IGT for State agencies (i.e., fees are not collected and remitted through the EPIC system). Administrative fees for all other employer types shall be paid by check or electronic fund transfer via ACH.

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. 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 in tiers as set by the Finance Board. 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 separate from employment but, not to immediately retire, 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. They may, however, 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 was hired and 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 was hired and 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 continue 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 at the time of retirement. Accrued leave may not be divided to increase the retirement benefit and to extend employer-paid insurance coverage. Once the policyholder has made their choice they may not change their election.

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, you will be treated as a new hire with an effective date of coverage in the

PEIA plan after July 1, 2001. Therefore, you will be ineligible for the sick/annual leave benefit. Two exceptions will be made to this rule:

1. Active employees hired before July 1, 2001, who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2001) hire date for purposes of this benefit.
2. Retired employees who had an original hire date prior to July 1, 2001, may return to active employment and retain their pre-July 1, 2001, original hire date for purposes of determining their eligibility for this benefit, but may only use leave earned after they return to active employee status.

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

Employees hired on or after July 1, 2009, are not eligible for this benefit. Two exceptions will be made to this rule:

1. Active employees hired before July 1, 2009, who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2009) hire date for purposes of this benefit.
2. Retired employees who had an original hire date prior to July 1, 2009, may return to active employment and retain their pre-July 1, 2009, original hire date for purposes of determining their eligibility for this benefit, but may only use leave earned after they return to active employee status.

Policyholder/Spouse Both Public Employees. 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 depending upon agreement of their former employers. If the policyholder and spouse retire concurrently, they may be able to 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 Programs. Retired employees with 5 or more years of service 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. Medicare-eligible retirees with 15 or more years of service may receive assistance with drug co-payments through a grant provided by the PEIA. For co-payments, 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 co-payments assistance. Applications are mailed to all retired employees each spring.

Retired members covered under The Health Plan are not eligible for this program.

Life Insurance Premiums. Life insurance premiums for all employees are set by PEIA's life insurance carrier subject to PEIA's approval. Optional life insurance premiums are paid by the employee and are based on age and amount of coverage. For retirees, basic life insurance premiums are paid by the retiree with the exception of retirees using extended or paid insurance.

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 pay the employee share of the premium established by PEIA. 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 plan being offered 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 (due date) 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. For Medicare-eligible retirees and Medicare-eligible dependents of retirees, Medicare rules will apply.

If payment is not received by PEIA within 30 days following the due date, all medical claims may be pended. Additionally, the PEIA drug card may be suspended. If payment is not received within 45 days following the due date, coverage will be cancelled, and all claims incurred will be your personal responsibility.

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 notification by PEIA of the default, or within the standard collection period ads established by PEIA, 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 pay all amounts owed to PEIA and establishes an automatic bank withdrawal to pay the insured's premiums thereafter. Such reinstatement is in the discretion of PEIA.

Direct Pay. For policyholders who pay premiums directly to PEIA, if payment is not received by PEIA within 30 days following the due date, a termination notice containing the termination date will be mailed to the policyholder. All claims incurred following the termination date will be the policyholder's personal responsibility. The policyholder has the right to appeal the termination in writing within 60 days following the termination date.

If the termination policyholder appeals the termination in writing 60 days from the date of termination, he or she may pay the past-due premiums, apply to pay premiums by direct draft from a bank account, and may be granted uninterrupted coverage at PEIA's discretion.

If the terminated policyholder appeals the termination in writing more than 60 days following the date of termination, PEIA, in its discretion, may only allow re-enrollment if the policyholder enrolls as anew enrollee and agrees to pay premiums by direct draft from a bank account. In this case, there may be a break in coverage. Two terminations for failure to pay within a 12-month period may result in permanent disqualification from coverage under the PEIA plan.

If extenuating circumstances prevent the policyholder from appealing within 60 days of the termination, the policyholder may appeal for and the PEIA director may grant, at his or her discretion, a waiver of the 60-day requirement.

Monthly Reports. By the 15th day of each month, the PEIA shall provide 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.

If an employee should appear on the report for that month but does not, the employer must immediately contact their PEIA eligibility representative to determine the status of the submitted enrollment transaction, forward the enrollment form, or approve the electronic enrollment transaction.

The employer must terminate an employee who should not appear on the invoice due to termination or ineligibility. For a policyholder who is changing coverage type or has had a change not reflected on the billing, the employer need only change the remittance amount until the coverage code (s) or eligibility status has been updated by PEIA eligibility. Forms or electronic transactions reflecting these changes, if not already forwarded, are to be sent immediately to the PEIA or approved electronically by the employer.

Any remittance changes made by the employer must be supported with an approved eligibility transaction to be effective. Until such time, invoiced amount is due.

When all changes have been made, the current remittance will be recalculated and forwarded by the 5th of the month following the month for which coverage was invoiced.

Administrative Expense and Enrollment Fee. The PEIA will determined 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 set by PEIA is charged to non-state agencies each time they join the Plan. PEIA encourages online transactions and may charge a separate paper-processing fee.

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, non-Medicare eligible retiree, or Medicare-eligible retiree or Medicare-eligible dependent(s) of a deceased retiree.

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 PEIA billing to reflect the previous overpayment.

Non-Medicare Eligible 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.

Medicare-Eligible Retiree/Medicare-Eligible Dependent(s) of Retiree. Medicare rules apply.

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

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

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 due with an incurred date in an immediate previous fiscal year or earlier 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) month's premium. If such employee has incurred health care claims between the date intended for termination by the employer and the actual termination date, no refund is due. Any premiums beyond two (2) months premium shall be treated as forfeited to PEIA and no coverage will be provided for such forfeited premium amounts.

When 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 for those claims that are within the Medicare timeframe to adjust claims. 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 12 months the policyholder for any premium difference that may be due as a result of the Medicare status and to request claim adjustments.

III.2. Contracts

The operation of the PEIA requires the assistance of numerous vendors. Such vendors include, but may not be limited to, the third-party administrators for medical claims, prescription drug claims and utilization review, manages 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 and 5-16-8 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, 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. Contracts and agreements entered into by the PEIA generally 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.

III.3. Payments

Payment of Claim 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 cause claim checks or EFTs to be made payable directly to in-state providers and the TPA-P will cause claim checks or EFTs to be made 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.

III.4. 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 PEIA Chief Financial Officer or another person authorized by the PEIA Director. Approved invoices will be forwarded to the State Auditor for payment.

Third-Party Administrative 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 PEIA Chief Financial Officer, or another person authorized by the PEIA Director.

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 purpose of determining the correct monthly payment.

III.5. 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 requested 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. PEIA may also perform audits to determine member or dependent eligibility.

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 per the PEIA collection policy. PEIA may also perform audits to determine member or dependent eligibility.

Eligibility. PEIA will from time-to-time conduct audits to verify eligibility of employees and their dependents. PEIA may request, and employers and employees must provide, reasonable documentation such as tax forms, marriage licenses or certificates, birth certificates, etc.

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 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.

III.6. 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 there from, 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 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.

III.7. Employer's Responsibility

Notification to Employees. All participating employers must give written notice to each covered employee within their agency of any changes in benefits to insureds. W.Va. Code § 5-16-8.

Certification of Enrollment. All such forms must be submitted by the agency in a timely manner and in the event of employee termination, immediately. An appropriate official of the employer agency shall on an employee's enrollment form, certify the eligibility of the employee and on any other change in status forms or transactions on behalf of the employee,

certify that the information on the form or transaction is accurate, to the best of the official's knowledge. The enrollment form shall be signed by the following persons:

- The chief executive of the agency or their designee, and
- The employee.

Deduction of Premium. The agency shall upon the enrollment of an eligible employee make the appropriate provision for the deduction of premium from the employees pay and shall remit the appropriate premium to PEIA.

Earned Extended Insurance Coverage. All agencies are responsible to remit to PEIA the monthly premiums for retired employees qualifying for earned extended insurance coverage for the time period of the employee's qualifying for earned extended insurance coverage for the time period of the employees earned extended insurance coverage. Employees of non-State agencies who retire may receive the earned extended insurance coverage only if the employee qualifies as a retired employee and only if the employee's agency pays the amount of earned extended insurance coverage. If the agency fails to pay the PEIA, then the employee's earned extended insurance coverage may be terminated. For each employee retiring from an agency when the retiree is to use accrued annual leave or sick leave in exchange for continued PEIA premium payment into retirement the agency shall provide on the retiree's enrollment forms:

- The date of hire of the employee and whether the employee has been continuously employed by the agency since that date;
- The date of the employee's separation from employment and the date of retirement, if known;
- The number of accumulated unpaid sick and annual leave days to be credited to earned extended insurance coverage;
- Whether the employee wants his/her unpaid accumulated sick and/or annual leave credited to a single or family plan; and
- The number of months of earned extended insurance coverage as calculated by the employee's agency.

Non-state Agencies. The following applies to non-state agencies participating or seeking to participate in PEIA:

Participation Agreement. A participation agreement must be executed between the participating non-state agency and the PEIA governing the participation of said non-state agency in the PEIA plan. The participation agreement must be a minimum term of three (3) years.

West Virginia Retiree Health Benefit Trust Participation (Retiree Trust). The Retiree trust is intended to address the Other Post Employment Benefit (OPEB) liability of employers with current or future retirees participating in the PEIA health plans. State law mandates that all employers with employees who are eligible or who will become eligible to participate in PEIA as retirees, are MANDATORY participants in the Retiree Trust. (W.Va. Code §§5-16d-1 et seq.)

Non-State employers may opt out of the Retiree Trust ONLY upon a written Certification, under oath, to PEIA that the employer has no employees who are eligible or who will become to participate in the PEIA health plan as retirees. The employer must also agree to defend and hold

PEIA harmless from any and all claims by employees of the employer requesting PEIA coverage. PEIA will provide forms for non-State employers wishing to opt out of the Retiree Trust. PEIA will use the following policies in determining whether to accept an employer opt out request:

WV OPEB Plan Participation Scenario and Policy Document

Table 1 is a list of various scenarios concerning participation the WV Other Post Employment Benefit (OPEB) Plan. All scenarios assume participation with PEIA.

Any employer that opts out of the WV OPEB Plan, but remains on PEIA, must still contribute to the Trust at the minimum annual required payment (MARP) level. When opting out of the WV OPEB plan the employer is opting out of retiree eligibility and the billing of the remaining Annual Required Contribution (ARC).

If the employer opts out of PEIA, they may still be required to pay the non-participating premiums for their retirees still participating in PEIA, but they will no longer be considered a participating employer in the WV OPEB plan if they sign the Opt Out Hold Harmless Agreement. It will be the responsibility of the employer to determine their OPEB expense and liability, if any.

Table 1

List of Scenarios Regarding Employer WV OPEB Plan Participation

	CPRB Participating Employer	Retirees in PEIA Currently	Retirees in PEIA in Past
Employer Wishes to Opt Out of WV OPEB Plan			
Scenario 1	Yes	Yes	Yes
Scenario 2	No	Yes	Yes
Scenario 3	No	No	Yes
Scenario 4	No	No	No
Scenario 5	Yes	No	No
Employer Wishes to Participate in WV OPEB Plan			
Scenario 6	No	No	No
Scenario 7	No	No	Yes
Scenario 8	No	Yes	Yes
Scenario 9	No	Yes	No
No Action from Employer			
Scenario 10	No	No	No
Scenario 11	No	No	Yes

Scenario 12	No	Yes	Yes
Scenario 13	No	Yes	No

Table 2	
Policies for Scenarios Regarding Employer WV OPEB Plan Participation	
Employer Wishes to Opt Out of WV OPEB Plan	
Scenario 1	Reject opt out request. Employer participates in both PEIA and CPRB.
Scenario 2	Reject opt out request based on current PEIA retirees. Employer may be able to re-apply for opt out upon 5 years of no retiree participation in PEIA.
Scenario 3	Approve opt out request if employer signs hold harmless agreement and the past retiree participation is now beyond 5 years from last retiree's termination from PEIA; or Reject opt out request based on past retirees. Employer may be able to re-apply for opt out upon 5 years of no retiree participation in PEIA.
Scenario 4	Approve opt out request if employer signs hold harmless agreement.
Scenario 5	Reject opt out request. Employer participates in both PEIA and CPRB.
Employer Wishes to Participate in WV OPEB Plan	
Scenario 6	Approve, if Director approves retirement plan.
Scenario 7, 8 and 9	Approve, if Director approves retirement plan; or Effective January 1, 2013, new retirees must have 10 years of service as of January 1, 2013 to be eligible and Agency will be removed from the WV OPEB plan upon 5 years from last retiree's termination date.
No Action from Employer	
Scenario 10	Advise of new law and request decision to apply for approval of retirement plan. Failure to submit and receive approval of retirement plan will result in removal from WV OPEB plan eligibility.
Scenario 11, 12 and 13	Advise of new law and request decision to apply for approval of retirement plan. Advise they had been grandfathered due to past or present participation and, without approval of retirement plan, effective January 1, 2013, new retirees must have 10 years of service as of January 1, 2013, to be eligible or employer may request to opt out if there have been no retirees in the last 5 years and signs a hold harmless agreement.

(All terms are as defined in W.Va. Code §5-16d-1 et seq.)

Withdrawal from the Plan. When any participating non-state agency chooses to withdraw from or terminate the West Virginia Public Employees Insurance Plan:

a. Written thirty (30) days' notice shall be required prior to formal withdrawal from the Plan;
b. All non-state agency retirees participating in the CPRB and covered by the PEIA prior to the effective date of these rules may remain covered under the conditions of their present coverage and subject to the agency's payment of premiums as addressed above;
c. All non-state agency retirees not participating in the CPRB or a retirement system approved, in writing, by the PEIA Director must look to the withdrawing non-state agency for coverage and are not eligible to continue participation in PEIA; and
d. A twelve (12) month waiting period shall be imposed by the PEIA for any such non-state agency choosing to re-enter the plan.

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 non-taxable 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 county board of education, or eligible municipality or other eligible local entity 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) and 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, the Dependent Care Reimbursement and Medical Reimbursement Plan, Health Savings Account, Hearing Aid Plan, and related plans.

2.23 "Open enrollment" means the period of time prior to or during a Plan Year which PEIA has designed 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 Employees Insurance Agency Section 125 Plan as set forth herein, together with any and all amendments and supplements hereto.

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

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

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

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

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

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

ARTICLE III – PARTICIPATION

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

(a) With respect to Premium Conversion Benefits, each Eligible Employee shall automatically become a Participant in this Plan for a Period of Coverage on the first day of the 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 who 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 Pan 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 provided in Section 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; and

(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 type 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 Section 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 reimbursement account in accordance with the Dependent Care Reimbursement Plan and/or the Medical Reimbursement Plan. 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 shall be determined in accordance with the Dependent Care Reimbursement Plan and/or Medical Reimbursement Plan.

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 Document 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 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 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, a dependent child becoming eligible for CHIP, 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 statue 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 from 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 reimbursement under the Medical Reimbursement Plan, as set forth in such plan, 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 elect's 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 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 the 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 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 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 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 designed 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 fee 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 inly 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 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 the 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

V.1. 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 Plans A, B, and D 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.

PEIA PPB Plan C

Plan C is a High Deductible Health Plan that is different than the more traditional PEIA Plans A, B and D. While the core benefits of Plan C are similar to Plans A, B, and D the

deductibles, co-payments coinsurance, and out-of-pocket expenses are very different. Certain benefits are also treated differently or are not available under Plan C. The Plan c PEIA Summary Plan Description (SPD) sets out the details of Plan C and should be referred to for Plan C information. See the SPD specific to Plan C for any information about Plan C. The sections below apply to the PEIA PPB Plans A and B and D when there is a reference to the PEIA PPB Plan or the Medical Benefits Plan. While the sections may generally apply to PPB Plan C, specific information relating to benefits, copays, coinsurance, deductibles, and out-of-pocket maximums are set out in the SPC and may be different for Plan C.

PEIA PPB Plan D

PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-network coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

V.2. Deductibles, Coinsurance, Copayments and Plan Maximums

The PEIA PPB Plans are 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 UMR/PEIA PPO 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 the 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 PPO 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 OOSINNA deductible is twice the amount of the in-network deductible. Any medical charges applied toward the OOSINNA 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 OOSINNA deductible; it must be satisfied separately.

Deductible 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 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 PEIA PPB Medical Benefits Plans A, B, and D 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 PPO Network and whether prior approval is granted. For services provided within the State of West Virginia or in a bordering county of a surrounding state using PPO providers, the Plan pays the higher level of benefit toward the allowed expense and the insured pays the remaining portion. 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 or from out-of-state PPO providers without prior approval. Coinsurance levels due from insureds may be reduced by obtaining prior approval whenever they receive services either outside of the State or from non-PPO providers.

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 and certain preventive care visits. Specialty care office visits will be subject to a $40 copayment. Insureds do not have meet the annual deductible in order for the office visit copayments to apply. However, these copayments 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.

Non-Covered Services. Non-Covered services are the members' responsibility.

Out-of-Pocket Maximums. An out-of-pocket maximum is the most money, in coinsurance, (excluding copayments), that an insured has to pay 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 coinsurance amount of the PEIA allowance in addition to the Plan benefit amount 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.

There are separate out-of-pocket maximums for in-network and OOSINNA expenses. For insureds living within the State of West Virginia or bordering county, any medical charges, which result from care received from a West Virginia provider or from a UMR/PEIA PPO 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 OOSINNA 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 OOSINNA out-of-pocket maximum. However, expenses for OOSINNA 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.

V.3. 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.

V.4. 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. Additionally, the provider must meet any PEIA policies surrounding particular PEIA benefit programs. 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 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. Generally, most outpatient services performed at a facility are paid according to the Outpatient Prospective Payment System (OPPS). Services not paid through OPPS, are paid according to the RBRVS, or other, PEIA payment schedule. Facility admissions and services that are not covered under the PPS or OPPS 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 UnitedHealthCare Choice Plus PPO are paid according to their contractual agreements. Services of out-of-state non-participating physicians and providers are not covered unless it is emergency are or services not available in West Virginia and are approved in advance by TPA-C. Such approved services may be paid a negotiated rate, paid in full or most often paid the West Virginia fee allowance. In some circumstances, the insured may be paid directly when the provider is a nonparticipating provider. When a member has seen two physicians NOT working in the same practice, for two separate opinions, and those opinions both suggest getting care out of state, PEIA would usually consider that attempting/failing to find available care in state.

Out-of-State Providers. Out-of-state providers participating in the UnitedHealthCare Choice Plus PPO are paid according to their contractual agreements. For non-participating facilities services are not covered unless it is an emergency, or the services are approved in advance by the TPA-C. With respect to such emergency or approved services, inpatient and outpatient services may be paid on a negotiated rate, paid in full or paid the West Virginia fee allowance. In some circumstances, the insured may be paid directly when the provider is a nonparticipating provider.

Established Relationship. If a member has seen a physician outside of West Virginia for a specific condition and needs to have a follow up visit the same condition or the same diagnosis, PEIA may consider that an established relationship. Seeing the same physician outside of West Virginia for a new problem or condition does not mean that the member has an established relationship with this physician. The establishment is based on a clinical situation, not a person-to-doctor visit. The relationship is establishment only when the previous clinical scenario is being re-addressed. For example, if a member sees an orthopedic doctor in another state for a shoulder diagnoses and then later for a knee diagnoses the member is not considered to have an existing established relationship with that doctor. However, if the same shoulder injury were to recur, the relationship would be considered established.

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 state, who participate. Care for covered services received from a provider in the PEIA PPO by a PEIA insured are generally covered at the highest level of benefit and the services received do not require prior approval.

PEIA PPB Plan D has NO coverage for out-of-state services. Plan D members cannot receive services outside WV, except in a medical emergency or when UMR determines that a needed service is not available within WV. In these cases, out-of-state care is covered as in-network care.

Resident 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 the receive out-of-state care (beyond the bordering county) that has not been previously approved, even if the provider is a member of the UnitedHealthCare Choice Plus PPO.

PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-state coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

Out-of-State Residents. PEIA insureds who live beyond the bordering counties of West Virginia may seek care from a UnitedHealthCare Choice Plus PPO participating provider at any time without prior approval for covered services. Covered services from a UnitedHealthCare Choice Plus PPO participating provider that have not received prior approval will be covered at the highest level of benefit for out-of-state residents only.

PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-state coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside west Virginia. All other services must be provided within West Virginia.

Emergency Out-of-State Care. If any PEIA insured who is a resident of West Virginia or a bordering county must seek true 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 are not covered.

Sanctioned Providers. Providers, both in and out of state, who are under sanction by Medicare, Medicaid or both are excluded from PEIA's network for the duration of their sanction. Additionally, providers may be excluded from PEIA's network based upon adverse audit findings. If you have questions about a specific network provider, please contact UMR at 1-888-440-7342.

V.5. 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 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;
- 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:

Allergy Services. Including testing and related treatment; in-network care is covered with applicable coinsurance after deductible is met. Allergy testing (for more than 70 tests) requires precertification.

Ambulance Services

- Local Ground Transportation: Services are covered when medically necessary 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. Non-medically necessary, non-emergency ground transportation is not covered.
- Non-Local Ground Transportation: Transportation of a patient between a hospital which does not offer the required service to the nearest hospital which is able to provide those services is covered when medically necessary.
- Air Ambulance Transportation: Expenses for air ambulance services are covered up to the PEIA allowance if the services are medically necessary and the services provide

transportation to the nearest hospital able to provide the treatment. The PEIA allowance for air-ambulance is the current Medicare Rural rate. The benefit limit for air ambulance services is $25,000. Non-emergency air ambulance transportation requires precertification and is generally not covered.

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

- Except in circumstances above, non-emergency transportation is not covered.

Ambulatory Surgery. This benefit is subject to a $100 copayment and applicable coinsurance after the deductible has been met. See "Outpatient Surgery".

Annual Routine Physical and Screening Examination. The PEIA PPB Plans cover a routine physical exam once every year for insureds age 16 and over. Exams may be provided more often if the patient's medical history indicates a need, but these additional visits are subject to copayments. The Routine Physical and Screening Examination office visit, generally, includes, but is not limited to all health risk screenings and prevention counseling based on the age and gender of the patient required under the Patient Protection and Affordable Care Act (PPACA), Diagnostic testing, lab and x-rays, provided in conjunction with a routine physical are covered, if mandated under the PPACA or if medically necessary and billed with a medical diagnosis. PPACA screenings are covered at 100%. The applicable deductible and coinsurance will apply to other testing billed with a medical diagnosis. Only the screenings specifically required under PPACA or listed in this section, will be covered as routine screenings.

Autism Spectrum Disorder. Applied behavior analysis (ABA) services, to the extent mandated by W.Va. Code §5-16-7(a)(8), when provided in-network are covered with applicable coinsurance after the deductible is met.

Bariatric surgery. This benefit is subject to a $500 copayment and applicable coinsurance after the deductible has been met. Must meet plan guidelines.

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

- 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; and

- 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 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 with applicable coinsurance after the deductible is met.

- 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 applicable coinsurance after the deductible is met.

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 with applicable coinsurance after the 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. Plan approved 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 Pain Management and Rehabilitative Outpatient Services Benefit (see below) and are covered. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. Coverage may be extended beyond the 20-visit limit for members in case management due to a catastrophic illness or injury, if approved in advance by UMR. Initial 20 visits require a $20 copayment per visit. Visits 21+, if approved by UMR, require a $25 copayment per visit and applicable coinsurance after the deductible is met. Office visits are subject to a copayment and x-rays are covered with applicable coinsurance after the deductible is met. Preauthorization is recommended for services for children under age 16. See Pain Management and Rehabilitative Outpatient Services for more information.

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 may be subject to the applicable office visit copayment.

Table: Preventive Care PPB Plan Benefits for PEIA

Benefit	Coverage

Colorectal Cancer Screening*	100% coverage in-network; 60% out-of-state, in-network, without approval. This benefit is covered as follows: 82270 Fecal-occult blood tests – 1 in 12 months/age 50 and over 45330 Flexible Sigmoidoscopy – 1 in 5 years/age 50 and over 45378 Colonoscopy – 1 every 24 months/high risk** patients or 1 every 10 years/age 50 and over 74280 X-ray, barium enema – 1 in 5 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.)

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 with applicable coinsurance after the $500 copayment and deductible are 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. The Least Expensive Professionally Acceptable Alternative Treatment (LEPAAT) for accident-related dental services will be covered. For example, the dentist may recommend a crown, but the Plan will only provide reimbursement for a large filing. Contract UMR 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 UMR within the initial six months.

Dental Services (impacted teeth). Medically necessary extraction of impacted teeth is covered with applicable coinsurance after the $500 copayment and deductible are met. Extractions for the purpose of orthodontia are not covered.

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 with applicable coinsurance after the 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 diabetes are covered expenses when the program has been reviewed, determined to meet national standards for diabetes education programs and approved by PEIA. The TPA-C should be contacted to see if the program being considered is approved.

Dietician Services. Services of a licensed, registered dietician are covered with the appropriate office visit copayment. Coverage is limited to two visits per year when prescribed by a physician for adult members with chronic medical conditions. Benefit maybe extended to children who meet criteria.

Durable Medical Equipment (DME) and Prosthetics. Standard durable medical equipment is covered expense. Precertification is required for all DME purchases of $1,500, or more, or rentals of $500 or for 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. Omnipod and other disposable insulin delivery systems are not covered.

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 (office visit) 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, ear plugs, and ear molds are not covered expenses.

Emergency Room Services (including supplies; for the first six visits in a Plan Year)*. Services received in an emergency room when the condition has been certified as an emergency are subject to a $100 copayment and applicable coinsurance. The copayment and coinsurance amounts apply after the annual deductible has been met.

Emergency Room Treatment (for the first six visits in a Plan Year)*. Services received in an emergency room when the condition is determined to be a non-emergency are subject to a $100 copayment and applicable coinsurance after the deductible is met. Members who visit the emergency room for non-emergency services an excessive number of times may be placed on case management or otherwise have payment for their ER services restricted or terminated by the PEIA Plans.

Emergency Room Treatment over six visits in a plan year (Including supplies, testing, consultation, and all associated costs)*. Emergency Room treatment should only be used when there is an actual "Emergency Medical Condition". An emergency medical condition is defined by applicable State law as:

"Emergency medical condition" that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected (by a prudent layperson) to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of a bodily part or organ.

If you have such a condition, PEIA urges you to go immediately to a hospital emergency room.

However, use of the emergency room for non-emergency care is an appropriate and very expensive for the member and the PEIA Plans.

After the sixth emergency room visit by a policyholder and their dependent(s) in a Plan Year, any emergency room visits will be assumed to be non-emergency care and will not be covered (including associated costs). However, the member may appeal these claims and if, upon appeal, the claim is shown by the member to be for an actual emergency medical condition, the claim will be adjusted and paid the same as an emergency room, claim for the first six visits per policyholder per plan year.

*Emergency Room services arising out of high risk behaviors are subject to an additional five-hundred-dollar ($500.00) copayment. These include but are not limited to: injuries from riding an ATV/UTV or motorcycle without a helmet; DUI/DWI or drug related accidents; and failure to wear seatbelts.

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 include a lens implant. Vision therapy services indicated by a medical diagnosis are also covered. Preauthorization is recommended, and this benefit is subject to the 20-visit outpatient therapy benefit limit.

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

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

- Diagnostics services (such as X-rays and lab work);
- Orthotics (precertification is required);
- Treatment of bunions, neuromas, hammertoe, hallux valgus, calcaneal spurs or exostosis;
- 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 with no deductible or coinsurance. Annual screening pap smears and mammograms are covered at 100% and are not subject to deductible, coinsurance or copayments.

Disease Management Program. The Disease Management Program identifies those individuals who have certain chronic diseases and would benefit from this program. Specially trained nurses work telephonically with members to help them improve their chronic diseases and maintain quality of life. UMR identifies individuals with one or more of the seven targeted chronic conditions:

1. Asthma,
2. coronary artery disease,
3. congestive heart failure,
4. chronic obstructive pulmonary disease,
5. diabetes,

6. hypertension, and
7. depression as a comorbidity linked to another chronic condition we manage.

Identified members are invited to participate in the appropriate Disease Management program, and then work with specially trained nurses through phone calls and printed materials to learn more about their condition and how to manage it.

In addition to the telephonic services, UMR Disease Management also provides HealtheNotes. These targeted mailings are sent to members' homes and to their health care providers. They identify chronic condition gaps in care and include information on ways to prevent long-term issues and avoid health care costs.

HealtheNotes provide useful, personalized information based on an individual member's health care utilization, including information on provider visits, prescriptions, and health screenings. HealtheNotes is an educational tool in the Disease Management Program for managing a member's chronic condition(s).

Hemophilia Disease Management Program. To provide quality care at a reasonable cost, PEIA has partnered with the Charleston Area Medical Center (CAMC) and West Virginia University Hospitals (WVUH) to provide a Hemophilia Care Program to PEIA PPB Plan members. Members who participate in the program will be eligible for the following benefits:

- An annual evaluation by specialists in the Hemophilia Disease Management Program which will be paid at 100% with no deductible, copay or coinsurance. (This evaluation is not intended to replace, or interrupt care provided by your existing provider or specialists. This evaluation does not include routine or sick care visits with your doctor or ER).
- Hemophilia factor expenses incurred at CAMC or WVUH will be paid at 100% with no deductible, copay or coinsurance.
- Reimbursement for travel and lodging for an annual evaluation
    a) Child and 1 or 2 parents
    b) Adult and an accompanying adult
    c) Lodging will be at an approved hotel for a maximum of two (2) nights for one room only.
    d) Gas will be reimbursed at the federal rate for one vehicle only.
    e) Receipts for food will be paid at 100% for the child and parents or for the 2 adults.

Lodging and Travel Expenses:

Lodging expenses include:

a) a) Expenses incurred by the patient traveling between his or her home and the participating facility to receive services in connection with the Hemophilia Disease Management Program.
b) b) Expenses incurred by the patient's companion to enable the patient to receive services from the Hemophilia Disease Management Program.

1. For children under the age of 18, lodging will be covered for one (1) or two (2) parents.
2. For patients over the age of 18, lodging will be covered for one (1) companion.

Lodging will be covered at 100% of the charge at an approved hotel.

Travel expenses (gas & meals) include:

1. Expenses incurred while traveling with the patient between the patient's home and the medical facility to receive services in connection with the Hemophilia Disease Management program.
2. Gas receipts are required for reimbursement.
3. Reimbursement of meal expenses up to $30 per day per person. Receipts are required for the reimbursement of meals.

All claims must be submitted within the six-month timely filing period, including the submission of all travel expenses.

For more information about this program please contact: UMR at 1-888-440-7342.

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 pre-certified by the TPA-UM, if more than twelve (12) visits are necessary.

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 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 denied by Workers' Compensation; and
- Days for which the patient has a therapeutic leave of absence pass.

Hyperbaric Oxygen Therapy. Covered with applicable coinsurance after the deductible is met.

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. Unless specifically excluded, all immunizations with FDA-licensed vaccines are covered when recommended by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) or the American Academy of Family Physicians (AAFP).

- Childhood immunizations from birth through age 16, as recommended by the ACIP or AAP, are payable at 100% of the PEIA allowed amount and are not subject to a deductible, coinsurance or copayment (see Pediatric Care in this Section). This coverage includes immunizations listed on the ACIP "Recommended Childhood and Adolescent Immunization Schedule" and all others recommended by ACIP or AAP, whether routine or administered for certain circumstances, such as when traveling aboard.
- Routine office visits at the time of immunization are also covered at 100% of the allowed amount for children through age 16, without a deductible, coinsurance or copayment.
- For adults and children over 16, routine immunizations provided and administered in a physician's office as recommended by the ACIP, AAP or AAFP and/or listed on the ACIP's periodicity schedules of recommended adolescent and adult immunizations are covered at 100% of the PEIA allowed amount. If purchased at a pharmacy, the member will be reimbursed according to PEIA's fee schedule.
- All other non-routine immunizations recommended by the ACIP, AAP or AAFP for adults and children over 16 are covered at 80% in-network and 60% for out-of-network, after the OOSINNA deductible has been met.
- An in-network Annual Well visit for an insured age 17 and over is covered at 100% with no coinsurance, copay or deductible.

If a new vaccine is recommended by the ACIP, AAP or AAFP as a routine immunization after the annual release of the ACIP childhood, adolescent or adult immunization schedules, then PEIA will cover this routine immunization at 100% of the PEIA allowed amount, effective from the date of FDA licensure.

Any immunization not recommended by the ACIP, AAP or AAFP will be paid at the normal copayment for the offices visit with applicable coinsurance after the deductible has been met.

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

- In vitro fertilization;
- GIFT (gamete intrafallopian transfer);
- Embryo transport;
- Surrogate parenting;

- Donor semen; and

- All other methods of artificial insemination.

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 with applicable coinsurance after the copayment and the deductible are met. *In addition to the penalties discussed*, all unapproved out-of-network inpatient admissions are not covered.

Inpatient Medical Rehabilitation Services. When ordered by a physician, coverage is subject to applicable coinsurance after the deductible is met and is limited to 150 days per plan year. In addition to penalties for failure to obtain precertification, all unapproved out-of-network inpatient admissions are not covered.

Intensive Modulated Radiation Therapy (IMRT). Covered with applicable coinsurance after the deductible is met.

Massage Therapy. Therapeutic services by a provider licensed to perform massage therapy for treatment of neuromuscular-skeletal conditions are covered under the Outpatient Therapy benefit when ordered by a physician. Initial 20 visits require a $10 copayment and applicable coinsurance per visit. Coverage may be extended beyond the 20-visit limit for members in case management due to a catastrophic illness or injury, if approved in advance by UMR. Visits 21 +, if approved by UMR, require a $25 copayment per visit. Maintenance services are not covered. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. See Outpatient Therapy Services for more information.

Therapeutic 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. Documentation of the treatment plan and physician's prescription must be submitted to UMR with the initial claim.

PEIA requires that all Massage Therapists follow appropriate "Medical Massage Treatment Guidelines" as stipulated in PEIA's Massage Therapy Policy.

Mastectomy and follow-up. 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 lymphedemas.

Maternity Care. Benefits are payable for the policyholder, the policyholder's spouse and covered dependents. 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 with applicable coinsurance 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 with applicable coinsurance 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.

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

You will need to contact UMR 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.

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of long-term hospital stays for both mothers and babies. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the member's risk level and educational needs. The program uses incentives in order to increase participation and encourage program completion.

UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they are pregnant. Members self-enroll in the pre-pregnancy coaching program by calling UMR's toll-free number. They are then contacted by nurse case managers who have extensive clinical backgrounds in obstetrics/gynecology. The nurses complete pre-pregnancy assessments to determine risk levels, if any, and provide members with education and materials based on their needs.

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.

- CPT Codes for consultation services (99241 through 99255) are not covered when billed as such. However, consultations may be billed, when ordered by the attending physician, with the appropriate E & M code.

Medical Supplies. Supplies for ostomy and colostomy are covered if a letter from 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. Cases requiring more than 20 visits 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 with applicable coinsurance after the $100 copayment and the in-network deductible are met. Unapproved out-of-network inpatient care is not covered.

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 with applicable coinsurance after the deductible is met.

MRA. Magnetic Resonance Angiography services when performed on an outpatient basis are covered with applicable coinsurance after the deductible is met.

MRI. Magnetic Resonance imaging services of the knee and spine, including cervical, thoracic and lumbar require precertification. All other MRI services on an outpatient basis are covered with applicable coinsurance after the deductible and applicable copayment.

Neuromuscular stimulators and bone growth stimulators when criteria are met are covered with applicable coinsurance after the deductible is met.

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.

Oral Conditions (See also "Dental Services"). These services for mouth, teeth, and gum care are covered expenses:

- Accident-related dental services limited to the least expensive professionally acceptable alternative treatment, including extraction, oral examinations, repair to damaged teeth, replacement with prosthetic (false) teeth or replacement of existing prostheses;

- Medically necessary oral surgery, limited to orthognathic and ridge reconstruction;

- Diagnosis of myofascial 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, initial treatment must occur within 72 hours of the accident, 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 per transplant 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.

Transplant services at non-network facilities are not covered, unless approved in advance by the TPA-UM 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.

Outpatient or Inpatient Care/Mental Health/Substance Abuse: Covered mental health and substance abuse expenses include:

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

These services are not covered:

- Chemical dependency treatment when the patient leaves care against medical advice;
- Residential treatment;
- 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

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

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

The following procedures/services must be pre-certified:

1. All admissions to out-of-state hospitals/facilities
2. All admissions to rehabilitation or skilled nursing facilities
3. Ambulance Service for Non-Emergency transport, including air ambulance
4. Any potentially experimental/investigational procedure, medical device, or treatment
5. Autism Spectrum Disorder services
6. Chelation Therapy
7. Continuous glucose monitors
8. Durable medical equipment purchases and/or rentals of $500 per month rental or $1500 per purchase or more
9. Elective (non-emergent) facility to facility air ambulance transportation
10. Electroconvulsive shock therapy (ECT) and Trans magnetic stimulation (TMS)
11. Heart Perfusion Imaging
12. Home health care and/or IV therapy in the home
13. Hyperbaric Oxygen Therapy (HBOT)
14. Limited Molecular Diagnostic/Genetic Testing used to diagnose or treat disease. Examples include: Hereditary Non-Polyposis Colorectal Cancer (HNPCC) testing, BRCA gene testing, Oncotype DX breast cancer assay, Familial Adenomatous Polyposis (FAP) testing, Catecholaminergic Polymorphic Ventricular Tachycardia (FPVT) testing
15. Inpatient Mental Health and substance abuse treatment

16. Outpatient CTA (CT angiography)
17. Outpatient Dialysis Services
18. Outpatient IMRT (intensity modulated radiation therapy)
19. Outpatient MRI scan of the breast or spine (includes cervical, thoracic, and lumbar)
20. Outpatient PET Scans
21. Oxygen rental and supplies, with the exception of oxygen concentrators
22. Partial/day mental health or substance abuse treatment programs
23. Sleep studies, services and equipment.
24. Specialty drugs provided in a physician's office, by a pharmacy or mail order
25. SPECT (single photon emission computed tomography) of brain or lung
26. Stereotactic Radiation Surgery and Stereotactic Radiation Therapy
27. Surgeries
    a) artificial disc surgery
    b) bariatric surgery
    c) cochlear implants
    d) discectomy with spinal fusion surgery
    e) Potentially cosmetic surgeries including but not limited to abdominoplasty, blepharoplasty, breast reduction, breast reconstruction, panniculectomy, penile implants/vascular procedures, otoplasty, rhinoplasty, scar revision, testicular prosthesis, and surgery for varicose veins
    f) Endoscopic treatment of GERD
    g) hysterectomy
    h) implantable devices including, but not limited to: implantable pumps, spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators
    i) knee arthroscopy
    j) laminectomy, including laminectomy with spinal fusion surgery
    k) spinal fusion surgery
    l) total joint replacement
    m) transplants
    n) uvulopalatopharyngoplasty
    o) Vertebroplasty, Kyphoplasty, and Sacroplasty
28. Transplants and transplant evaluations (including but not limited to: kidney, liver, heart, lung and pancreas, small bowel, and bone marrow replacement or stem cell transfer after high dose chemotherapy)

Outpatient Therapy Benefit. Coverage for the following outpatient therapies is combined into one benefit and is available with applicable coinsurance after the deductible is met. The benefit is limited to a maximum of 20 visits per person per plan year for all the therapies combined. Coverage may be extended beyond the 20-visit limit for members in case management due to a catastrophic illness or injury, if approved in advance by UMR. Maintenance services are not covered. Initial 20 visits require a $10 copayment per visit. Visits 21+, if approved in advance by UMR, require a $25 copayment per visit.

- **Massage Therapy.** When ordered by a physician, therapeutic massage therapy services of a licensed massage therapist are covered with applicable coinsurance after the deductible and $10 or $25 copayment (details above) are met.
- **Outpatient Speech Therapy.** When ordered by a physician, this benefit is covered with applicable coinsurance after the deductible and $10 or $25 copayment (details above) are met.
- **Vision Therapy.** This benefit is covered with applicable coinsurance after the deductible and $10 or $25 copayment (details above) are met.

Pain Management and Rehabilitative Outpatient Services. Coverage for the following outpatient therapies is combined into one. The benefit is limited to a maximum of 20 visits per person per plan year for all the therapies combined. Coverage may be extended beyond the 20-visit limit for members in case management if approved in advance by UMR. Initial 20 visits require a $20 copayment per visit. Visits 21+, if approved in advance by UMR, require a $25 copayment per visit and applicable coinsurance after the deductible is met.

- **Chiropractic Treatment.** Services of a chiropractor for treatment of neuromuscular-skeletal conditions are covered with the cost-sharing described above. Office visits are subject to a copayment and x-rays are covered with applicable coinsurance after the deductible is met.
- **Occupational Therapy.** This benefit is covered with the cost-sharing described above.
- **Osteopathic Manipulations.** Services of an osteopathic physician to eliminate or alleviate somatic dysfunction and related disorders are covered with the cost-sharing described above..
- **Outpatient Physical Therapy.** This benefit is covered with the cost-sharing described above.

Pap Smear. An annual Pap smear and the associated office visit to screen for cervical abnormalities are covered. The screening is covered in full if conducted as a part of the Routine Physical and Screening Exam, or with a $10 preventive care office visit copayment, if not. When billed with a medical diagnosis (instead of as screening test), it is considered a diagnostic test, and the deductible and applicable coinsurance will apply.

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 Pediatric from birth through age 16 covered at 100% and no deductible, copayment or coinsurance is required.

Physical Therapy. This benefit is included in the Pain Management and Rehabilitative Outpatient Services Benefit (see above) and coverage for the combined therapies is limited to 20 visits per person per Plan Year. This service is covered 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 copayment.

Prescription Drugs. Most prescription drugs are covered under the Prescription Drug Plan.

Preventive Care. The following services are covered in full in-network for all PEIA PPB Plans. The services are covered with no copayment only to the extent mandated by the Federal Patient Protection and Affordable Care Act (the Act). If the Act no longer mandates 100% coverage, the services will be subject to normal copayments applicable to similar services:

Type of Service	Your In-Network Cost
Covered Preventive Services for Adults	
Abdominal Aortic Aneurysm one-time screening for men aged 65-75 who have ever smoked	$0; Covered in Full
Alcohol Misuse screening and counseling	$0; Covered in Full
Aspirin use for men and woman of certain ages (requires a prescription; covered under prescription drug plan	$0; Covered in Full
Blood Pressure screening for all adults	$0; Covered in Full
Cholesterol screening for men age 35 and older and women age 45 and older or others at high risk	$0; Covered in Full
Colorectal Cancer screening for adults over 50	$0; Covered in Full
Depression screening for adults	$0; Covered in Full
Type 2 Diabetes screening for adults with high blood pressure	$0; Covered in Full
Diet counseling for adults at higher risk for chronic disease	$0; Covered in Full
HIV screening for all adults at higher risk	$0; Covered in Full
Immunization vaccines for adults-doses, recommended ages, and recommended populations vary: Hepatitis A — Hepatitis B Herpes Zoster — Human Papillomavirus Influenza (Flu Shot) — Measles, Mumps, Rubella Meningococcal — Pneumococcal Tetanus, Diphtheria, Pertussis — Varicella	$0; Covered in Full
Obesity screening and counseling for all adults	$0; Covered in Full
Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk	$0; Covered in Full
Tobacco Use screening for all adults and cessation interventions for tobacco users aged 18 and over (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	$0; Covered in Full
Syphilis screening for all adults at higher risk	$0; Covered in Full
Vitamin D for men and women of certain ages (requires a prescription; covered under prescription drug plan)	$0; Covered in Full

Covered Preventive Services for Women, Including Pregnant Women	
Anemia screening on a routine basis for pregnant women	$0; Covered in Full
Bacteriuria urinary tract or other infection screening for pregnant women	$0; Covered in Full
BRCA counseling about genetic testing for women at higher risk	$0; Covered in Full
Breast Cancer Mammography screenings every year	$0; Covered in Full
Breast Cancer Chemoprevention counseling for women at higher risk	$0; Covered in Full
Breastfeeding comprehensive support and counseling from trained providers, as well as Access to breastfeeding supplies, for pregnant and nursing women*	$0; Covered in Full
Cervical Cancer screening for sexually active women	$0; Covered in Full
Chlamydia Infection screening for younger women and other women at higher risk	$0; Covered in Fu
Contraception: Food and Drug Administration-approved contraception methods, sterilization procedures, and Patient education and counseling (contraceptives require a prescription; covered under the prescription drug plan)	$0; Covered in Full
Domestic and interpersonal violence screening and counseling for all women*	$0; Covered in Full
Folic Acid supplements for women who may become pregnant (requires a prescription; covered under prescription drug plan)	$0; Covered in Full
Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk	$0; Covered in Full
Gonorrhea screening for all women at higher risk	$0; Covered in Full
Hepatitis B screening for pregnant women at their prenatal visit	$0; Covered in Full
Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women	$0; Covered in Full
Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years For women with normal cytology results who are 30 or older*	$0; Covered in Full
Osteoporosis screening for women over age 60 depending on risk factors	$0; Covered in Full

Types of Service	Your In-Network Cost
Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk	$0; Covered in Full
Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	$0; Covered in Full
Sexually Transmitted Infections (STI) counseling for sexually active women	$0; Covered in Full
Syphilis screening for all pregnant women or other women at increased risk	$0; Covered in Full
Well-woman visits to obtain recommended preventive services	$0; Covered in Full
Covered Preventive Services for Children	
Alcohol and Drug Use assessments for adolescents	$0; Covered in Full
Autism screening for children at 18 and 24 months	$0; Covered in Full
Behavioral assessment for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.	$0; Covered in Full
Blood Pressure screening for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.	$0; Covered in Full
Cervical Dysplasia screening for sexually active females	$0; Covered in Full
Congenital Hypothyroidism screening for newborns	$0; Covered in Full
Depression screening for adolescents	$0; Covered in Full
Developmental screening for children under age 3, and surveillance throughout childhood	$0; Covered in Full
Dyslipidemia screening for children at higher risk of lipid disorders. Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.	$0; Covered in Full
Fluoride Chemoprevention supplements for children without fluoride in their water source (requires a prescription; covered under the prescription drug plan)	$0; Covered in Full
Gonorrhea preventive medication for the eyes of all newborns	$0; Covered in Full
Hearing screening for all newborns	$0; Covered in Full

Height, Weight and Body Mass Index measurements for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	$0; Covered in Full
Hematocrit or Hemoglobin screening for children	$0; Covered in Full
Hemoglobinopathies or sickle cell screening for newborns	$0; Covered in Full
HIV screening for adolescents at higher risk	$0; Covered in Full
Immunizations vaccines for children from birth to age 18-doses, recommended ages, and recommended population vary: Diphtheria, Tetanus, Pertussis — Haemophilus influenza type b Hepatitis A — Hepatitis B Human Papillomavirus — Inactivated Poliovirus Influenza (Flu Shot) — Measles, Mumps, Rubella Meningococcal — Pneumococcal Rotavirus — Varicella	$0; Covered in Full
Iron supplements for children ages 6 to 12 months at risk for anemia (requires a prescription; covered under the prescription drug plan)	$0; Covered in Full
Lead screening for children at risk of exposure	$0; Covered in Full
Medical History for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.	$0; Covered in Full
Obesity screening and counseling	$0; Covered in Full
Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.	$0; Covered in Full
Phenylketonuria (PKU) screening for this genetic disorder in newborns	$0; Covered in Full
Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk	$0; Covered in Full
Tuberculin testing for children at higher risk of tuberculosis Ages: 0 to 11 months, 1 to 4 years, 11 to 14 years, 15 to 17 years.	$0; Covered in Full
Vision screening for all children	$0; Covered in Full

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 annual preventive care are paid at 100%, while other physician services are covered with the applicable coinsurance after the deductible is met.

Prostate Cancer Screening. Coverage is provided for an annual office visit and exam to detect prostate cancer in men age 50 and over. The screening is covered in full if conducted as a part of the Routine Physical and Screening Exam, or with preventive care office visit copayment, if not. The PSA blood test associated with this screening, when ordered by a physician, is covered at 100% with no deductible or coinsurance in-network.

Prostheses and Implants. Covered expenses include:

- Artificial eyes, limbs, larynx, and other standard 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 3 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 reconstruction 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.

Diagnostic testing, lab and x-rays, provided in conjunction with a routine physical are covered, if mandated under the PPACA or if medically necessary and billed with a medical diagnosis. PPACA screenings are covered at 100%. The deductible and applicable coinsurance will apply to other testing billed with a medical diagnosis. Only the screenings specifically required under PPACA and specifically listed in this Plan Document or the PEIA SPD, will be covered as routine screenings. To the extent 100% coverage is not mandated by PPACA the screenings will be subject to copayments.

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 and is subject to a copayment.

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.

Sleep Management Services. The PEIA PPB Plans cover services for the diagnosis and treatment of sleep apnea and other sleep-related conditions that can affect your health. To ensure compliance and to administer prescribed sleep services at the highest quality, UMR, the third-party administrator for PEIA, has contracted with CareCentrix to provide sleep diagnostic and therapy management services for PPB Plan members. A precertification process has been

established to qualify services as medically necessary and appropriate. PEIA requires that the ordering physician request approval from CareCentrix prior to a member receiving sleep services that include sleep testing, sleep therapy or sleep therapy supplies and services out of state.

Using evidence-based guidelines, CareCentrix will review your request for a sleep study and make recommendations for those studies that can be performed in the member's home. If the member is appropriate for a diagnostic home sleep study, the member will be directed to a CareCentrix-contracted home sleep testing provider.

In addition to managing sleep testing services, CareCentrix also manages PAP therapy services by providing prior approval for PAP therapy and supply requests. CareCentrix directs the member to a CareCentrix-contracted DME provider. In addition, CareCentrix provides comprehensive support for members' prescribed PAP therapy to provide assistance with adherence to therapy through the iComply program.

To obtain prior authorization for sleep services, you may call CareCentrix at 1-888-49-SLEEP (75337), or you may fax your request to 1-888-571-8816 using the Prior Authorization Fax Form found at http://help.carecentrix.com/ProviderResources/PEIA_Health_Fax_Request_form.pdf. Non-resident PPB Plan members must call UMR for precertification of sleep management services

Specialty Injectable Medications. Coverage is provided for treatments utilizing specialty drugs through a program managed by UMR. Injectables covered under the medical benefit plan are covered with applicable coinsurance after the deductible is met. Injectables covered under the prescription drug program are covered with a $100 copay after the prescription drug deductible is met if on the West Virginia Preferred Drug List and a $150 copay if not on the West Virginia Preferred Drug List. Many specialty medications have manufacturer programs which will financially assist patients in the purchase of the medication. PEIA requires that if a financial assistance program is available, you must participate in the program. Only your actual out-of-pocket payments will count toward your drug deductible; and annual out-of-pocket maximum. Amounts discounted off the price by the manufacturer or seller of the specialty medication do not count.

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 20 visits 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.

Single Photon Emission Computed Tomography (SPECT). Of the brain or lung requires precertification. All other SPECT is covered with applicable coinsurance after the deductible is met.

Surgery. To assure an insured has the right type of care and full benefits under the Medical Benefits Plan, some surgeries must be reviewed in advance by the TPA-UM.

Precertification is required for these surgeries:

- Hysterectomy;

- Artificial Disc surgery;
- Cataract surgery;
- Cochlear implants;
- Colonoscopy (out-of-state only);
- Discectomy with spinal fusion surgery;
- Knee arthroscopy;
- Laminectomy;
- Insertion of implantable devices including, but not limited to vascular access, implantable pumps spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators;
- Uvulopalatopharyngoplasty;
- Elective and cosmetic surgeries including, but not limited to breast reduction, blepharoplasty, abdominoplasty, breast reconstruction, Panniculectomy, Penile implants/vascular procedures otoplasty, rhinoplasty, scar revision, testicular prosthesis, and surgery for varicose veins;
- Bariatric surgery (including, but limited to: gastric bypass, lap-band, sleeve gastrectomy, etc.);
- Spinal fusion surgery;
- Total joint replacement;
- TTE Transthoracic Echocardiogram;
- Transplants;
- Vertebroplasty, Kyphoplasty, Scroplasty; and
- All admissions to out-of-state hospitals/facilities.

Covered expenses generally include:

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

These surgical expenses are not covered:

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

Other special provisions

- If two or more surgical procedures are performed on the same day, the allowance for the second through fifth procedure is covered at 50% of the allowed amount. The sixth procedure requires special review by the TPA-UM.

- Certain surgeries require precertification by the TPA-UM. These are listed above.

- 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 Plans A, B, & D provide benefits for participants who wish to quit smoking or using smokeless tobacco products. Only those members who have been paying the Standard (tobacco-user) premium are eligible for the Tobacco Cessation benefit. if you signed an affidavit claiming to be tobacco-free, you will be declined the Tobacco Cessation benefit.

To access the benefits, simply visit your primary care provider. PEIA will cover an initial and follow-up visit to your physician or nurse practitioner. PEIA covers both prescription and non-prescription tobacco cessation medications if they are dispensed with a prescription.

PEIA will cover a total of two 12-week cycles of drug therapy, even if more than one type of therapy is used. If extended therapy is required, the provider must submit a written appeal to the Director of PEIA with proof of medical necessity.

You can use the benefit (office visits and prescriptions) twice per year (rolling 12-month period).

For pregnant participants, PEIA will provide 100% coverage for the tobacco cessation benefit during any pregnancy.

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 correction a covered medical condition. Preauthorization is recommended, but precertification is required beyond the 20 visit Outpatient Therapy Benefit amount. Coverage is with applicable coinsurance after the in-network deductible is met.

Weight Management Program. PEIA offers a facility-based weight management program for PEIA PPB members who meet the program qualifications and are willing to make the necessary commitment to the program. Members will be subject to monthly program compliance checks and must meet certain goals to continue in the program. To participate in the PEIA Weight Management Program, PPB Plan Members must have a Body Mass Index of 30 or greater; or a waist circumference of 35 inches or greater (for women) or 40 inches or greater (for men). The program includes comprehensive services from registered and licensed dietitians, degreed exercise physiologists and personal trainers at approved fitness centers. The current list of participating facilities is on PEIA's website at **www.wvpeia.com**. This is a twice per lifetime benefit with a maximum of 24 months. The program requires a copayment of $20 per month. Members who previously participated in the PEIA Weight Management Program for fewer than 18 months may be eligible for a second program attempt. Members who have exhausted the lifetime benefit, have undergone bariatric or lap band surgery within the last 10 years, or are under age 18, are not eligible for this benefit. To enroll, you must complete the online application, which includes some medical information. For more information, or to enroll in the program, go to **www.wvpeia.com**.

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 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.

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, 30 months, 3 years and 4 years.
- Late childhood: Annually from ages 5 through 12.
- Adolescence: annually from ages 13 through 16.

Adolescents over the age of 16 receive the Annual Routine Physical and Screening Exam benefit described above.

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. The following are specifically excluded from coverage:

1. Acupuncture
2. Aqua therapy
3. Autopsy and other services performed after death, including transportation of the body or repatriation of remains
4. Biofeedback
5. Chemical dependency treatments when a patient leaves the hospital or facility against medical advice
6. Cologuard
7. Coma stimulation
8. Cosmetic or reconstructive surgery when not required as the result of accidental injury or disease, or not performed to correct birth defects. Services resulting from or related to these excluded services also are not covered
9. 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, including applied behavior analysis (ABA), except to the extent ABA is mandated to be covered for treatment of autism spectrum disorder by W.Va. Code §5-16-7(a)(8)
10. Dental implants, whether medically indicated or not
11. Dental services including dental implants, routine dental care, x-rays, treatment of cysts or abscesses associated with the teeth, dentures, bridges, or any other dentistry and dental procedures
12. Daily living skills training
13. Duplicate testing, interpretation or handling fees
14. Education, training and/or cognitive services, unless specifically listed as covered services
15. Elective abortions
16. Electronically controlled thermal therapy
17. Emergency evacuation from a foreign country, even if medically necessary
18. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts
19. Expenses incurred as a result of the commission of a felony, while incarcerated or while under the control of the court system

20. Experimental, investigational or unproven services, unless pre-approved by UMR
21. Fertility drugs and services
22. Foot care. Routine foot care including:
    - Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or 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
23. Genetic testing for screening purposes is generally not covered, unless specifically mandated by the Patient Protection and Affordable Care Act.
24. Glucose monitoring devices or test strips, except Accu-Chek Aviva Plus, Accu-Chek Nano and Accu-Chek Guide models covered under the prescription drug benefit
25. Homeopathic medicine
26. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery
27. Hypnosis
28. Incidental surgery performed during medically necessary surgery
29. 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, including the workup for infertility treatment
30. Maintenance outpatient therapy services, including, but not limited to:
    - Chiropractic
    - Massage Therapy
    - Occupational Therapy
    - Osteopathic Manipulations
    - Outpatient Physical Therapy
    - Outpatient Speech Therapy
    - Vision Therapy
31. Marriage counseling
32. Medical equipment, appliances or supplies of the following types:
    - Augmentative communication devices
    - Bariatric beds and chairs
    - Bathroom scales
    - Educational equipment
    - Environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters
    - 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 (including Hoyer lifts); recliners; contour chairs; adjustable beds; or tilt stands

- Support devices which are widely available over the counter such as prophylactic wrist, ankle and knee supports
- Exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines
- Hearing aids of any type
- Hygienic equipment such as bed baths, commodes, and toilet seats
- Motorized scooters
- Nutritional supplements, over-the-counter (OTC) formula (with the exception of amino acid-based formula for the treatment of severe protein allergic conditions or absorption disorders or infant formula administered through a feeding tube), food liquidizers or food processors
- Omnipod, V-go, Finesse and other disposable insulin delivery systems
- Orthopedic shoes, unless attached to a brace
- Professional medical equipment such as blood pressure kits or stethoscopes
- Replacement of lost or stolen items
- Supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags
- Standing/tilt wheel chairs
- Traction devices
- Vibrators
- Whirlpool pumps or equipment
- Wigs or wig styling

33. Medical rehabilitation and any other services that are primarily educational or cognitive in nature
34. Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning
35. Optical services:
    - Routine eye examinations, refractions, eye glasses, contact lenses and fittings
    - Glasses and/or contact lenses following cataract surgery
    - Low-vision devices, including magnifiers, telescopic lenses and closed-circuit television systems
36. Oral appliances, including, but not limited to, those treating sleep apnea
37. Orientation therapy
38. Orthodontia services
39. Orthotripsy
40. Physical examinations and routine office visits except those covered under the Periodic Physicals benefit
41. 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
42. 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

43. 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
44. Provider charges for phone calls, prescription refills, or physician-to-patient phone consultations
45. Radial keratotomy, Lasik procedure and other surgery to correct vision. Surgery to prevent legal blindness or restore vision from legal blindness is covered, if not correctable by lenses or other more conservative means
46. Reversal of sterilization and associated services and expenses
47. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities
48. Screenings, except those specially listed as covered benefits
49. Service/therapy animals and the associated services and expenses, including training
50. 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
51. Services rendered outside the scope of a provider's license
52. Surgical or pharmaceutical treatments associated with gender dysphoria or any physical, psychiatric, or psychological examinations, testing, treatments or services provided or performed in preparation for, or as a result of, sex transformation surgery
53. Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit
54. Sensory stimulation therapy
55. Take-home drugs provided at discharge from a hospital or any facility
56. 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
57. The difference between private and semi-private room charges
58. Therapy and related services for a patient showing no progress
59. Therapies rendered outside the United States that are not medically recognized within the United States
60. Transportation other than medically-necessary emergency ambulance services, or as approved under the Organ Transplant Network benefit or the Travel Benefit
61. War-related injuries or illnesses. Treatment in a State or Federal hospital for military or service-related injuries or disabilities
62. 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 the Weight Management Program offered by PEIA

63. Work-related injury or illness

V.6. 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. **See Section V.5. Covered Services.** 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 are medically necessary and appropriate based on the patient's medical documentation. Notification to the TPA-UM 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. Admissions for partial hospitalizations and day programs also require prior approval.

Notification:

Notification to the TPA-UM or their sub-contractor, as applicable 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 pre-certify or notify TPA-UM 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 in-state, 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 TPA-UM inappropriately denied an admission or the extension of an admission, or that extenuating circumstances existed that prevented notification to TPA-UM within the timeframes set forth, the insured or provider may file an appeal.

Exception: it is the patient's responsibility to pre-certify inpatient stays and outpatient procedures when these services are received out-of- network. If you do not pre-certify these in-state OOSINNA 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 in-state out-of-network providers does not pre-certify services. Services of non-network out-of-state providers are not covered, except emergency care or certain limited services not available in-state which are approved in advance by the TPA-C.

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

Timely Precertification Requirements	
Type of Admission	**Advance Notice Required**
Scheduled:	
Planned inpatient admission	3 business days in advance
Inpatient or outpatient elective surgery or procedure	3 business days in advance
Maternity (notify UMR during your first trimester)	
Term pregnancy	Within 48 hours of admission
Caesarean section (planned)	3 business days in advance
Caesarean section (emergency)	Within 48 hours of admission
Other Admissions	
Urgent/Emergency service or procedure	Within 48 hours of admission
Extended stay	Additional days may be recommended based on medical necessity

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 pre-certify 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 in-state 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 voluntary 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.

Prior Approval of Out-of-State Services. Non-network out-of-state services are not covered. When West Virginia resident PEIA insureds receive care from out-of-state providers even if they do not participate in the PEIA PPO, the TPA-C must prior approve these services. Prior approval for access to out-of-state providers at the higher level of benefit will usually not be granted if the care is available at in-state providers. Prior approval may be requested by contracting the TPA-C. prior approval for access to non-network out-of-state providers will not be granted if the care is available in-state or in-network.

To be covered, 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 counties with prior approval from UMR is covered at the higher level of benefit 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 UnitedHealthCare Choice Plus PPO without prior approval. Any services from a non-PPO out-of-state provider without prior approval are not covered. In-network, out-of-state care provided without prior approval from the TPA-C is only covered at the lower level of benefit, 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. PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-network coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

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 while maintaining quality care and outcomes. The insured or participating provider, must notify the TPA-UM three (3) business days, where possible, prior to receiving any of the following covered services:

- Home health care for more than twelve (12) 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 of more than (7) seven visits;
- 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
- Pregnancy. 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 out-of-state or out-of-network 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 an out-of-state 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, an in-state provider can successfully treat these chronic conditions. If there is not an in-state 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.

V.7. Claims

In-State Claims. As one of West Virginia's state health care programs, the PEIA uses an electronic claim 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 15 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 that 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 will be processed differently than in-state claims, depending on whether the provider participates in the Out-of-State Provider Network. Non-network out-of-state claims are not covered.

PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-network coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

Out-of-State Provider Networks. Under the current TPA-C contract PEIA insureds have access to the PEIA/UMR Network. 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/UMR Network. 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. Non-network out-of-state claims are not covered.

PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-state coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside west Virginia. All other services must be provided within West Virginia.

Out-of-State Waiver Program. Out-of-state, non-network services are not covered unless approved in advance by the TPA-C. However, PPB Plan insureds who receive services out-of-state from a provider that does not participate in the UnitedHealthCare Choice Plus PPO with prior approval of the TPA-C or in an emergency, 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 program is not available for air-ambulance fees in excess of the PEIA allowance.

PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-state coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

The Director, has sole discretion, to grant the out-of-state waiver under the following circumstances:

1. The PEIA is the primary payor;
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 OOSINNA 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 while traveling 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. Ex-spouses are not eligible regardless of Court Order.

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 or with the PEIA's contracted TPA-C or TPA-P must accept assignment at all times.

V.8. 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 and full reimbursement against the medical payment insurance coverage.

Medicare Coordination. The PEIA PPB Plan will reimburse the difference between the amount allowed by Medicare and the amount paid by Medicare under Medicare Part A and Part B, 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 under Medicare Part A and Part B, and PEIA is the secondary insurer. All medical claims must be submitted to Medicare and then to PEIA along with an Explanation of Medicare Benefits (EOMB). Generally, claims are submitted to Medicare and then to PEIA by your provider or by Medicare through the Medicare Crossover program.

When you become an eligible beneficiary of Medicare, you must enroll in Medicare Part A and Medicare Part B. Part A is an entitlement program and is available without payment of a premium to most individuals. Part B is the supplementary medical insurance program that covers physician services, outpatient laboratory and x-ray tests, durable medical equipment and outpatient hospital care. Part B is a voluntary program that requires payment of a monthly premium. You DO NOT need to enroll in Medicare Part D, the prescription drug program, since PEIA continues to provide prescription drug coverage for retirees with Medicare.

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 UMR 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 UMR or PEIA to determine who the primary insurer will be.

Subrogation and Reimbursement. If the PEIA pays an insured's medical expenses for an illness, injury, disease or disability for which another person's is legally liable, the PEIA has the right of subrogation and reimbursement. This right of subrogation allows the PEIA to be fully 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 full and complete 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 and the right to full reimbursement 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 and full reimbursement constitutes a lien against any settlement or judgment obtained by or on behalf of an insured for recovery of such benefits. Any such settlement or lien shall not preclude PEIA from enforcing its rights under this section.

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, judgement, or arbitration award;

- Accept that the PEIA has the right to seek full 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 and fully 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.

- Notify medical providers that they are covered by PEIA and provide their PEIA I.D. card,
  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 fee and/or other expenses incurred by the PEIA in obtaining the required information or full 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 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 payor, 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 as a matter of State law 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 payor, the above balance billing prohibition does not apply. In addition, the insured cannot be balance billed if the service is provided by participating UnitedHealthCare Choice Plus PPO Provider.

Recovery of Overpayment, Incorrect Payments, or Payments Made for Which a Third-Party is Responsible. The PEIA has the right to 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 has 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 or who fail to provide relevant information such as a divorce or remarriage are subject to termination of coverage. PEIA may term the coverage(s) of dependents determined to be ineligible for coverage(s). In addition, PEIA may proceed with civil or administrative proceedings 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 civil or administrative proceedings to recover any moneys owed it.

In accordance with W.Va. Code § 5-16-12, 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.

V.9. Appeals

An insured or a provider has the right to appeal the denial of a claim or request for service.

PEIA PPB Plans

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. All appeals must be initiated within 120 days of claim payment or denial.

Type of Error	Who to Call	Where to Write
Pre-Service Medical claim or case management denial	UMR Appeals 1-800-808-4424 Ext. 15227	UHC Appeals – UMR P.O. Box 400046 San Antonio, TX 78229 Fax: 1-888-615-6584 Attn: UMR Appeals
Post-Service Medical claim	UMR 1-888-440-7342	UMR P.O. Box 30541 Salt Lake City, UT 84130-0541
Out-of-state care denial or denial of precertification	UMR 1-888-440-7342	UMR P.O. Box 30541 Salt Lake City UT 84130-0541
Prescription drug claim	CVS Caremark 1-844-260-5884	CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-2084
Common Specialty Medications claim	CVS Caremark 1-844-260-5884	CVS Caremark Specialty Appeals Department 800 Biermann Court Mount Prospect, IL 60056
Specialty Injectable Drugs	UMR 1-888-440-7342	UMR P.O. Box 30541 Salt Lake City, UT 84130-0541

If your medical claim or service has been denied, or if you disagree with the determination made by one of the Third-Party Administrators, the second step is to appeal in writing within 120 days of the denial to the Third-Party Administrator at the address listed above. Explain what you think the problem is, and why you disagree with the decision. Please have your physician provide any additional relevant clinical information to support your request. The Third-Party Administrator will respond to you by reprocessing the claim or sending you a letter.

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;
   a. Reason why the claim or service should not have been denied;
   b. The Explanation of Benefits if the claim has been processed; and
   c. Any additional information that supports the insured's or provider's position.

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 the Third-Party Administrator. Facts, issues, comments, letters, Explanations of Benefits (EOBs), and all pertinent information about the case should be included and mailed to: Director, Public Employees Insurance Agency, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345.

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.

External Review: If we have denied your request for the provision of or payment for a health care service or course of treatment, our decision may be reviewed by independent health care professionals who have no association with us if our decision involved making judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. An external review may be initiated by us or requested by you. You may submit a request for external review within four (4) months after receipt of the notice of denial to the PEIA Clinical Unit, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345. For standard external review by your request, a decision will be made within forty-five (45) days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may request an expedited external review of our denial. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may request an external review of our denial. External reviews are the final level of appeal, regardless of whether the external review was initiated by us or requested by you. External review is not available for items or treatments that are simply not covered by the plan or for out-of-state benefit level appeals.

VI: PRESCRIPTION DRUG PLAN

VI.1. Introduction

The PEIA Prescription Drug Plan works in coordination with 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.

PEIA PPB Plan C

This plan is a High Deductible Health Plan that is different than the more traditional PEIA Plans A, B, & D. While the core benefits of Plan C are similar to Plans A and B, & D, the deductibles, copayments, coinsurance, and out-of- pocket expenses are very different. Certain benefits are also treated differently or are not available under Plan C. The Plan C section of the PEIA Summary Plan Description sets out the details of Plan C and should be referred to for Plan C information.

VI.2. 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 $150 per family for Plans A and D, 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.

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

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 deductibles are met, the plan pays on all members of the family. After a member meets their deductible, they will pay copayments or coinsurance based on the amount and the type of drug you're taking.

Copayments. Once an insured's annual deductible has been met, the Prescription Drug (PD) 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 (PD) 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 TPA-P contracted rate plus the dispensing fee, and minus the insured's responsibility. The Insured will be responsible for any difference in the submitted amount and the allowed amount. The allowed amount is usually less than the submitted amount. All prior authorization, step therapy, and quantity limits will still apply.

If you purchase a Maintenance Medication at a non-network pharmacy, you will not be reimbursed for your purchase. Maintenance Medications must be purchased from Retail Maintenance Network pharmacies or using the CVS Caremark Mail Service Pharmacy Program.

VI.3. Copayments (Retiree Drug Copay Assistance)

Medicare-eligible retired employees who are in the MAPD with fifteen (15) years of service, 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 PEIA MAPD or The Medicare Special Plan. Managed care members are not eligible for this program. Applications are mailed to all retired PPB Plan members annually. (See Appendix H).

Prescription Out-of-Pocket Maximum. PEIA has an out-of-pocket maximum on drugs. The maximum is $1,750 for an individual and $3,500 for a family. The maximum is $250 for an individual Medical-eligible retired employee meeting the above requirements for Retiree Drug Copay Assistance. 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 v. Generic. If an insured's doctor prescribes any generic drug, the copayment at a network drug store is $10.00 for up to a 30-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 $25.00 ($30.00 for PEIA PPB Plan B). However, if the medication is a Non-Preferred brand-name drug, the insured will pay a 75% coinsurance amount. Maintenance medications will only be covered for 90-day supplies when purchased from Retail Maintenance Network Pharmacies or CVS Caremark Mail Service Pharmacy.

Non-Preferred Drugs. Non-preferred (tier 3) drugs are brand name drugs that do not appear on the PDL. Non-preferred drugs require 75% coinsurance after the prescription drug deductible.

If your doctor prescribes a non-preferred brand name drug, and you have tried and failed on the generic and preferred brand name alternatives offered by CVS Caremark, your provider may file an appeal to lower your out-of-pocket cost. To file the appeal, your provider must submit medical justification, in writing, to:

CVS Caremark
Attn: Exceptions Dept
1300 E. Campbell Rd.
Richardson, Tx 75081 .
Or fax to: 1-888-487-9257

Your tier appeal, if approved by CVS Caremark, will lower your out-of-pocket cost from 75% of the cost of the drug to the $25 preferred drug monthly copay. The decision by CVS Caremark is final. There is no further level of appeal for a tier exception.

VI.4. 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 PPO 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 PPO 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.

Maintenance medications must be purchased in 90-day supplies at either a Retail Maintenance Pharmacy or from the CVS Caremark Mail Service Pharmacy Program.

Non-Network Providers.

The PEIA will pay for covered 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 TPA-P contracted rate

plus the dispensing fee, and minus the insured's responsibility. The allowed amount is usually less than the submitted amount.

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 must be filled by mail or at a participating retail maintenance pharmacy in a 90-day supply for the price of two copayments (see **Maintenance Drug List** this section) for generic and brand-preferred medications only. 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.

VI.5. 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;
- One Touch Ultra test strips, One Touch Verio test strips, One Touch strips, One Touch Blue test strips;
- Compound medication that received prior authorization and approval;
- Disposable needles/syringes;
- Glucose elevating agents;
- Inspirease spacers;

- Insulin;
- Lancets;
- Legend contraceptives, Oral and injectable contraceptives may be dispensing 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 35 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 is available at a reduced cost. The copayments for drugs listed on the Preferred Drug List (PDL) are $10.00 for generic and $25.00 ($30.00 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;
- Immunosuppressant's – 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, antiparkonism agents, antipsychotic drugs, CNS stimulants;
- Depression – antidepressants;
- Dermatological/Topical – corticosteroids, anesthetics and acne;
- Diabetes – insulin, blood glucose strips, sulfonylureas, insulin sensitizers, oral hypoglycemic;
- Gastrointestinal conditions – H^2 antagonists, proton pump inhibitors to treat ulcers and reflux;

- Glaucoma – alpha agonist, beta blockers, carbonic anhydrase inhibitors, prostaglandin;
- Infections – antibiotics, antifungals, and antivirals to treat common infections like bronchitis, ear infections, toenail and fingernail infections, herpes;
- Migraine – selective serotonin – 1 receptor agonists;
- Topical – anesthetics, corticosteroids, anti-acne drugs, keratolytics, anti-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 http://www.peia.wv.gov.

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:

1. acitretin (Soriatane®)
2. adapalene (Differin®)
3. amphetamines (Adderall XR®, Vyvanse®)
4. anabolic steroids (Anadrol, Oxandrin)
5. armodafinil (Nuvigil®)
6. atomoxetine (Strattera®)
7. becaplermin (Regranex®)
8. buprenorphine (Subutex®)

9. buprenorphine/naloxone (Suboxone®, Bunavail™, Zubsolv®)
10. Butrans Patch
11. Calcitonin gene-related peptide (CGRP) receptor antagonists (Aimovig™, Ajovy™, Emgality™)
12. ciclopirox topical solution (Ciclodan®, Penlac®)
13. chenodiol (Chenodal™)
14. cinacalcet (Sensipar®)
15. Compounded Medications
16. cyclosporine ophthalmic emulsion (Restasis®)
17. dextromethorphan hydrobromide/quinidine sulfate (Nuedexta®)
18. diclofenac sodium gel (Solaraze®, Voltaren®)
19. diclofenac sodium topical solution (Pennsaid®)
20. edoxaban tosylate (Savaysa™)
21. enfuvirtide (Fuzeon®) *
22. Sacubitril/Valsarten (Entresto)
23. fentanyl oral and topical (Abstral®, Actiq®, Duragesic®, Fentora®, Lazanda®, and Subsys™)
24. fluocinonide 0.1% (Vanos®)
25. Hydrocodone Extended Release (Zohydro ER)
26. linezolid (Zyvox®)
27. lidocaine patch (Lidoderm®)
28. lifitegrast (Xiidra®)
29. metformin ext-rel (Fortamet/Glumetza)
30. modafinil (Provigil®)
31. naltrexone extended-release injectable suspension (Vivitrol®)
32. naproxen sodium extended release (Naprelan®)
33. omeprazole sodium bicarbonate (Zegerid)
34. Oral Acne medications (Absorica, Clavaris)
35. PCSK-9 Inhibitors (Praluent®, Repatha®)
36. select medical devices (e.g. Avenova®, Beau Rx, Eletone®, Epiceram®, Gelclair®, HPR Plus™, PromiseB®)
37. select medical devices – artificial saliva (e.g. NeutraSal®, SalivaMAX®)
38. sodium oxybate (Xyrem®)
39. Specialty medications*
40. stimulants (Concerta®, Focalin XR®, methylphenidate)
41. tazarotene (Tazorac®, Fabior®)
42. testosterone products (oral, topical, injectable products)
43. tiopronin (Thiola®)
44. tolvaptan (Samsca®)
45. Topical Antifungals (Jublia, Kerydin)
46. tretinoin cream (e.g. Retin-A) for individuals 35 years of age or older
47. vacation supplies of medication for foreign travel (allow 7 days for processing)
48. vitamin D analogs, topical (Calcipotriene, Calcitrene, Dovonex®, Enstilar®, Sorilux®, Taclonex®, Vectical®)
49. vorapaxar (Zontivity®)

*These drugs must be purchased through the Common Specialty Medications Program

This list is subject to change during the plan year if circumstances arise which require adjustment. Changes will be communicated to members in writing. 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*.

VI.6. 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:

1. Angiotensin II Receptor Antagonists (Benicar, Benicar HCT, Tekturna, Tekturna HCT, Edarbi, Edarbyclor)
2. Anti-depressants (Pristiq®, Aplenzin®, Khedezla®, Fetzima™, Irenka)
3. Antifungal, topical (Ecoza™, Ertaczo®, Exelderm®, Loprox®, Lotrisone®, Luzu™, Mentax®, Naftin®, Oxistat®, Vusion®, Xolegel®)
4. Benign Prostatic Hypertrophy (Cardura/XL®, Rapaflo®)
5. Bisphosphonates (Fosamax Plus D™, Binosto®)
6. Cholesterol-lowering medications (Altoprev®, Crestor®, Vytorin®, Livalo™, Liptruzet™)
7. crisaborole (Eucrisa®)
8. Dermatologicals (doxepin Cr, Prudoxin®, Zonalon®)
9. Insulins (Apidra, Humalog, Humalog Mix, Humulin 70/30, Humulin N, Humulin R, Novolin R Relion, Novolin N Relion, Novolin 70/30 Relion)
10. Febuxostat (Uloric®)
11. Fenofibrates (Triglide®, Fenoglide®)
12. Lyrica®, Gralise®, Horizant®
13. Migraines (Sumavel Dosepro™, Alsuma, Treximet®, Onzetra Xsail, Zembrace)
14. Nasal Steroids (Beconase AQ®, Veramyst®, Omnaris®, Dymista®, Qnasl®, Zetonna®)
15. Non-Steroidal Anti-inflammatory Drugs (brand-name NSAID e.g., Cambia®, Duexis, fenoprofen 200mg, Fenortho 200 mg, Flector®, Pennsaid®, Nalfon, Tivorbex, Vivlodex, Zipsor, Zorvolex)
16. Ophthalmic prostaglandins (Lumigan®, Travatan/Z®, Zioptan®)
17. Opioid pain medications
18. Overactive Bladder: (Oxytrol, Toviaz®, Vesicare®, Enablex®, Gelnique®, Myrbetriq®)
19. Proton Pump Inhibitors (e.g., Dexilant®, Prilosec/Protonix/Zegerid Powder packets, compounding kits for PPI suspension formulations)
20. Sedative Hypnotics (Belsomra, Rozerem™, Edluar™, Zolpimist™, Silenor®)
21. Selective Serotonin Reuptake Inhibitors (e.g., Pexeva, Viibyrd®, Trintellix)

22. Tetracyclines (e.g., Adoxa®, Doryx®, Oracea®, Solodyn®, Oraxyl®, Vibramycin®)
23. Topical Acne products, kits and cleansers (e.g., Acanya, Aczone, Akne-Mycin, Azelex, Clindagel, Fabior, Panoxyl, Riaz, Tretin-X)
24. Topical immunomodulators (Elidel®, Protopic®)

This list is subject to change during the plan year, if circumstances arise which require adjustment. Changes will be communicated to members in writing. 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 (QLL)

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. 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. Acetaminophen and Aspirin containing pain reliever medications are limited to quantities not to exceed 4 grams of acetaminophen or aspirin per day.

2. Amphetamines, methylphenidate and stimulant products to treat ADHD or narcolepsy are subject to limits on quantity within FDA approved doses.

3. Antipsychotic Drugs (Abilify® 30 units, Abilify Discmelt® 60 units, Fanapt™ 60 units, Geodon® 60 units, Invega® varies, Risperdal® 60 units, Saphris® 60 units, Seroquel/XR® varies, Zyprexa® 30 units, and Zyprexa Zydis® 30 units, Latuda® 30 units)

4. Antiemetics:
    - Aloxi® is limited to 2 vials per 21 days.
    - Anzemet® is limited to 6 tablets per 21 days.
    - Anzemet 100/5 & 12.5/0.625 injection is limited to 15ml per 180 days.
    - Akynzeo is limited to 2 capsules per 21 days.
    - Cesamet® is limited to 18 capsules per 30 days.
    - Emend® 40 mg is limited to 3 capsules per 6 months.
    - Emend® 80 mg is limited to 4 capsules per 21 days.
    - Emend® 150 mg vial is limited to 2 vials per 21 days.
    - Emend® 125 mg is limited to 2 capsules per 21 days.
    - Emend® Tri-fold Pack is limited to 2 packages per 21 days.
    - Kytril® is limited to 12 tablets per 21 days.
    - Kytril® 0.1mg/ml is limited to 2ml per 21 days.
    - Kytril® 1mg/ml is limited to 2ml per 21 days.
    - Kytril® 4mg/4ml (1mg/ml) injection is limited to 2ml per 21 days.
    - Marinol is limited to 60 capsules per 25 days.

- Netupitant-Palonosetron is limited to 2 capsules per 21 days.
- Sancuso® is limited to 2 patches per 21 days.
- Varubi is limited to 4 tablets per 21 days.
- Zofran® 24 mg is limited to 2 tablets per 21 days.
- Zofran® 4mg and 8mg are limited to 18 tablets per 21 days.
- Zofran® ODT 4mg and 8mg are limited to 18 tablets per 21 days.
- Zofran® Solution is limited to 200ml per 21 days.
- Zofran® 2mg/ml injection is limited to 20ml per 21 days.
- Zofran® 40mg/20mg (2mg/ml) is limited to 20ml per 21 days.
- Zuplenz® is limited to 18 films per 21 days.

5. Abstral®, Actiq®, Fentora®, Onsolis, Subsys® Coverage is limited to 120 units per 30 days; Lazanda®: Coverage is limited to 30 bottles per 30 days.

6. Benzodiazepines (excluding insomnia) (alprazolam, Ativan®, chlordiazepoxide, clonazepam, diazepam, Klonopin®, lorazepam, Niravam®, oxazepam, Tranxene®, Valium®, Xanax®, Xanax® XR)

7. Buprenorphine/naltrexone containing products (Bunavail™, Suboxone®, Subutex®, and Zubsolv®) is limited to 24mg in initial 60-day period then 16mg.

8. Cholesterol Lowering Medications. (Advicor® varies, Caduet® 30 units, Vytorin® 30 units, Altoprev® 30 units, Crestor® 30 units, Lescol® varies, Lipitor® 30 units, lovastatin varies, Mevacor® 30 units, Pravachol® 30 units, pravastatin sodium 30 units, Simcor® 30 units, simvastatin 30 units, Zocor® 30 units and Livalo® 30 units)

9. Diabetic test strips (204/month)

10. Enbrel®: Coverage is limited to 4 syringes or 8 vials per 28 days.

11. Estrogen patches: Alora®, Estraderm®, Minivelle®, Vivelle/Dot® limit is 8 patches/28 days. Climara/Pro and Menostar® limit is 4 patches per 28 days.

12. Gabepentin (Neurontin). Coverage is limited to 3,600mg per day.

13. Humira®: Coverage is limited to 2 syringes/pens per 28 days.

14. Lidocaine/Lidocaine topical products is limited to one tube/pack every 25 days.

15. Migraine medications. Coverage is limited to quantities listed below:

Generic name	Brand name	Quantity Level Limit for 30-day Period
Almotriptan tablets 6.25 mg	Axert®	12 tablets

Almotriptan tablets 12.5 mg	Axert®	12 tablets
Diclofenac potassium, 50 mg powder packet	Cambia	9 packets
Dihydroergotamine nasal spray vials, 4mg/mL vial	Migranal®	1 kit=8-unit dose sprayers
Eletriptan 20mg, 40mg	Relpax®	12 tablets
Frovatriptan tablets 2.5mg	Frova®	18 tablets
Naratriptan tablets 1mg, 2.5mg	Amerge®	12 tablets
Rizatriptan tablets 5mg, 10mg	Maxalt®	18 tablets
Rizatriptan tablets 5mg, 10mg, orally disintegrating tablets	Maxalt-MLT®	18 tablets
Sumatriptan injection pre-filled auto-injectors, 6mg/0.5ml	Alsuma®	6 kits (12 syringes)
Sumatriptan auto-injectors 3mg/0.5ml	Zembrace Symtouch	24 injectors (12ml)
Sumatriptan injection syringes, 6mg/0.5ml	Imitrex® Statdose System	6 kits=12 injections
Sumatriptan injection vials, 4mg/0.5 ml	Generics	18 vials
Sumatriptan injection vials, 6mg/0.5 ml	Imitrex®, generics	12 vials
Sumatriptan nasal spray 20 mg	Imitrex®, generics	2 boxes=12-unit dose spray devices
Sumatriptan nasal spray 5mg	Imitrex®, generics	4 boxes= 24-unit dose spray devices
Sumatriptan nasal spray 11mg	Onzetra Xsail	1kit=8 pouches
Sumatriptan needle-free injection vial 4mg/0.5ml	Sumavel™ DosePro™	3boxes=18 needle-free devices
Sumatriptan tablets 25mg, 50mg, 100mg	Imitrex®, generics	12 tablets
Sumatriptan (85mg) naproxen sodium (500mg) tablets	Treximet™	9 tablets
Sumatriptan (10mg) and naproxen sodium (60mg) tablets	Treximet™	9 tablets
Zolmitriptan nasal spray 5mg	Zomig®	2 boxes=12-unit dose spray devices
Zolmitriptan tablets 2.5 mg, 5mg, orally disintegrating	Zomig-ZMT®	12 tablets
Zolmitriptan tablets 2.5 mg, 5mg	Zomig®	12 tablets

16. Multiple Sclerosis: Avonex® 4 units per 30 days, Betaseron®/Extavia 14 or 15 units per 30 days,
Copaxone® 1 kit per 30 days, Rebif® 1 pkg/12 syringes per 30 days.

17. Nuvigil®: Coverage limit varies.

18. Opioid pain medications have a quantity limit (QL) for all medications in the opioid class. Additional quantities require Prior Authorization. Long-acting Opioids and immediate-

acting Opioids – quantities vary based on strength of medications. Medications in this class include, hydrocodone products, Avinza, Nucynta, Nucynta ER, Xartemis XR, Kadian, Embeda, morphine products, Oxycontin, Hysingla ER, Zohydro ER, Opana, Opana ER, methadone, codeine products, hydromorphone products, oxycodone products, Meperidine products, Exalgo, Vicoprofen, Talwin NX, Tramadol and Tramadol-containing products, Soma and Soma-containing products. Initial prescription is limited to a 7-day supply only.

19. Other Antidepressants (Budeprion SR® 60 units, Budeprion XL ® 30 units, Bupropion HCL SR® 60 units, Forfivo® XL 30 units, Wellbutrin SR® 60 units, and Wellbutrin XL® 30 units, Aplenzin® 30 units).

20. Provigil®: Coverage limit varies.

21. Respiratory/Asthma inhalers, nasal steroid inhalers, and COPD inhalers are limited to quantity in accordance with FDA-approved dosing.

22. Sedative Hypnotics (Ambien®, Ambien CR™, Doral®, estazolam, flurazepam, Intermezzo®, Lunesta™, Restoril®, Rozerem™, Sonata®, Edluar™, Silenor®, temazepam, triazolam). Coverage is limited to 15 units per 30 days. Zolpimist™, coverage is limited to 1 bottle.

23. Selective Serotonin Reuptake Inhibitors (Celexa® 30 units, citalopram HBR 30 units, fluoxetine HCL varies, fluvoxamine maleate varies, Lexapro® 30 units, Luvox CR® varies, paroxetine HCL® varies, Paxil® varies, Paxil CR® 60 units, Pexeva® varies, Prozac Weekly® 5 units, Sarafem® 30 units, Selfemra™ varies, sertraline HCL® varies, Viibyrd® 30 units, and Zoloft® varies).

24. Serotonin and Norepinephrine Reuptake Inhibitors (Cymbalta® varies, Effexor® varies, Effexor XR® varies, Pristiq® 30 units, Savella® varies, venlafaxine ER® varies, Viibryd® 1 pack).

25. Sprix: Coverage is limited to 5 days of therapy per prescription.

26. Tamiflu® and Relenza®: Coverage is limited to one course of treatment every 90 days. Additional quantities require prior authorization from RDT.

27. Topical steroids (120gm or ml/month)

28. Toradol: Coverage is limited to 20 tables per prescription.

Exclusions. The following prescriptions, in addition to those listed in the Summary Plan Description (SPD) are excluded from the Prescription Drug Plan:

1. Abortifacient (i.e., Mifeprex)
2. Anorexiants (any drug used for the purpose of weight loss)

3. Anti-wrinkle agents (e.g. Renova®)
4. Arestin
5. Bleaching agents (e.g., Eldopaque®, Eldoquin Forte®, Melanex®, Nuquin®, Solaquin®)
6. Bulk ingredients (i.e. bulk chemicals, bulk powders, bulk compounding ingredients, hormone replacement bulk ingredients, high cost bases, compound kits, etc.)
7. Charges for the administration or injection of any drug
8. Compounds containing one or more ingredients which are commercially available in alternate medications, are an over-the counter (OTC) product or lack clinical evidence in compounded dosage forms. This list is subject to change throughout the Plan Year.
9. Contraceptive devices and implants
10. Diagnostic agents
11. Drugs dispensed by a hospital, clinic or physician's office
12. Drugs excluded from the formulary by CVS Caremark. You can find a list of these medications at https://peia.wv.gov/prescription_drug_lists/Documents/Formulary_Exclusions.pdf
13. 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.
14. Drugs requiring prior authorization when prescribed for uses and quantities not approved by the FDA
15. Drugs requiring a prescription by State law, but not by federal law (State controlled) are not covered
16. Erectile dysfunction medications
17. Fertility drugs
18. Fioricet® with Codeine (butalbital/acetaminophen caffeine with codeine)
19. Fiorinal® with Codeine (butalbital/aspirin caffeine with codeine)
20. Hair growth stimulants
21. Homeopathic medications
22. Hypoactive Sexual Desire Disorder (HSDD) Agents
23. Immunizations, biological sera, blood or blood products, Hyalgan®, Synvisc®, Remicade®, Synagis®, Xolair®, Amevive®, Raptiva®, Vivitrol®, (these are covered under the medical plan)
24. Latisse™
25. Medical or therapeutic foods
26. 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
27. Medications 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.
28. Newly released prescription medications that have been on the market less than 12 months
29. Non-legend drugs
30. Nutritional Supplements (that require a prescription, i.e., Metanx, Limbrel, Deplen)
31. Omnipod V-go®, Finesse® or other disposable insulin delivery systems
32. Pentazocine/Acetaminophen (Talacen®)

33. 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.
34. Replacement medications for lost, damaged or stolen drugs
35. Requests for less than a 90-day supply of maintenance medications, or requests for more than a 30-day supply of short-term medications.
36. Respiratory Therapy Supplies: Nebulizers
37. Respiratory Therapy Supplies: Peak Flow Meters
38. Stadol® Nasal Spray (butorphanol)
39. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those listed above.
40. Unit dose medications
41. Vacation supplies, unless leaving the country. If you are leaving the country, and want PEIA to cover a vacation supply, you must submit documentation (copy of an airline ticket, travel agency itinerary, etc.) to substantiate your international travel arrangements. Please allow seven (7) days for processing.

Dispensing Limits

Acute Medications. Reimbursement for medication taken for short periods to treat acute medical conditions will be limited to a 30-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 30-day supply.

Maintenance Medications. A maintenance drug is taken for a long-term condition such as high blood pressure or diabetes. 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 for generic and brand-preferred medications only.

All Maintenance Medications must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through CVS Caremark mail service. You must receive a 90-day supply of the medications and classes listed below. Maintenance medications dispensed in quantities less than 90 days are not covered by the plan. If you are starting on a new maintenance medication, you may receive up to two 30-day fills to be sure you tolerate the medication and that your dosage is correct. After the second 30-day fill, the maintenance medication will be covered only in a 90-day supply, and only when filled at a Retail Maintenance Network pharmacy or using the CVS Caremark Mail Service Pharmacy Program.

1. Allergies
2. Alzheimer's Disease
3. Antipsychotics
4. Blood Modifiers/Thinners
5. Cancer (non-specialty)
6. Contraceptives/Hormone Replacement
7. Depression
8. Diabetes
9. Accu-Chek test strips/lancets
10. Digestive Enzymes
16.. High Blood Pressure & Heart Disease
17. High Cholesterol
18. Immune Disorders (non-specialty)
19. Inflammatory Bowel Disease (non-specialty)
20. Irritable Bowel Disease
21. Kidney Disease
22. Osteoporosis
23. Overactive Bladder
24. Parkinson's Disease
25. Respiratory Agents

11. Diuretics
12. Enlarged Prostate
13. Gastrointestinal agents
14. Glaucoma
15. Gout
26. Rheumatoid Arthritis
27. Seizure Disorders
28. Thyroid
29. Ulcer/GERD

VI.7. 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 coinsurance. 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.

Specialty Drug Program

PEIA's Specialty Drug Program has two components:
1. **Specialty Injectable Drugs** are administered by injection or infusion, and are managed by UMR through the medical benefit.

2. **Common Specialty Medications** are self-administered, and are managed by CVS Specialty Pharmacy

Specialty Injectable Drugs are prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring. The PEIA PPB Plans cover specialty injectable drugs through a program managed by UMR. The program provides comprehensive direction to policyholders and their dependents for treatments utilizing specialty drugs. If your physician prescribes a specialty drug, that physician, you, or the pharmacist must call UMR at 1-888-440-7342. The Specialty Injectable Drug list is located at https://fhs.umr.com/print/UM1428.pdf. To obtain a paper copy, call 1-888-680-7342. UMR will review the drug for medical necessity If denied, UMR will contact your physician for additional information which may allow approval of the requested medication.

Common Specialty Medications are self-administered specialty injectable drugs through the CVS Specialty Pharmacy. Through the CVS Specialty Pharmacy, you will be assigned a dedicated CareTeam with specialists in your condition. These specialists will check in to see what you need and how they can help moving forward. They'll also make arrangements for injection training, as needed. If your physician prescribes a common specialty drug, they can call 1-800-237-2767, fax 1-800-323-2445, or e-prescribe the specialty drug to the CVS Specialty Pharmacy. CVS Specialty will then work with your doctor to obtain prior authorization for the specialty medication. Once approved, you can have your specialty medications delivered directly to you. Many specialty medications have manufacturer programs which will financially assist patients in the purchase of the medication. PEIA requires that if a financial assistance program is available,

you must participate in the program. Only your actual out-of-pocket payments will count toward your drug deductible and annual out-of-pocket maximum; not amounts discounted off the price by the manufacturer or seller of the specialty medication. 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

After you have met your prescription drug deductible, the copayment on these medications will generally be $100 for any Common Specialty Medications on the WV Preferred Drug List and $150 for any Common Specialty Medications not on the WV Preferred Drug List; however, certain specialty medications are subject to variable copayments, depending on the availability of programs. Only your actual out-of-pocket payments will count toward your drug deductible and annual out-of-pocket maximum, not amounts discounted off the price by the manufacturer or seller of the specialty medications. Contact CVS Caremark to verify copayments. These drugs are not available in 90-day supplies. If you are prescribed one of these common specialty medications, call CVS Caremark at 1-844-260-5894

Common Specialty Medications

Drug Name	Category
Acthar® HP [QLL]	Multiple Sclerosis
Actimmune	Anti-Neoplastic
Adcirca® [QLL]	Pulmonary Hypertension
Afinitor [QLL]	Anti-Neoplastic
Ampyra [QLL]	Multiple Sclerosis
Aranesp®	Anemia
Avonex [QLL]	Multiple Sclerosis
Betaseron® [QLL]	Multiple Sclerosis
Boniva®	Osteoporosis
Cerezyme® [QLL]	Gaucher Disease
Copaxone® [QLL]	Multiple Sclerosis

Drug Name	Category
Neupogen®	Neutropenia
Nexavar [QLL]	Anti-Neoplastic, Immunosuppressant
Norditropin®	Growth Hormone
Nutropin®	Growth Hormone
Octreotide Acetate	Endocrine disorders
Pegasys®	Hepatitis C
Peg-Intron® [QLL]	Hepatitis C
Procrit®	Anemia
Pulmozyme® [QLL]	Cystic Fibrosis
Rebif® [QLL]	Multiple Sclerosis
Revatio® [QLL]	Pulmonary Arterial Hypertension

Eligard	Anti-Neoplastic		Revlimid® [QLL]	Anti-Neoplastic, Immunosuppressant
Enbrel® [QLL]	Inflammatory Conditions		Riba pak	Hepatitis
Epclusa* [QLL]	Hepatitis C		Ribavirin®	Hepatitis C
Epogen®	Anemia		Sandostatin LAR [QLL]	Endocrine disorders
Forteo® [QLL]	Osteoporosis		Simponi® [QLL]	Rheumatoid Arthritis
Genotropin	Growth Hormone		Sprycel [QLL]	Anti-Neoplastic
Gilenya® [QLL]	Multiple Sclerosis		Sutent® [QLL]	Anti-Neoplastic
Gleevec® [QLL]	Anti-Neoplastic		Tarceva® [QLL]	Anti-Neoplastic
Harvoni* [QLL]	Hepatitis C		Tasigna [QLL]	Anti-Neoplastic
Humatrope®	Growth Hormone		Temodar®	Anti-Neoplastic
Humira® [QLL]	Inflammatory Conditions		Tev-Tropin®	Growth Hormone
Incivek	Hepatitis		Thalomid® [QLL]	Anti-Neoplastic
Inlyta® [QLL]	Cancer		Thyrogen® Kit	Diagnostic
Intron A®	Interferons		Tobi® [QLL]	Cystic Fibrosis
Jakafi® [QLL]	Cancer		Tracleer® [QLL]	Pulmonary Arterial Hypertension
Kalydeco® [QLL]	Respiratory conditions		Tykerb [QLL]	Anti-Neoplastic
Kineret® [QLL]	Inflammatory Conditions		Tyvaso® [QLL]	Pulmonary Arterial Hypertension
Kuvan	Enzyme deficiencies		Victrelis [QLL]	Hepatitis
Letairis® [QLL]	Pulmonary Arterial Hypertension		Votrient [QLL]	Anti-Neoplastic
Leukine	Hematopoietic		Xalkori® [QLL]	Cancer
Lupron Depot®	Endometriosis, Anti-Neoplastic, Precocious Puberty		Xeloda® [QLL]	Anti-Neoplastic
Lupron Depot®-Ped	Precocious Puberty		Xenazine® [QLL]	CNS Disorders
Lupron®	Anti-Neoplastic		Zarxio	Neutropenia
Neulasta® [QLL]	Neutropenia		Zoladex®	Anti-Neoplastic
			Zolinza [QLL]	Anti-Neoplastic
			Zytiga® [QLL]	Anti-Neoplastic

All Common Specialty Medications require Precertification from CVS Caremark.

[QLL] This drug is subject to Quantity Level Limits (QLL). This list is not all-inclusive and is subject to change throughout the Plan Year.

*Coverage of this drug is limited to a once-in-a lifetime course of treatment.

Diabetes Management

PEIA covers diabetes management items under its Maintenance Medication benefit, which means that needles, syringes, lancets and test strips must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through CVS mail service. For patients just starting use of needles, syringes, lancets or test strips, PEIA will permit two 30-day fills of the new prescription at a network pharmacy, but after that, all items must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through CVS mail service.

Blood Glucose Monitors: Covered diabetic insureds can receive a free Accu-Chek Aviva Plus, Accu-Chek Nano, or Accu-Chek Guide blood glucose monitor with a current prescription. All major chain pharmacies and some doctor's offices have vouchers for the Accu-Chek meters. Take your prescription to them or call the CVS Caremark Diabetic Meter Program at 1-800-588-4456 to request a meter.

Glucose Test Strips: The plan covers only Accu-Chek Aviva Plus test strips Accu-Chek Nano test strips, and Accu-Chek Guide test strips at the preferred copayment of $50 per 90-day supply for PPB Plans A and D, and $60 per 90-day supply for PPB Plan B. Other brands require a 100% copayment.

Needles/Syringes and Lancets: The plan covers only BD needles and syringes. You can obtain a supply of disposable needles/syringes and lancets for the copayments listed below.

Diabetes Management Copayments				
	PEIA PPB Plan A or D		**PEIA PPB Plan B**	
	Up to 30-day supply	**90-day supply***	**Up to 30-day supply**	**90-day supply***
Lifescan One Touch Glucose test strips, as noted above	Not Covered	$50	Not Covered	$60
BD needles/syringes	Not Covered	$20	Not Covered	$20
Lancets	Not Covered	$20	Not Covered	$20

*You must purchase all Diabetes Management items in 90-day supplies through a Retail Maintenance Network pharmacy or through Mail Service.

PEIA insureds must have a diabetes diagnosis in order to receive diabetic supplies and/or medications.

VI.8. Tobacco Cessation Program

PEIA has a tobacco cessation program that includes coverage for both prescription and over-the-counter (OTC) tobacco cessation products. The oral medications are covered under your prescription drug program.

What is Covered?

PEIA will cover prescription and over-the-counter) OTC) tobacco cessation products if they are dispensed with a prescription. Toll-free numbers are provided by the manufactures of most of these products for phone coaching and support.

Coverage is limited to two twelve-week cycles per rolling twelve-month period. Tobacco-cessation products are available at no cost to the member; both the deductible and the copayment are waived when prescribed by a physician and purchased at a network pharmacy.

Who is Eligible for Tobacco Cessation?

Only those members who have been paying the Standard (tobacco-user) premium are eligible for this benefit. If you have signed an affidavit claiming to be tobacco-free, and then you attempt to use the tobacco cessation benefit, you will be declined services. Pregnant women will be offered 100% coverage during any pregnancy.

VI.9. 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.

VI.10. 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 prescription dispensed by a Network Pharmacy will be submitted electronically to the TPA-P. Claims will be approved prior to dispensing. The insured will be responsible for any copayment, coinsurance, 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. The prescription receipt must be attached to the form. 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. All prior authorization, step therapy, and quantity limits still apply.

Filing Claims for Court-Ordered Dependents. Prescription drug claims for court-ordered dependents will be processed using the PEIA identification 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 Benefit Plan, Claims**).

VI.11. 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 the TPA-P to have the secondary claim processed:

a. a completed TPA-P 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.

2. **Medicare Part B:** 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. TPA 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. This includes all major chains. 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 offers prescription drug coverage through Medicare Part D. Please be aware that you should NOT purchase a separate Medicare Part D plan. PEIA will provide prescription drug coverage to its Medicare members through a Medicare Part D Plan administered by Humana. If you are a Medicare Advantage plan member and enroll in a separate Medicare Part D plan, you will be disenrolled from all medical and prescription benefits from PEIA. You will have only original Medicare A & B for medical coverage and your Medicare Part D plan with no secondary coverage.

Medicare Part D Creditable Coverage Notice

The coverage you have now through West Virginia PEIA is considered by Medicare to be creditable coverage, or coverage as good as or better than that offered under Medicare's standard Part D benefit. If you are eligible for Medicare and decide to opt out of this plan's coverage, you should consider joining another plan as soon as possible to avoid having to pay a late enrollment penalty. If you choose to leave this plan and do not join another plan within 63 days of the termination date of this coverage, you will be charged a late enrollment penalty of at least 1% per month you went without coverage as good as or better than that offered under Medicare Part D.

When Can You Change to a Different Plan?

Generally, Medicare-eligible members can change plans during the yearly enrollment period (called the "annual coordinated election period") from October 15 through December 7, 2011. Generally, this is the only time of year to choose a different Medicare plan. Certain individuals, such as those with Medicaid, those who get "Extra Help" paying for their drugs, or those who move out of the geographic service area, can make changes at other times.

VI.12. 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**).

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 CVS Caremark 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 CVS Caremark 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 (for Physician's offices or pharmacists ONLY)	RDT 1-800-847-3869	Rational Drug Therapy Program WVU School of Pharmacy P.O. Box 9511 HSCN Morgantown, WV 26506
Prescription drug claim payment error or denial	CVS Caremark 1-844-260-5894	CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-2084
Appealing a Specialty Drug Claim	CVS Caremark Call:1-844-260-5894 **Fax: 1-855-230-5548**	CVS Caremark Specialty Appeals Department 800 Biermann Court Mount Prospect, IL 60056

CVS Caremark or RDT will respond in writing to you and/or 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 CVS Caremark or RDT.

Mail third step appeals to:

Director, Public Employees Insurance Agency, 601 57th Street, SE, Charleston, WV 25304-2345.

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 CVS Caremark at 1-844-260-5894.

External Review: If we have denied your request for the provision of or payment for a health care service or course of treatment, our decision may be reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. An external review may be initiated by us or requested by you. You may submit a request for external review within four (4) months after

receipt of the notice of denial to the PEIA Clinical Unit, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345. For standard external review by your request, a decision will be made within forty-five (45) days of receiving you request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may request an expedited external review of our denial. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may request an external review of our denial. External review is the final level of appeal, regardless of whether the external review was initiated by us or requested by you. External review is not available for drugs, services, or items which are simply not covered by the plan, or for a change in plan design, including but not limited to, a change in drug cost-sharing tier. External review is also not available for out-of-state benefit level appeals.

VII: MANAGED CARE PLANS

VII.1. 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.

VII.2. 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 that 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 enrollment period, PEIA produces the Shopper's Guide, a reference document developed to assist policyholders in the selection of a medical benefit plan.

VII.3. 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 changes outside of the open enrollment period only as a result of a qualifying event. Examples of qualifying events are:

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.

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 Section 125 Plan should consult that Plan to determine whether he/she may terminate or change coverage.

VII.4. 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.

VII.5. 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.

VII.6. 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.

VII.7. 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 ensure 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 25^{h} 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.

VII.8. 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.

VII.9. Solicitation

All solicitation material to be sent to PEIA insureds is subject to inspection and prior approval by the PEIA.

VII.10. Communication

All communication materials to be mass-distributed to PEIA insureds are subject to inspection and prior approval by the PEIA.

VII.11. Appeals

Managed care plan members who think 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 120 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
601 57th Street, SE, Suite 2
Charleston, WV 25304-2345

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)

VIII.1. 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.

VIII.2. 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.

VIII.3. Basic Life Insurance Benefits

Amount of Benefits. Upon receipt of proof of death of an enrolled employee, the Plan will provide the following Basic Life Insurance benefits:

Active Employees:

	Amount of Life Coverage	Amount of AD&D Coverage
Under age 65	$ 10,000	$ 10,000
Between ages 65 and 70	$ 6,500	$ 6,500
Age 70 and older	$ 5,000	$ 5,000

Retired Employees:

	Amount of Life Coverage	Amount of AD&D Coverage
At retirement	$ 5,000	$ 0
At age 67 and older	$ 2,500	$ 0

Disabled Employees (Disabled Prior to Age 60):

	Amount of Life Coverage	Amount of AD&D Coverage
Under age 65	$ 10,000	$0
Age 65 but Under Age 70	$ 5,000	$0
Age 70 or older	$ 2,500	$0

VIII.4. 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

Age	Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII	Plan VIII	Plan IX	Plan X
Under 65	$5,000	$10,000	$20,000	$30,000	$40,000	$50,000	$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

Age	Plan XI	Plan XII	Plan XIII	Plan XIV	Plan XV	Plan XVI	Plan XVII	Plan XVIII
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

Retired Employee – Optional Life with no AD&D

Age	Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII	Plan VIII	Plan IX	Plan X
Under 65	$5,000	$10,000	$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 or above, 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.

Active Employee's Dependent Life and AD&D Insurance
Plan 1 ($5,000 Spouse/$2,000 Child)
Plan 2 ($10,000 Spouse/$4,000 Child)

Plan 3 ($15,000 Spouse/$7,500 Child)
Plan 4 ($20,000 Spouse/$10,000 Child)
Plan 5 ($40,000 Spouse/$15,000 Child)

Retired Employee's Dependent Life Insurance
Plan 1 ($5,000 Spouse/$2,000 Child)
Plan 2 ($10,000 Spouse/$4,000 Child)
Plan 3 ($15,000 Spouse/$7,500 Child)
Plan 4 ($20,000 Spouse/$10,000 Child)
Plan 5 ($40,000 Spouse/$15,000 Child)

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 that 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.

VIII.5. 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.

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. Their coverage will become effective the first day of the month following enrollment. Coverage is not automatic, even if you have an existing family plan.

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.

VIII.6. 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 or one foot and the sight of one eye.

50% - 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 caused directly or indirectly by, resulting from, or where there is a contribution from, any of the following:

1. Suicide or attempted suicide, whether sane or insane; or
2. The insured's participation in or attempt to commit a felony; or
3. Bodily or mental infirmity, illness or disease; or

4. The abuse of drugs, or the use of poisons, gases or fumes, voluntarily taken, administered, absorbed, inhaled, ingested or injected, except as administered by a licensed medical professional; or
5. Bacterial infection, other than infection occurring simultaneously with, and as a result of, the accidental injury; or
6. War or any act of war, whether declared or undeclared.

VIII.7. 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.

VIII.8. 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.

VIII.9. 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.

VIII.10. 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 twenty-six (26), 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 die 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 covert 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.

VIII.11. 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 Employees Insurance Agency
   Attn: Life Insurance Supervisor
   601 57th Street, SE, Suite 2
   Charleston, WV 25304-2345

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.

VIII.12. 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.

VIII.13. 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 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, HEARING BENEFITS, LEGAL AND LONG AND SHORT-TERM DISABILITY PLANS

IX.1. 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.

IX.2. 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.

IX.3. 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.

IX.4. 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.

IX.5. Administration

The Vision, Dental, Hearing Benefits, Legal, 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.

IX.6. 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 July 1, 2006.

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 and/or Grace Period by the Participant, Spouse or Dependents.

2.2 "Effective Date" means this amendment and restatement is effective July 1, 2000.

2.3 "General Purpose Medical Reimbursement Plan" means a Plan that applies to all Health Care Expenses.

2.4 "Grace Period" means the period of two months and fifteen days following the end of the Period of Coverage (Plan Year) during which amounts unused at the end of the Period of Coverage (Plan Year) may be used to reimburse qualifying Health Care Expenses incurred during the Grace Period. All amounts allocated to the Medical Reimbursement Plan that are not used to reimburse qualifying Health Care Expenses incurred during the Period of Coverage (Plan Year) and/or Grace Period shall be forfeited.

2.5 "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 and/or the immediately following Grace Period; (c) not incurred prior to the date the Employee's participation in the Plan commenced; and (c) not incurred prior to the date the Employee's participation in the Plan commenced; and (d) not reimbursed by the Medical Plan or any other source. Health Care Expenses shall not include an expense incurred for the payment of premiums under a health insurance plan. For purposes of this Plan, expenses are incurred when the Participant or Beneficiary is furnished the health care or services giving rise to the claimed expense. Further, for the purposes of this Plan, if an individual chooses to elect a Limited Purpose Medical Reimbursement Plan, the term "Health Care Expenses" shall mean only dental and vision expenses.

2.6 "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.

2.7 "Limited Purpose Medical Reimbursement Plan" means a plan that applies only to Health Care Expenses related to dental and vision expenses.

2.8 "Open Enrollment" means the period 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.

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

2.10 "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.

2.11 "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.

2.12 "Plan Year" means the twelve-month period beginning July 1 and June 30.

2.13 "Required Premiums" 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.

2.14 "Run-out-Period" means the 120 days following the close of the Period of Coverage (Plan Year) during which participants may submit for reimbursement those expenses incurred during the Period of Coverage (Plan Year), and incurred during the Grace Period.

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 and select either a General Purpose Medical Reimbursement Plan or a Limited Purpose Medical Reimbursement Plan. Health Savings Account benefits cannot be elected with a Medical Reimbursement Plan unless the Limited Purpose Medical Reimbursement Plan is selected.

3.2 Commencement of Participation. An Eligible Employee may elect to become a Participant in either the General Purpose Medical Reimbursement Plan or the Limited Purpose Medical Reimbursement Plan by completing a Benefit Election Form and filing it with the Employer. Such individual must elect either the General Purpose Medical Reimbursement Plan or the Limited Purpose Medical Reimbursement Plan, bot not both; the election will last for the entire plan year. 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 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 reimbursement 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 remining 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 reimbursement 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 that 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 $2,650 (as indexed for inflation for future years and communicated in enrollment materials) or such lesser amount as is communicated in enrollment materials.

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.}

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 or Grace Period. 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.

5.3 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 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 forfeiture under Section 5.5.

5.4 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 Grace Period, and only if the Participant applies for reimbursement on or before the end of the Run-out 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).

5.5 If Congressional Action or Treasury/IRS Regulatory Changes modify or rescind the Use it or Lose It Rule, the Employer has the discretion to eliminate or modify the forfeiture provisions of this plan by notifying employees in advance of the Grace Period for any given Plan Year.

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 and/or Grace Period 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 often 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 of expense incurred during the Period of Coverage and/or Grace Period may be submitted at any time during the Period of Coverage or within the Run-out 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 and/or Grace Period, 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 Run-out Period to be eligible for reimbursement.

Subject to Article VII, the amount available for reimbursement shall, at all time during the Period of Coverage and/or Grace Period, 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 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 there under), 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 Run-out Period following the close of the Period of Coverage and/or Grace Period. 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.

7.4 No reimbursement under this Article VII shall exceed the remaining balance, if any, in the Participant's Medical Reimbursement Account for the Period of Coverage in which the expenses were incurred.

ARTICLE VIII – ADMINISTRATION

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

The Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the plan authorizing or providing for such direction, information or action. Furthermore, the Administrator may rely upon any such direction, information or action of another Employee of the Employer as being proper under this Plan, and is not required under this Plan to inquire into the propriety of any such direction, information or action. It is intended under this Plan that the Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Administrator nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

All usual and reasonable expenses of the Administrator that are not properly chargeable to or payable by the Plan (including payment out of forfeitures pursuant to Section 5.5) shall be paid by the Employer, and any expenses not paid by the Employer shall not be the responsibility of the Administrator personally. The Administrator or any other designated representative of the Employer who is an Employee of the Employer shall not receive any compensation with respect to services hereunder except as such person may be entitled to Benefits under this Plan.

It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

The Administrator will have full power to administer the Plan in all of its details subject to applicable requirements of law.

8.2 Records and Reports. The Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records

of the Participants and the balances, if any, which are maintained under this Plan. The Administrator shall be responsible for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 105(b) plans.

8.3 Examination of Records. The Administrator will make available to each Participant such records as pertain to the participant, for examination at reasonable times during normal business hours.

8.4 Reliance on Tables, etc. In administering the Plan, the Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by the accountant, counsel or other expert who is employed or engaged by the Administrator.

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

8.6 Facility of Payment. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a Benefit or installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such person or to the person's legal representative or to a relative of such person or such person's benefit, or the Administrator may direct the Employer to apply the payment for the Benefit of such person in such a manner as the Administrator considers advisable. Any payment of a Benefit or installment thereof in accordance with the provisions of this Section 8.6 shall be a complete discharge of any liability for 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 and 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' fee 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 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 payments is not so excludable.

10.9 Indemnification of Employer by Participants. If any Participant's receives one or more payments or reimbursement 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 enforce 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, agrees 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 provisions 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 July 1, 2006.

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 and/or Grace period 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 July 1, 2006.

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 period of two months and fifteen days following the end of the Period of Coverage (Plan Year) during which amounts unused at the end of the Period of

Coverage (Plan Year) may be used to reimburse qualifying Dependent Care Expenses incurred during the Grace Period. All amounts allocated to the Dependent Reimbursement Plan that are not used to reimburse qualifying Dependent Care Expenses incurred during the Period of Coverage (Plan Year) and/or Grace Period shall be forfeited.

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 "Run-out Period" means the 120 days following the close of the Period of Coverage (Plan Year) during which participants may submit for reimbursement those expenses incurred during the Period of Coverage (Plan Year), and incurred during the Grace Period.

2.16 "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 reimbursement 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 Reimbursement 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 and Grace Period. Amounts debited to each such Dependent Care Reimbursement Account shall be treated as payments of the earliest amounts credited to the Account and not yet treated as paid under this Section 5.3, under a "first-in, first-out" approach.

5.4 Forfeiture of Accounts. The amount credited to a Participant's Dependent Care Reimbursement Account for any Period of Coverage shall be used only to reimburse the Participant for Dependent Care Expenses incurred during such Period of Coverage and

Grace Period, and only if the Participant applies for reimbursement on or before the end of the Run-out 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).

If Congressional Action or Treasury/IRS Regulatory Changes modify or rescind the Use it or Lose It Rule, the Employer has the discretion to eliminate or modify the forfeiture provisions of this Plan by notifying employees in advance of the Grace Period for any given Plan Year.

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 and Grace Period 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 required.

(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 Run-out 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 and Grace Period, 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 Run-out 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 exceeds 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 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 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 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 fee 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 on 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 payments 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 UMR P.O. Box 30541 Salt Lake City, UT 84130-0541 1-888-440-7342	***Administrator for PEIA Basic and Optional Life Insurance and AD&D*** Securian Financial One Bridge Place, 10 Hale Street, 5th Floor Charleston, WV 25301 1-800-203-9515
Third-Party Administrator for Medical Utilization Review UMR P.O. Box 30541 Salt Lake City, UT 84130-0541 1-888-440-7342	***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
Third-Party Administrator for Prescription Drug Plan CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-2084 1-844-260-5894	***Third-Party Administrator for Managed Care Plan*** The Health Plan of West Virginia, Inc. 1110 Main Street Wheeling, WV 26003 1-800-624-6961
Administrator for Mountaineer Flexible Benefits FBMC Benefits Management, Inc. P.O. Box 1878 Tallahassee, FL 32302-1878 1-800-559-8248	***Administrator for Medicare Advantage Plan/Prescription Drug (MAPD) Plan*** Humana 1-800-783-4599

APPENDIX B: PREMIUMS (PPB, MANAGED CARE AND LIFE)

PLAN YEAR 2020 (July 1, 2019 – June 30 2020)

A listing of premiums for Plan Year 2020 may be found here:

https://peia.wv.gov/Forms-Downloads/Pages/Premium-Rates.aspx

https://peia.wv.gov/Forms-Downloads/Pages/Shopper's-Guides.aspx

https://peia.wv.gov/Forms-Downloads/Pages/Medicare-Shopper's-Guides.aspx

https://peia.wv.gov/Forms-Downloads/Pages/Summary-Plan-Descriptions.aspx

APPENDIX C: DEDUCTIBLES, COINSURANCE AND COPAYMENTS FOR PEIA PPB MEDICAL BENEFITS PLANS A, B, AND D

ANNUAL MEDICAL DEDUCTIBLES

	Annual Salary	Employee Only	Employee & Child(ren)	Family	Family with Employee Spouse*
PEIA PPB Plan A & D (state agencies, colleges, universities and county boards of education)	$0 - $22,700	$325	$650	$650	$650
	$22,701 - $32,700	$375	$750	$750	$750
	$32,701 - $38,700	$425	$850	$850	$850
	$38,701 - $44,700	$450	$900	$900	$900
	$44,701 - $52,700	$475	$950	$950	$950
	$52,701 - $65,200	$600	$1,200	$1,200	$1,200
	$65,201 - $77,700	$625	$1,250	$1,250	$1,250
	$77,701 - $102,700	$650	$1,300	$1,300	$1,300
	$102,701 - $127,700	$725	$1,450	$1,450	$1,450
	$127,701 +	$825	$1,650	$1,650	$1,650
PEIA PPB Plan B (state agencies, colleges, universities and county boards of education)	$0 - $44,700	$725	$1,450	$1,450	$1,450
	$44,701 +	$1,225	$1,950*	$1,950*	$1,950*
Non-State Plan A	Not Applicable	$450	$900	$900	N/A
Non-State Plan B	Not Applicable	$725	$1,450	$1,450	N/A
Non-Medicare Retirees Plan A	Not Applicable	$525	N/A	$1,050	N/A
Non-Medicare Retirees Plan B	Not Applicable	$925	N/A	$1,850	N/A
Deputy Sheriff's Early Retirement Plan A	Not Applicable	$450	N/A	$900	N/A
Deputy Sheriff's Early Retirement Plan B	Not Applicable	$725	N/A	$1,450	N/A
State-funded Elected Officials Plans A and D	Not Applicable	$450	$900	$900	$900
State-funded Elected Officials Plan B	Not Applicable	$725	$1,450	$1,450	$1,450

*One family member may have to meet the 'employee only' deductible, which is $1,225. See the paragraph above.

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 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.

Deductibles for Family with Employee Spouse coverage are based on the average of the two employee's salaries. Add the annual together and divide by two to get the basis of the premium. This provision does not apply to local government agency or retired employees.

The OOSINNA deductibles satisfies the in-network deductibles, but the in-network deductible does not meet the OOSINNA deductible. Please note that the amounts listed in the chart are for in-network deductibles. OOSINNA deductibles are twice the amount of the in-network deductibles listed above.

Prescription drug benefits are subject to a separate deductible. See the "Prescription Drug Benefit" section for details.

PEIA PPB PLANS A, B** & D***

Coinsurance for In-Network and Out-of-Network Benefits for PEIA PPB Plans

	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	Plan A: 20% coinsurance Plan B: 30% coinsurance Plan D: 20% coinsurance	Plan A: 20% coinsurance Plan B: 30% coinsurance	Plan A: 20% coinsurance Plan B: 30% coinsurance
Access care in a bordering county of a surrounding state using PPO providers*	Plan A: 20% coinsurance Plan B: 30% coinsurance Plan D: not covered	Plan A: 20% coinsurance Plan B: 30% coinsurance	Plan A: 20% coinsurance Plan B: 30% coinsurance
Access care outside WV (beyond bordering counties) using PPO providers with prior	Plan: A 30% coinsurance Plan: B 35% coinsurance Plan: D Not covered	Plan A: 30% coinsurance Plan B: 35% coinsurance	Plan A: 30% coinsurance Plan B: 35% coinsurance
Access care outside WV (beyond bordering counties) using non-PPO providers with prior approval*	Plan A: 30% coinsurance + amounts that exceed the Reasonable and Customary amount. Plan B: 35% coinsurance + amounts that exceed the Reasonable and Customary amount.	Plan A: 30% coinsurance + amounts that exceed the Reasonable and Customary amount. Plan B: 35% coinsurance + amounts that exceed the Reasonable and Customary amount.	Plan A: 30% coinsurance + amounts that exceed the Reasonable and Customary amount. Plan B: 35% coinsurance + amounts that exceed the Reasonable and Customary amount.

Access care outside WV (beyond bordering counties) using PPO providers without prior approval* (OOSINNA)	Plan A: 40% coinsurance + up to a $500 copayment for unapproved out-of-state care. Plan B: 50% coinsurance + up to a $500 copayment for unapproved out-of-state care.	Plan A: 40% coinsurance + up to a $500 copayment for unapproved out-of-state care. Plan B: 50% coinsurance + up to a $500 copayment for unapproved out-of-state care.	Plan A: 30% coinsurance + amounts that exceed the Reasonable and Customary amount. Plan B: 35% coinsurance + amounts that exceed the Reasonable and Customary amount.
Access care outside WV using non-PPO providers without prior approval*	Not covered. You are responsible for 10% of the provider's charges, except if the care is the result of a medical emergency.	Not covered. You are responsible for 100% of the provider's charges, except if the care is the result of a medical emergency.	Not covered. You are responsible for 100% of the provider's charges, except if the care is the result of a medical emergency.

***PEIA PPB Plan D has NO coverage for out-of- state services.** Plan D members cannot receive services outside WV, except in a medical emergency or when UMR determines that a needed service is not available within WV. In these cases, out-of-state care is covered as in-network care.

**Prior approval for access to out-of-state providers at the higher level of benefit (i.e. 80%) will not usually be granted if the care and/or treatment is available at in-state providers.

***Non-network out-of-state care is not covered except for emergency care and a limited number of services which are not available from West Virginia providers or in-network and which are approved in advance by the TPA-C.

****Prior approval for access to out-of-state providers at the higher level of benefit (i.e., 80%) will not usually be granted if the care is available at in-state providers.**

SERVICES COVERED IN FULL

The following services are covered in full in-network for all PEIA PPB Plans for any period during which the Patient Protection and Affordable Health Care Act (PPACA) mandates 100% coverage. If PPACA does not mandate 100% coverage, normal copayments apply:

Type of Service	**Frequency**
Covered Preventive Services for Adults *AWV=Annual Wellness Visit	
Abdominal Aortic Aneurysm one-time screening for men aged 65-75 who have ever smoked	Once per lifetime
Alcohol Misuse screening and counseling	Included in AWV
Aspirin use for men and women of certain ages (requires a prescription; covered under prescription drug plan)	As Needed
Blood Pressure screening for all adults	Included in AWV

Cholesterol screening for men age 35 and older and women age 45 and older or others at higher risk	Included in AWV
Colorectal Cancer screening for adults over 50	See Section V.5. Covered Services, Colorectal Cancer Screening
Depression screening for adults	Included in AWV
Type 2 Diabetes screening for adults with high blood pressure	Included in AWV
Diet counseling for adults at higher risk for chronic disease	Included in AWV
Hepatitis B screening for people at high risk	As Needed
Hepatitis C screening for everyone born between 1945-1965 and people at high risk	As Specified
HIV screening for all adults at higher risk	Annually
Immunization vaccines for adults—doses, recommended ages, and recommended populations vary: Hepatitis A Hepatitis B Herpes Zoster Human Papillomavirus Influenza (Flu Shot) Measles, Mumps, Rubella Meningococcal Pneumococcal Tetanus, Diphtheria, Pertussis Varicella	As Recommended by the American Academy of Family Physicians
Lung cancer screening for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years	As Specified
Obesity screening and counseling for all adults	Included in AWV
Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk	Included in AWV
Tobacco Use screening for all adults and cessation interventions for tobacco users (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	See Section VI.8. Tobacco Cessation Program
Syphilis screening for all adults at higher risk	Annually
Covered Preventive Services for Women, Including Pregnant Women	
Anemia screening on a routine basis for pregnant women	As Needed
Bacteriuria urinary tract or other infection screening for pregnant women	As Needed
BRCA counseling about genetic testing for women at higher risk	As Needed
Breast Cancer Mammography screenings every 1-2 years for women over 40	Every 1-2 years
Breast Cancer Chemoprevention counseling for women at higher risk	Once per lifetime
Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women	As Needed
Cervical Cancer screening for sexually active women	Annually
Chlamydia Infection screening for younger women and other women at higher risk	Annually
Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling (generic oral contraceptives require a prescription; covered under the prescription drug plan)	As Needed
Domestic and interpersonal violence screening and counseling for all women	Included in AWV
Folic Acid supplements for women who become pregnant (requires a prescription; covered under prescription drug plan)	As Needed
Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes	Once per pregnancy
Gonorrhea screening for all women at higher risk	Annually

Hepatitis B screening for pregnant women at their first prenatal visit	Once per pregnancy
Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women	Annually
Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older	Every 3 years
Osteoporosis screening for women over age 60 depending on risk factors	Annually after age 60
Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk	As Needed
Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	See Section VI.8. Tobacco Cessation Program
Sexually Transmitted Infections (STI) counseling for sexually active women	Included in AWV
Syphilis screening for all pregnant women or other women at increased risk	Annually
Well-woman visits to obtain recommended preventive services	Annually
Covered Preventive Services for Children (*WCC=Well Child Care)	
Alcohol and Drug Use assessments for adolescents	Included in WCC
Autism screening for children at 18 and 24 months	Included in WCC
Behavioral assessments for children of all ages Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Blood Pressure screening for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Cervical Dysplasia screening for sexually active females	Annually
Congenital Hypothyroidism screening for newborns	Once, for newborn
Depression screening for adolescents	Included in WCC
Developmental screening for children under 3, and surveillance throughout childhood	Included in WCC
Dyslipidemia screening for children at higher risk of lipid disorders Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	As specified
Fluoride Chemoprevention supplements for children without fluoride in their water source (requires a prescription; covered under the prescription drug plan)	As Needed
Gonorrhea preventive medication for the eyes of all newborns	Once, for newborn
Hearing screening for all newborns	Included in WCC
Height, Weight and Body Mass Index measurements for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Hematocrit or Hemoglobin screening for children	Once per lifetime
Hemoglobinopathies or sickle cell screening for newborns	Once, for newborn
HIV screening for adolescents at higher risk	Annually
Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis — Haemophilus Influenzae type B Hepatitis A — Hepatitis B Human Papillomavirus — Inactivated Poliovirus Influenza (Flu Shot) — Measles, Mumps, Rubella Meningococcal — Pneumococcal Rotavirus — Varicella	As Recommended by the American Academy of Pediatrics
Iron supplements for children ages 6 to 12 months at risk for anemia (requires a prescription; covered under the prescription drug plan)	As Needed

Lead screening for children at risk of exposure	As Needed
Medical History for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Obesity screening and counseling	Included in WCC
Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years	Included in WCC
Phenylketonuria (PKU) screening for this genetic disorder in newborns	Once, for newborn
Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk	Included in WCC
Tuberculin testing for children at higher risk of tuberculosis Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	As specified
Vision screening for all children	Included in WCC

SERVICES SUBJECT TO 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 Plans A, B & D begin 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**
Primary Care Physician Office Visits – treat illness or injury	$20 copayment per visit with no deductible
Specialist Office Visit	$40 copayment per visit with no deductible
Out-of-State Primary Care Office Visits (In-Network)	$20 copayment per visit with no deductible
Second Surgical Opinions*	$40 copayment per visit with no deductible
Pain management and Rehabilitative Outpatient Services Visits 1-20	$20 copayment per visit with no deductible

*No copayment if required by UMR.

COPAYMENT, COINSURANCE AND DEDUCTIBLE

Type of Service	**Your In-network Cost**
Emergency Services (including supplies)	$100 copayment + deductible and coinsurance *An additional $500 copayment will be assigned for high risk behaviors including but not limited to injuries resulting from: ATV, UTV, and/or motorcycle accidents where no helmet was worn; motor vehicle accidents where no seatbelt was worn; and DUI/DWI and/or drug related accidents or injuries
Non-emergency services at emergency room*	$100 copayment + deductible and coinsurance

Ambulatory surgery/Outpatient surgery (facility-based)	$100 copayment + deductible and coinsurance
Bariatric surgery and dental procedures	$500 copayment + deductible and coinsurance
Out-of-network transplant services	Deductible + coinsurance + additional $10,000 deductible
Outpatient Therapy Services visits 1-20	$10 copayment + deductible and coinsurance
Outpatient Therapy Services visits 21 +	$25 copayment + deductible and coinsurance

*Non-emergency services received at the emergency room are very expensive to the PEIA Plans. Members who visit the emergency room for non-emergency services an excessive number of times may be placed on case management or otherwise have payment for their ER services restricted or terminated by the PEIA Plans.

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

COINSURANCE AND DEDUCTIBLE

Services not listed in the three preceding charts are covered after the deductible is met. The coinsurance amounts are shown in the chart below:

	In WV and within contiguous counties*	In-Network Outside WV WITH Approval from UMR* Higher Level of Benefit	Out-of-State, In-Network Not Approved by UMR (OOSINNA) Lower Level of Benefit	Out-of-network Outside WV WITHOUT Approval from UMR
Plan A	80/20	70/30	60/40	Not Covered
Plan B	70/30	65/35	50/50	Not Covered
Plan D	80/20**	70/30	Not Covered	Not Covered

You pay your deductible, coinsurance, and any charges for services not covered by the plan directly to your health care provider.

* Boyd County, Kentucky, and Washington County, Ohio, are excluded.

** Contiguous counties are not covered in Plan D.

APPENDIX D:

OUT-OF-POCKET MAXIMUMS, PEIA PPB PLANS A, B & D

ANNUAL BENEFIT MAXIMUMS

Employee Status	Employee's Annual Salary	Annual In-network Out-of-Pocket Maximum	Annual In-Network Out-of-Sate w/o Approval* Out-of-Pocket Maximum
PEIA PPB Plans A and D (Active, State Agency, Colleges and Universities, Board of Education)	$0 - $22,700	$1,800/single; $3,600/family	$3,600/single; $7,200/family
	$22,701 - $32,700	$2,100/single; $4,200/family	$4,200/single; $8,400/family
	$32,701 - $38,700	$2,250/single; $4,500/family	$4,500/single; $9,000/family
	$38,701 - $44,700	$2,500/single; $5,000/family	$5,000/single; $10,000/family
	$44,701 - $52,700	$2,750/single; $5,500/family	$5,500/single; $11,000/family
	$52,701 - $65,200	$2,800/single; $5,600/family	$5,600/single; $11,200/family
	$65,201 - $77,700	$2,850/single; $5,700/family	$5,700/single; $11,400/family
	$77,701 - $102,700	$2,900/single; $5,800/family	$5,800/single; $11,600/family
	$102,701 - $127,700	$3,000/single; $6,000/family	$6,000/single; $12,000/family
	$127,701 +	$3,250/single; $6,500/family	$6,500/single; $13,000/family
PEIA PPB Plan B (state agencies, colleges, universities and county boards of education)	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family
Non-State Plans A & D	Not Applicable	$2,500/single; $5,000/family	$5,000/single; $10,000/family
Non-State Plan B	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family
Non-Medicare Retirees Plan A	Not Applicable	$1,500/single; $3,000/family	$3,000/single; $6,000/family
Non-Medicare Retirees Plan B	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family
Deputy Sheriff's Early Retirement Plan A	Not Applicable	$2,500/single; $5,000/family	$5,000/single; $10,000/family
Deputy Sheriff's Early Retirement Plan B	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family
State-funded Elected Officials Plans A and D	Not Applicable	$2,500/single; $5,000/family	$5,000/single; $10,000/family
State-funded Elected Officials Plan B	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family

*PEIA PPB Plan D has no out-of-network or out-of-state benefit, so this column does not apply to Plan D members.

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 catastrophic cases involving serious long-term illness or injury resulting in loss or impaired function requiring medically necessary therapeutic intervention, the case manager may, based on medical documentation, recommend additional treatment for services marked with an asterisk (*). For details of these benefits, see Section V.5. Covered Services. All services listed below must be medically necessary; otherwise, they are not covered.

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)
Pain Management and Rehabilitative Outpatient Services	20 visits (total amount allowed for all therapies combined)
Inpatient Rehabilitation	150 Days
Skilled Nursing Facility	100 Days

APPENDIX E: MEDICAL EQUIPMENT NOT COVERED

Examples of Durable Medical Equipment that are not covered expenses:

- Augmentative communication devices
- Bath Paraffin (Unit)
- Bariatric beds and chairs
- Bathroom Equipment:
    - Toilet Seat
    - Commode
    - Scale
    - Bathtub seat, Bathtub fit Rail or Grab Bar
- Bed Baths
- Bed Board
- Breast Pump
- Chair Tables
- Chair, Recliner or Autotilt
- Child's Stroller
- Contour Chair
    - Dehumidifier
- Diapers (Adult or Infant)
- Diathermy Machines
    - Dust Extractor
- Ear plugs or Molds
- Educational equipment
- Electric Bed
- Enuresis Unit
- Environmental Control Equipment:
    - Air Cleaner or Filters
    - Air Conditioner
    - Air Filter
    - Air Freshener
    - Assistance Devices
    - Humidifiers
    - Dehumidifiers
    - Portable Heaters
    - Dust extractors
    - Sweeper
- Equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; star lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs (including Hoyer lifts); recliners; contour chairs; adjustable beds; or tilt stands

- Support devices which are widely available over the counter such as prophylactic wrist, ankle, and knee supports
- Escalator, Elevator or Stair Lift
- Exercise Biker, Stairmaster
- Exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines
- Food Liquidizer/Food Processor
- Geri Chairs
- Hearing Aid
- Heat Lamps
- Heating Pad
    - Humidifier
- Hydraulic Van or Car Lift
- Hygienic equipment such as bed baths, commodes, and toilet seats
- Ice Bag
- Irrigating Kit
- Language Master and Other Vocabulary
- Lift Chair and Lifts
- Low Vision Devices:
    - Magnifiers, Telescopic Lenses, Closed Circuit TVs
- Massage Devices, Vibrators
- Motorized Scooters
- Muscle Stimulators
- Nutritional supplements, over-the-counter (OTC) formula, food liquidizers or food processors
- Omnipod, V-go, Finesse and other disposable insulin delivery systems
- Orthopedic Mattress
- Orthopedic shoes (unless attached to Brace)
- Orthopedic Shoes, (unless attached to a brace)
- Percussion Packs
- Professional Medical Equipment:
    - Blood Pressure Kit
    - Stethoscope, etc
- Pulse Tachometer
- Replacement of lost or stolen items
- Rollabout Chairs
- Room Heater (portable)
- Sauna Baths
- Special Adaptive Equipment
- Standing tables
- Standing or tilt wheelchairs
- Supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags

- Telephone Arms
- Thermometer
- Traction Devices
- Transfer Bars or Benches
- Trapeze Bar
- Treadmill, Jogger
- Vibrators
- Walking Cane with Seat
- Waterbed
- Whirlpool or Hydro Massage Equipment
- Whirlpool pumps or equipment
- Wig and/or Wig Styling

Supplies such as tape, gauze, diapers, swabs, and elastic bandages, are not covered for any reason.

APPENDIX F: PEIA OUT-OF-STATE PPO PROGRAM

(Not applicable to Plan D)

Preferred provider Organizations

For services provided outside the State of West Virginia, the PEIA/UMR network principally utilizes the UMR network. This network reviews 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. All services received out-of-state by a W.Va. resident member (including border counties), 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. Prior approval for access to out-of-state network providers at the higher level of benefit (80%) will usually not be granted if the service is available from in-state providers. 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.

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 UMR or their sub-contractor 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 UMR 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 the PEIA/UMR Network.

5. Call UMR or their sub-contractor 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 UMR.

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). UMR will send insureds an Explanation of Benefits.

PEIA PPB Plan D has NO coverage for out-of-state services. Plan D members cannot receive services outside WV, except in a medical emergency or when UMR determines that a needed service is not available within WV. In these cases, out-of-state care is covered as in-network care.

The PEIA PPB Plans A, B & D are 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, PEIA uses UMR network with a few exclusions.

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 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 designed (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 payments 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 and another plan, This Plan is 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(b) 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 rules 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 rules 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 that 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.

APPENDIX H: ANNUAL PRESCRIPTION DRUG COPAYMENTS/COINSURANCE

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 TPA-P contracted rate less the PEIA discount, plus the dispensing fee, minus the insured's responsibility. The allowed amount is usually less than the submitted amount.

Prescription drug Copayments and Coinsurance		
PEIA PPB Plan A or D		
	Up to a 30-day supply	90-day supply*
Generic Drug	$10	$20
Brand-name drug listed on the WV Preferred Drug List	$25	$50
Brand-name drug not listed on the WV Preferred Drug List*	75% Coinsurance	75% Coinsurance
Common Specialty Medications on WV Preferred Drug List	$100	Not Available
Common Specialty Medications NOT on WV Preferred Drug List †	$150	Not Available
PEIA PPB Plan B		
Generic Drug	$10	$20
Brand-name drug listed on the WV Preferred Drug List	$30	$60
Brand-name drug not listed on the WV Preferred Drug List#	75% Coinsurance	75% Coinsurance
Common Specialty Medications on WV Preferred Drug List	$100	Not Available
Common Specialty Medications NOT on WV Preferred Drug List†	$150	Not Available

*For maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. You must purchase all medications on the Maintenance Drug List in 90-day supplies through a Retail Maintenance Network pharmacy or through Mail Service. Read on for details.

† Should your doctor prescribe, or you request the brand-name Specialty Medication when a generic drug is available, you must pay 75% coinsurance.

Should your doctor prescribe, or you request the brand-name drug when a generic drug is available, you must pay 75% coinsurance.

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. In accordance with 45 CFR Part 160 and Subparts A and C of Part 164, 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 disclosure 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. The plan sponsor conveys the right(s) and authority to the group health plans to conduct certain vendor assurances on any and/or all contractors and/or subcontractors who perform administrative and/or healthcare operational services for the plans to ensure compliance with any and/or all applicable rule(s), regulation(s), and/or rule referenced guidance as it relates to maintaining and ensuring the privacy, security, confidentiality, and integrity of any and/or all personally identifiable information (PII) and/or protected health information (PHI) managed by and/or for the plans.

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 unless compelled to do so by a subpoena or Order from a court of competent jurisdiction.

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, U. S. 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 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.

    a. 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,

    b. 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.

    c. 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

If you have questions about this notice, please contact the person listed under "Who to Contact." 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 that is created or received by PEIA or its Business Associates that relates to the past, present, or future physical or mental health, healthcare, or payment for the healthcare of an individual.

Who Must Abide by This Notice

- PEIA
- All employees, staff, students, volunteers, contractors, and other personnel who work 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 *and security* 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 respond to your requests or concerns within a timely manner.
- 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.

This notice describes how we may use your personal, protected health information, or disclose it to others, for a number of different 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 and use the results to discuss with your health issues. 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 administrators 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 that 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. These third-parties are called "Business Associates" and are held to the same standards as PEIA with regard to ensuring the privacy, security, integrity, and confidentially of your personal information. If, in the course of healthcare operations, your confidential information is transmitted electronically, PEIA requires

that information to be sent in a secure and encrypted format that renders it unreadable to unauthorized users.

4. Legal Requirements 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. We will only disclose the minimum amount of health information necessary to fulfil the legal requirement.

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. We will only disclose the minimum amount of health information necessary to fulfill the investigation request.

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 a de-identified format in connection with approval 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. We will only disclose the minimum amount of health information necessary to fulfill the authorization request. 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 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 and certain specific exclusions do apply. 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 will accept electronic request for releases of information in the form of e-mails or other electronic means. If you choose, you may receive your records in an electronic format but PEIA has the right to make sure that electronic information is delivered in a safe, secure, and confidential format. We may charge a fee for the cost of copying, mailing and/or e-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 including 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 have any questions about the privacy and security of your records, 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 & Security Officer, West Virginia Public Employees Insurance Agency, 601 57th Street, SE, Charleston, WV 25304-2345, **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.Help@wv.gov

Revised July 1, 2019

Summary Plan Description
PPB Plan A,B & D
Plan Year 2020

July 1, 2019-June 30, 2020



JOIN PEIA

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

Group health plans sponsored by state and local government employers must generally comply with federal law requirements in the title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. PEIA has elected to exempt the PEIA PPB Plans from item two of the following requirements:

1. Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.
2. Protections against having benefits for mental health and substance-use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.
3. Certain requirements to provide benefits for breast reconstruction after a mastectomy.
4. Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these federal requirements will be in effect for the 2020 plan year, beginning July 1, 2019 and ending June 30, 2020. The election may be renewed for subsequent plan years.

Medicare Part D Notice

If you (and/or your covered dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page page 101 for details.

Summary of Benefits and Coverage

Want to compare all of the plans offered by PEIA? There's an easy way! Go to www.wvpeia.com and click on Members, then Active Members, then scroll down to choose the "Summary of Benefits and Coverage" link. This link allows you to enter a bit of information and receive customized comparisons of the PEIA PPB Plans. If you don't have internet access, you can call PEIA's customer service unit at 1-888-680-7342 and we can generate the SBCs for you!

PEIA PPB Plan C

PEIA also offers an IRS-qualified High-Deductible Health Plan (HDHP) which we call PEIA PPB Plan C.
For information about Plan C, download the Summary Plan Description (Plan C) at www.wvpeia.com or call 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 in the PEIA PPB Plans A, B and D for Plan Year 2020 (July 1, 2019- June 30, 2020). It includes important information for all public employees who have ANY coverage through PEIA. PEIA also offers PPB Plan C, which is an IRS-qualified High-Deductible Health Plan (HDHP). For information about Plan C, download the Summary Plan Description (Plan C) at www.wvpeia.com or call 1-888-680-7342.

Managed Care Members

For those who are enrolled in managed care plans, this booklet provides all 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 benefits and 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 Plans A, B and D, this booklet includes many details of the Preferred Provider Benefit (PPB) Plans. 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 health care benefits.

This Summary Plan Description (SPD) provides PEIA PPB Plan participants with an easy-to-read description of benefits available through the Plans 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.

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

PEIA PPB Plan A is PEIA's most popular plan. PEIA PPB Plan B is similar to the standard PPB Plan A, but offers lower premiums with higher deductibles, higher out-of-pocket maximums, a greater coinsurance requirement, and higher copayments for prescription drugs. The medical coverage is the same as in PPB Plan A. PEIA PPB Plan C is PEIA's IRS-qualified High Deductible Health Plan, and the details of Plan C are covered in the Summary Plan Description – Plan C, which is available at www.wvpeia.com or by calling 1-888-680-7342. Plan D is the West Virginia ONLY plan whose benefits mirror those of Plan A, but with no out-of-state benefits except for medical emergencies and a few services that are not available within WV.

Medicare-primary Members

For most Medicare-eligible retired employees and Medicare-eligible dependents of retired employees, PEIA has a contract with Humana to provide medical and prescription drug benefits. Information in this booklet regarding benefits for Medicare retirees is very limited. You should refer to your Humana Evidence of Coverage booklet for benefit details. Each eligible member has received detailed information about the plan from Humana. If you have questions, please use the numbers on the back of your ID card to obtain answers.

Life Insurance Only

For employees who carry only life insurance with PEIA, your eligibility and enrollment details are in this booklet. Details of the life insurance coverage are in the Life Insurance Booklet. For questions about life insurance or to file a life insurance claim, call Securian Financial at 1-800-203-9515.

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. 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 and Benefits, Precertification, Pre-authorization, Prior Approval of Out-of-State Care and Utilization Management

UMR at 1-888-440-7342 (toll-free) or on the web at www.uhc.com.

Provider Network Administration

UMR with UnitedHealthCare Choice Plus PPO at 1-888-440-7342(toll-free).

Prescription Drug Benefits and Claims

CVS Caremark at 1-844-260-5894 (toll-free) or on the web at www.caremark.com.

Common Specialty Medications

CVS Caremark Specialty Medication Program at 1-844-260-5894 (toll-free).

Sleep Testing, Equipment, and Supplies

CareCentrix at 1-888-497-5337

Subrogation and Recovery

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

PEIA

Answers to questions about eligibility and third-level claim appeals. Contact WV Public Employees Insurance Agency at 1-304-558-7850 or 1-888-680-7342 (toll-free) or on the web at www.wvpeia.com.

Humana

Medical and prescription drug benefits for Medicare-primary members. Answers to questions about eligibility, health claims, benefits, and claim appeals: Call Humana at 1-800-783-4599.

Securian Financial

Answers to questions about life insurance or to file a life insurance claim. Call Securian Financial at 1-800-203-9515.

Mountaineer Flexible Benefits

Dental, vision, disability insurance and flexible spending accounts. Contact FBMC Benefits Management at 1-844-559-8248 (toll-free) or on the web at www.myfbmc.com.

PEIA Face-to-Face Diabetes Management Program

For information call 1-888-680-7342 or visit www.peia2f.com.

PEIA Weight Management Program

For information about the program, call 1-866-688-7493 or email weightmanagement@wv.gov. To enroll, visit www.wvpeia.com.

The Health Plan of West Virginia, Inc. HMOs & POS

1-800-624-6961 (toll-free), 1-888-847-7902 or on the web at www.healthplan.org.

Terms & Definitions

Affordable Care Act (ACA) Out-of-Pocket Maximum: The Affordable Care Act places a limit on how much you must spend for healthcare in any plan year before your plan starts to pay 100% for covered essential health benefits. This limit includes deductibles (medical and prescription), coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not include premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing or spending for non-essential health benefits.

The maximum out-of-pocket cost for Plan Year 2020 can be no more than the rates set by the federal government for individual and family plans. Because PEIA's plans have out-of-pocket maximums that are substantially lower than the ACA required limits, the ACA out-of-pocket maximum should never come into play for most PEIA PPB Plan members.

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 Plans A, B and D, 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 (or Employee Only) 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 Plans. For more information, read the "Recovery of Incorrect Payments" section.

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

Case Management: A program from UMR to identify catastrophic and complex illnesses, transplants, and trauma cases, and work with members to maximize their benefits.

Claims Administrator: UMR adjudicates health claims for the PEIA PPB plans.

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

Common Specialty Medications: Self-administered specialty drugs that are provided through CVS Specialty Pharmacy. All Specialty medications require prior authorization.

Comprehensive Care Partnership (CCP) Program: This program promotes the use of services to keep the patient well, identify health problems early, maintain control of chronic conditions and to promote efficient utilization of healthcare resources. The CCP provider is responsible for preventative services, routine sick care, and coordination of care with specialists when needed. Members who enroll in the CCP program pay less for specified services at their CCP provider. Any time a CCP member uses any provider outside the CCP, including another primary care provider, the co-payment for the office visit will be $40. Insureds enrolled in PEIA PPB Plan C or who have Medicare as their primary coverage are not eligible for CCP enrollment.

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

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 PEIA PPB Plans A, B & D. Copayments do not count toward your annual out-of-pocket maximum or your annual deductible.

CVS Caremark: PEIA's prescription drug benefit manager (PBM). CVS Caremark processes and pays prescription drug claims and helps manage the prescription drug benefit.

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.

Disease Management: A program from UMR to identify individuals who have certain chronic diseases and would benefit from working with specially trained nurses to manage those chronic diseases and maintain quality of life.

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: A condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of a bodily part or organ.

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 your benefits, contact the benefit coordinator at your payroll location or call the PEIA.

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

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 is 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. Phase 2 and 3 Clinical Trials for terminal cancer and other life-threatening conditions which meet certain statutory criteria will be covered despite being experimental.

Explanation of Benefits (EOB): A form sent to the policyholder 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.

Health Maintenance Organization (HMO): 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 that 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.

Health Savings Account (HSA): A health savings account (HSA) is a tax-exempt trust or custodial account that members of PEIA PPB Plan C may set up with a qualified HSA trustee to pay or reimburse certain medical expenses. The HSA works in conjunction with a High Deductible Health Plan. For more information about PEIA's HDHP, download the Summary Plan Description (Plan C) at www.wvpeia.com or call 1-888-680-7342.

HealtheNotes: UMR provides targeted mailings to members and providers. HealtheNotes provide useful, personalized information to help members manage their health.

Healthy Tomorrows: A coordinated lifestyle and disease management program for all PEIA PPB Plan members.

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 Plans, a managed care plan, or life insurance only. Insured refers to anyone who has coverage under any plan offered by PEIA.

Legal Guardianship: A legal relationship created when a person or institution is named by the Court to take care of minor children. Eligibility for guardianship requires an Order from a Court of record. Notarized documents signed by parents assigning "guardianship" are not sufficient to establish eligibility. The term "guardian" may also refer to someone who is Court-appointed to care for and/or handle the affairs of a person who is incompetent or incapable of administering his/her affairs. Sometimes a separate person is appointed to handle the financial matters of the child(ren) or the adult and that relationship is called a conservatorship.

Maternity Management: A program from UMR that provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term.

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. 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 D (drug coverage) IS NOT required for members of the PEIA Plans.

Medicare Advantage and Prescription Drug (MAPD) Plan: A type of Medicare benefits that combines Medicare Parts A, B and D into one comprehensive benefit package. PEIA provides benefits to Medicare-eligible retired employees and Medicare-eligible dependents of retired employees almost exclusively through the Humana MAPD plan offered by PEIA.

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

Non-Resident PPB Plan Participants: A PEIA PPB Plan participant who resides outside WV and beyond the bordering counties.

Notification: The required process for reporting an inpatient stay to UMR. 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, freestanding facility, or physician's office but who is not admitted as a bed patient.

OOSINNA: Out-of-state (beyond the contiguous counties), in-network, not approved. Services of an out-of-state, in-network provider not approved in advance by UMR are covered at the lower benefit level. The patient is also responsible for double the in-network deductible and double the in-network out-of-pocket maximum. OOSINNA does not apply to non-resident PPB Plan participants.

Participant: A policyholder or dependent enrolled in one of the PEIA PPB Plans.

PEIA PPB Plan A: The most expensive PEIA PPB Plan offered to all eligible active employees and non-Medicare retirees.

PEIA PPB Plan B: A lower-cost PEIA PPB Plan offered to all eligible active employees and most non-Medicare retirees. Plan B offers lower premiums with higher deductibles, higher out-of-pocket maximums, increased coinsurance, and higher copayments for prescription drugs. The medical coverage is the same in Plans A, B and D. The differences in deductibles, out-of-pocket maximums, coinsurance and drug copayments are noted in the tables in the "What You Pay with the PEIA PPB Plans A, B & D " section and the "Prescription Drug Benefit" section of this book.

PEIA PPB Plan C: The IRS-qualified High Deductible Health Plan (HDHP) offered by PEIA to all eligible active employees. The plan offers lower premiums, but a high deductible that must be met before the plan begins to pay. The plan is designed to work with either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). For more information about PEIA's HDHP, download the Summary Plan Description (Plan C) at www.wvpeia.com or call 1-888-680-7342.

PEIA PPB Plan D: PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, and the premiums are much lower than Plan A. The difference is that the only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia.

For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

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 properly licensed WV providers who provide health care services or supplies to any PEIA participant, as well as most out-of-state providers in UnitedHealthCare Choice Plus Preferred Provider Organization. For services provided outside of the State, contact UMR to find a network provider.

Pharmacy Benefits Manager (PBM): A company with which PEIA has a contract to administer the prescription drug benefit component of PEIA PPB plans. The PBM processes and pays prescription drug claims and helps manage the prescription drug benefit.

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 for active PEIA participants. January 1 to December 31 for participants in the Special Medicare Plan.

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 contact UMR in advance of a procedure to verify that the service is a covered benefit and medically necessary.

Precertification: The required process of reporting any out-of-state inpatient admission, any mental health inpatient admission, in-state admissions for certain procedures and certain outpatient procedures in advance to UMR to obtain approval for the admission or service.

Premium: The payment required to keep coverage in force.

Primary Care Provider: A general practice doctor, family practice doctor, internist, pediatrician, geriatrician, OB/GYN, nurse practitioner or physician assistant working in collaboration with such a physician, who, generally, provides basic diagnosis and non-surgical treatment of common illnesses and medical conditions.

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

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

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.

Qualifying Event: A qualifying event is a personal change in status which may allow you to change your benefit elections. Examples of qualifying events include, but are not limited to, the following:

1. Change in legal marital status – marriage or divorce of policyholder or dependent
2. Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship
3. Change in employment status of the employee's spouse or employee's dependent – switching from part-time to full-time employment status or from full-time to part-time, termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in employee/dependent becoming ineligible for coverage
4. Dependent satisfies or ceases to satisfy eligibility requirements

If you experience a qualifying event, you have the month in which the event occurs and the two following calendar months to act upon that qualifying event and change your coverage. If you do not act within that timeframe, you cannot make the change until the next Open Enrollment. **Qualifying events which end eligibility (such as <u>divorce</u>) must be reported immediately.** For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce

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 Plans.

Reasonable and Customary: The usual, customary and reasonable amount determined by the plan, for a geographic area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill or experience to treat successfully.

Resident PPB Plan Participants: PEIA PPB Plan participants who live in West Virginia or a bordering county of a surrounding state.

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 page 98.

Special Medicare Plan: The Plan created by PEIA to provide benefits to retirees unable to access providers in the Medicare Advantage plan and those retirees who become eligible for Medicare benefits during a plan year. Medical claims under this plan are paid by Medicare first, then by UMR and prescription claims are paid by CVS Caremark. The medical benefits are identical to those provided to members of the Humana MAPD plan, including a plan year that runs from January through December.

Specialty Injectable Drugs: These are prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring. The PEIA PPB Plans cover specialty injectable drugs through a program managed by UMR.

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. Some specialty medications are covered under the medical benefit and are managed by UMR, and some are covered under the prescription drug benefit and administered by CVS Specialty Pharmacy. Those covered under the prescription drug benefit, have a two-tier copay; after meeting your deductible, preferred specialty drugs have a $100 copay, non-preferred specialty drugs have $150 copay. Specialty Injectable drugs managed by UMR require 20% coinsurance after deductible. All specialty medications covered under the prescription benefit (oral and self-injectable) require prior authorization through CVS Caremark. PEIA will allow a one-time initial fill of the medication at a retail pharmacy.

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.

UMR: The third-party administrator that handles medical claim processing, case management, utilization management, precertification, prior approval and customer service for the PEIA PPB Plans.

UnitedHealthCare Choice Plus PPO: PEIA's out-of-state Preferred Provider Network. Not all providers in the UnitedHealthCare Choice Plus PPO network may participate with PEIA. Kings Daughters Medical Center and Our Lady of Bellefonte hospitals in Kentucky remain out-of-network for PEIA, regardless of their network status with the PPO network. Also, PEIA does not use the PPO network in Washington County, Ohio, or in Boyd County, Kentucky. PEIA reserves the right to remove providers from the network, so not all providers listed in the network may be available to you.

Utilization Management: A process by which PEIA controls health costs and saves money for plan members. 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 UMR.

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 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 four PEIA PPB Plans. Read on to see who is eligible to enroll in each plan.

1. Plan A is the most expensive plan available to all eligible enrollees, including active employees and non-Medicare retirees.
2. Plan B offers lower premiums with higher deductibles, higher out-of-pocket maximums, increased coinsurance, and higher copayments for prescription drugs. The medical coverage is identical in PPB Plans A, B & D. Plan B is available to all active employees and to non-Medicare retirees whose dependents do not have Medicare.
3. Plan C is an IRS-qualified High-Deductible Health Plan (HDHP). For more information about PEIA's HDHP, download the Summary Plan Description (Plan C) at www.wvpeia.com or call 1-888-680-7342. Plan C is available to active employees only.
4. Plan D is the West Virginia ONLY plan. Insureds enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-network coverage, except as noted above. Plan D is available to active employees only.

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 for information about the managed care plans 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 page 97 for a complete description of this provision. The PEIA PPB Plans may be of little or no value to you as secondary insurance on your dependents.

Life Insurance

As an active or retired employee, you may be eligible for basic decreasing term life insurance. This policy includes accidental death and dismemberment (AD&D) benefits for active employees only. If you enroll for health benefits as an active employee, you must also enroll for basic life insurance. If you choose not to enroll for health benefits, you may still 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.

Active employees may choose from among several options for dental, vision, hearing and short-and long-term disability insurance, as well as medical care and dependent care flexible spending accounts, and pay for these benefits on a pre-tax basis. A legal Plan is also available as a post-tax benefit option.

Retired employees are eligible for dental, hearing, and vision coverage and the group legal plan on a post-tax basis. Enrollment materials are mailed to all eligible retired employees prior to the April enrollment period. If you have questions about these benefits, contact Fringe Benefits Management Company at 1-844-559-8248.

Open Enrollment for Mountaineer Flexible Benefits is held each Spring for ALL active and retired employees. The current information about these benefits and associated premiums 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 1-844-559-8248.

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
Hearing Benefits	Coverage for hearing examination, diagnostic testing and hearing aids
Medical Flexible Spending Account	Deposit up to $2,700 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.

For a more complete description of benefits, see the Mountaineer Flexible Benefits Plan booklet.

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);
- a member of the West Virginia Board of Education (must pay 100% of the premium);
- a permanent full-time substitute teacher working on a contract of 90-days or more per school year;
- an elected member of a county board of education (must pay 100% of the premium); or
- a school service employee eligible under W.Va. Code, Chapter 18A.

Dependents: If you elect PEIA coverage, you may also enroll the following dependents with proper documentation:

- your legal spouse;
- your biological children, adopted children, or stepchildren under age 26;
- other children for whom you are the court-appointed guardian to age 18.

A child may not be enrolled for health coverage as both a policyholder (as a public employee in his or her own right) and as a dependent child. Dependent biological children, adopted children, or stepchildren may be covered under the

plan to age 26, regardless of their residency, marital status, or the availability of other insurance coverage. The dependent child's marriage is a qualifying event for the policyholder to remove the dependent child from coverage. The policyholder MAY remove the child, but is not required to do so.

From time to time PEIA may conduct eligibility audits to verify that policyholders and dependents in the plan qualify for coverage. If you are audited, you will have to produce documentation for the dependent in question. If you cannot prove that the dependent qualifies for coverage, coverage will be terminated retroactively to the date the dependent would otherwise have been terminated, and PEIA will pursue reimbursement of any medical or prescription drug claims paid during the time the dependent was ineligible.

How to Enroll or Make Changes

You may enroll for or make changes to PEIA health and life benefits using PEIA's online enrollment site, "Manage My Benefits," or by contacting your benefit coordinator. 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 enroll yourself and your dependents. Enrollment will authorize your employer or retirement system to deduct the premiums for the coverages you select from your salary or 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.

New Employees

New Employees 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 in which you are hired and the following two calendar months. This is your "initial enrollment period." To enroll your dependents, you will need to provide documentation substantiating their eligibility for benefits. The chart on page 26 shows the documentation required.

As an active employee, if you enroll for health insurance, you must enroll for basic life insurance, as well. If you enroll for basic life insurance, then you may enroll for optional life insurance if you so choose. No medical information is required for up to $100,000 of optional life insurance elected during this initial enrollment period. Medical information is always required for optional life insurance in excess of $100,000. You may also enroll for optional life insurance for your dependents up to $20,000. Dependent life insurance in excess of $20,000 requires medical information.

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. Your health care plan selection will remain in effect for a full plan year unless you move outside the service area of your plan or have a qualifying event that enables you to change or cancel coverage.

If you choose not to enroll for life insurance during this initial enrollment period, but want life coverage later (basic, optional or dependent) for you or your dependents, you may apply for that coverage at any time, but you will have to submit medical information 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 during an Open Enrollment period or if you have a qualifying event, in accordance with guidelines in effect at the time you choose to enroll. To enroll as a result of a qualifying event, you must do so during the month of the event or the following two calendar months or you will have to wait until the next Open Enrollment period.

Employees hired on and after July 1, 2010, will not receive any plan subsidy of their health insurance premiums at retirement. These employees may continue coverage in the plan at retirement but must pay the unsubsidized premium for the coverage of their choice. Two exceptions will be made to this rule:

1. Active employees hired before July 1, 2010, who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2010) hire date.
2. Retired employees who had an original hire date prior to July 1, 2010, may return to active employment and retain their pre-July 1, 2010, original hire date for purposes of determining their eligibility for premium subsidy.

Employees of non-state agencies that join the PEIA Plan after July 1, 2010, will be assigned a "hire date" in the PEIA systems that is the same as their effective date of coverage under the PEIA Plan. Upon retirement, these employees will be treated as those hired on or after July 1, 2010, and will be required to pay the full cost of coverage as noted above.

Actively at Work

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

PEIA has no pre-existing condition limitation. PEIA will provide coverage for all eligible medical conditions from the effective date of coverage. Managed care plans also 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:

- have completed a full day of active work on that date; and
- 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, coverage will become effective on the date you return to active work. Active work and actively at work mean performing regular duties for a full work day for the policyholder.

Existing Employees

Existing employees may make changes in their coverage as follows:

Health Coverage

Existing employees who choose not to take health coverage at the time of employment may enroll for health coverage by using PEIA's online enrollment site, **"Manage My Benefits"** or completing a Health Insurance Enrollment Form, provided that they have experienced one of the qualifying events shown in the chart on page 26.

To enroll as a result of a qualifying event, you must do so during the month of the event or the following two calendar months or you will have to wait until the next Open Enrollment. Coverage will be effective on the first day of the month following enrollment. In the absence of a qualifying event, coverage may be added for the employee and/or eligible dependents, only during PEIA's annual Open Enrollment period.

Life Insurance

Existing employees may add or increase the amount of life insurance at any time by using PEIA's online enrollment site, **"Manage My Benefits"** or completing an Optional Life Insurance Enrollment Form, submitting medical information, 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. 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, 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.

Dependents

You may enroll eligible dependents for health and life coverage during your initial enrollment period, and if you do, their coverage begins the same day as yours. To enroll dependents, you must provide documentation substantiating their eligibility for benefits. See page 26 for details. You may enroll dependents for health coverage outside your initial enrollment period only if you experience a qualifying event. If you enroll them at a later date, their coverage will become effective the first day of the month following enrollment. In the absence of a qualifying event, you may only enroll dependents for health coverage during Open Enrollment. Coverage will be effective on the first day of the following plan year. To add a dependent to your coverage, you must submit documentation to prove the dependent's eligibility. See page 26 for details.

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 medical information has been submitted to, and approved by, PEIA's life insurance carrier. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent. See page 26 for details.

To enroll or add dependents, you must use PEIA's online enrollment site, **"Manage My Benefits"** or complete paper forms available from your benefit coordinator. Coverage is not automatic, even if you have an existing family plan.

Dependents may be removed from coverage only during Open Enrollment or at the time of a qualifying event. To make a change as a result of a qualifying event, you must do so during the month of the event or the following two calendar months or you will have to wait until the next Open Enrollment. Qualifying events which end eligibility (such as divorce) must be reported immediately. The policyholder must provide documentation supporting the qualifying event to remove dependents. Coverage of removed dependents will terminate at the end of the month in which the policyholder removes them from coverage. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce.

Medicare for Active Employees

For PEIA PPB Plan active employees or dependents of active employees who are 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, neither you nor your Medicare-eligible dependent need to sign up for Medicare Part B and pay the premium. When you prepare to retire, you and your Medicare-eligible dependent must enroll for Medicare Part B.

If you do not enroll in Medicare Parts A & B, you will not be eligible for PEIA's Medicare Advantage plan, and your PEIA coverage may be terminated.

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, you must send a copy of your Medicare card to PEIA. This notification will make the claims payment process go much more smoothly.

Newly Eligible Active Employees

Employees who become eligible to enroll for health coverage due to a qualifying event may enroll for coverage during the calendar month of that qualifying event or the two following calendar months. Coverage will become effective the first day of the month following enrollment. Newly eligible employees may enroll in one of the PEIA PPB Plans or a managed care plan. They may make another plan selection during the next Open Enrollment period.

Special Rules for Newborn or Adopted Children

Newborn Child

When you have a child, you must:

- provide documentation;
- PEIA will accept the Certificate of Live Birth from the hospital as documentation to enroll the child initially, but you must provide the Birth Certificate as soon as you have it or PEIA will suspend the child's coverage until we receive it;
- 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 or to PEIA.

To enroll the child for health coverage you must:

- enroll your biological newborn child for health coverage during the calendar month of birth or the two following calendar months;
- coverage will be made effective retroactive to the date of birth;
- any premium increase associated with the addition of this child will also be retroactive to the month of birth; and
- if you do not enroll your newborn within this time frame, you cannot add the newborn child until the next Open Enrollment period.

To enroll the child for life insurance coverage you must:

- add a biological newborn child to your existing dependent life insurance policy during the calendar month of birth or the two calendar months following the date of birth;
- coverage will be made effective retroactive to the date of birth;
- any premium increase associated with the addition of this child will also be retroactive to the month of birth;
- if you add the child later, you will have to submit medical information and be approved to obtain dependent life insurance coverage for your child.

Adopted Child

When you adopt a child, you must:

- provide documentation;
- PEIA requires a copy of the adoption papers to enroll the child;
- in the case of a foreign adoption, PEIA requires adoption papers in English, and may require entry visa and/or statement from the U.S. consulate in the country of origin recognizing the adoption.

To enroll the child for health coverage you must:

- enroll an adopted child during the calendar month the child is placed in your home or the two following calendar months;
- coverage will be made effective retroactive to the date of placement;
- any premium increase associated with the addition of this child will also be retroactive to the date of placement;

- 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;
- if you do not enroll your child within this timeframe, the adopted child cannot be added to your coverage until the next Open Enrollment period.

To enroll the child for life insurance coverage you must:

- add an adopted child to your existing dependent life insurance policy (Plans 1-4) during the calendar month of or the two calendar months following the date of placement in your home;
- coverage can be made effective retroactive to the date of placement;
- any premium increase associated with the addition of this child will also be retroactive to the date of placement;
- if you add the child later, or elect Plan 5, you will have to submit medical information and be approved to obtain dependent life insurance coverage for your adopted child.

Eligibility and Enrollment for Retired Employees

Who is Eligible?

Retired public employees are eligible for health and life benefits through PEIA, provided:

1. you meet the minimum eligibility requirements of the applicable State retirement system or a PEIA-approved retirement system; and
2. your last employer immediately prior to retirement is a participating employer in the PEIA Plan and under the State retirement system or a PEIA-approved retirement system*.

Members who participate in a non-State retirement system must, in the case of education employees (such as TIAA CREF, TDC 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. The retiring employee and all enrolled dependents must re-enroll to continue health benefits into retirement.

PEIA offers non-Medicare retirees coverage through PEIA PPB Plan A or B or an HMO. Non-Medicare retirees must continue coverage in the plan in which they were covered as active employees until the next Open Enrollment, when they can choose any plan for which they are eligible. Retiring employees enrolled in PEIA PPB Plans C or D must choose either PEIA PPB Plan A or B upon retirement, since Plans C and D are not offered to retirees. Medicare-eligible PPB Plan members who retire after the beginning of a plan year, and retired employees who become eligible for Medicare during the plan year are transferred to PEIA's Special Medicare Plan until the beginning of the next Medicare plan year. Members enrolled in an HMO when they become Medicare-eligible will be transferred to the Special Medicare Plan. Medicare's Plan Year runs from January through December; PEIA follows that plan year for Medicare Retirees. Open Enrollment for Medicare members is held during the month of October with benefits effective on January 1.

* *Certain non-state agencies that participate in the PEIA health and life insurance plans for active employees have "opted out" of offering their employees PEIA's retiree insurance coverage, called the WV OPEB plan. If an employer opts out of the WV OPEB plan or is ineligible to participate in the WV OPEB plan due to retirement system participation, they are opting out of retiree eligibility for PEIA health and life coverage. Other post-employment benefits (OPEB) refers to the benefits, other than pensions, that a state or local government employee receives as part of his or her package of retirement benefits. Please be aware that, regardless of previous employment, previous or current coverage through PEIA and years of service, if an employee transfers to an opt-out agency immediately prior to retirement, the employee will not be eligible for retirement health or life insurance benefits through PEIA.*

Under the Special Medicare plan, the member must enroll for traditional Medicare Parts A and B, and their secondary medical and prescription claims are paid by UMR and CVS Caremark, respectively. Medical benefits under the Special Medicare Plan are generally the same as those provided under PEIA'S Medicare Advantage plan. Members remain in the Special Medicare Plan until the beginning of the next Medicare Plan Year (January 1), when they are transferred to PEIA's Medicare Advantage Plan.

These members can request to be transferred immediately to the Humana/PEIA Plan 1. There are two main benefit differences between the PEIA Special Medicare Plan and the Humana/PEIA Plan 1:

1. The Special Medicare Plan does not offer the SilverSneakers® fitness benefit that includes a free fitness center membership. This is only available from Humana.
2. The cost of non-preferred brand name medications is different.
    a. Under the Humana/PEIA Plan 1, the cost-sharing for a 30-day supply of a non-preferred drug is 50% of the cost of the drug, and maintenance medications in this category are eligible for the maintenance medication discount.
    b. Under the Special Medicare plan, a 30-day supply of a non-preferred drug will cost you 75% of the cost of the drug, and maintenance medications in this category are NOT eligible for the maintenance medication discount.

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. See page 34 for more information on extending employer paid insurance upon retirement.

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 in the PEIA Plan and under the State retirement system and as long as you meet the minimum retirement qualifications as determined by CPRB. Coverage will be effective on the first day of the month following enrollment.

Return to Active Employment

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, you have PEIA benefits as an active employee, which makes your new effective date of coverage in the PEIA plan after July 1, 2001, and therefore you are ineligible for the sick/annual leave benefit. The only exception to this rule is provided for those who participated in the plan prior to July 1, 2001, and who become re-employed with an employer participating in the plan within two years following separation from employment (retirement). In this case, the employee would be permitted to apply any sick and/or annual leave earned after re-employment, toward health premiums at retirement.

Employees hired on and after July 1, 2010, will not receive any plan subsidy of their premiums at retirement. These employees may continue coverage in the plan at retirement but must pay the unsubsidized premium for the coverage of their choice. Two exceptions will be made to this rule:

1. Active employees hired before July 1, 2010, who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2010) hire date.
2. Retired employees who had an original hire date prior to July 1, 2010, may return to active employment and retain their pre-July 1, 2010, original hire date for purposes of determining their eligibility for premium subsidy.

Deferred Retirement

If you separate from employment before your retirement from a participating employer under the State retirement plan, you may not enroll in PEIA as a retiree if you have other earned income just prior to retirement. If you are self-employed or have earned income from any other source, you will not be permitted to enroll as a retiree. To be eligible

to enroll in PEIA, your last employer immediately prior to retirement must have been a public entity that participates in the State retirement system or a PEIA-approved retirement system, and in the PEIA Plan.

Separated Pre-retirement Employees with 20 Years' Service

Employees with 20 or more years of service, who separate from public employment but who have not retired, may enroll in PEIA health benefits for up to two (2) years following separation. Employees in this category will be required to pay 105% of the total unsubsidized premium for the coverage they choose. Enrollees in this category are not eligible for PEIA's retiree premium assistance program or retiree premium subsidy until such time as they meet CPRB and PEIA's eligibility requirements as a full retiree. Employees in this category are not eligible to extend employer-paid insurance upon retirement using sick/annual leave or years of service credits.

Disability Retirement

A member who is granted disability retirement by a state retirement system or who receives Social Security disability benefits is eligible to continue coverage in the PEIA Plan as a retired employee, provided that the member meets the minimum years of service requirement of the applicable state retirement system. Members in this category continuously covered since before July 1, 2010, pay the same premiums as those with 25 or more years of service. Those hired on or after July 1, 2010, may continue coverage, but will pay the full, unsubsidized premium for that coverage. If you receive Social Security Disability benefits, please send a copy of your Disability Award letter to PEIA. Generally, those awarded Social Security disability benefits will receive Medicare benefits after a two-year waiting period. When you receive your Medicare ID card, you must provide a copy of that card to PEIA immediately. Disability retirees may be eligible for a life insurance waiver of premium. See page 35 for details.

Non-State Agency Retirees

Employees who retire from non-state entities which employer joined the PEIA Plan after July 1, 2010, will be assigned a "hire date" in the PEIA systems that is the same as their effective date of coverage under the PEIA Plan. Upon retirement, these employees will be treated as those hired on or after July 1, 2010, and will be required to pay the full cost of their coverage.

Deputy Sheriffs

Deputy sheriffs have the right to retire prior to attaining age 55 and continue their health benefits by paying the premiums designated for them in the Shopper's Guide each year. At the time of retirement, these retirees must continue coverage in the plan in which they were covered as active employees until the next Open Enrollment, when they can choose any plan for which they are eligible. Retiring employees enrolled in PEIA PPB Plans C or D must choose either PEIA PPB Plan A or B upon retirement, since Plans C and D are not offered to retirees.

Medicare

As a retired employee or a dependent of a retired employee, when you become an eligible beneficiary of Medicare, you must:

1. enroll in Medicare Part A and Medicare Part B; and
2. send a copy of your Medicare ID card to PEIA.

Your Medicare Beneficiary Identifier (MBI) number is required for coverage in PEIA's Medicare Advantage Plan or the Special Medicare Plan.

Most Medicare-eligible retired employees and Medicare-eligible dependents of retired employees have coverage through PEIA's Medicare Advantage plans.

- To be eligible for PEIA's Medicare Advantage plans, the member must enroll for Medicare Parts A and B.

- If you do not enroll in Medicare Parts A and B and pay the monthly premium, you will not be eligible for PEIA's Medicare Advantage plans, which is the only coverage offered to most retired, Medicare-eligible members.

The Medicare Advantage Plans provide different benefit options from which Medicare-eligible retirees can choose. Open Enrollment for Medicare retirees is held each October, with benefits effective on January 1. Medicare retirees' plan year runs from January through December. Benefits for non-Medicare dependents covered by PEIA will run on PEIA's plan year from July through June.

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

Medicare offers prescription drug coverage through a program called Medicare Part D. Please be aware that you should NOT purchase Medicare Part D coverage. You DO NOT need to enroll in a separate Medicare Part D plan, since PEIA will provide prescription drug coverage for retirees with Medicare. If you enroll in a separate Medicare Part D plan, you will be disenrolled from all medical and prescription benefits from PEIA. You will have only original Medicare Parts A, B and D with no secondary coverage.

Dependents

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

- your legal spouse;
- your biological children, adopted children, or stepchildren under age 26; or
- other children for whom you are the court-appointed guardian to age 18.

A child may not be enrolled for health coverage as both a policyholder (as a public employee in his or her own right) and as a dependent child.

From time to time PEIA may conduct eligibility audits to verify that policyholders and dependents in the plan qualify for coverage. If you are audited, you will have to produce documentation for the dependent in question. If you cannot prove that the dependent qualifies for coverage, coverage will be terminated retroactively to the date the dependent would otherwise have been terminated, and PEIA will pursue reimbursement of any medical or prescription drug claims paid during the time the dependent was ineligible.

How to Enroll

You may enroll for PEIA health and life benefits by completing enrollment forms available from your benefit coordinator or the PEIA website. On these forms, you will select the types of coverage you want and enroll the eligible dependents you wish to cover. When you have completed the forms, return them to your benefit coordinator (if initially retiring) or to PEIA (if already retired). Participation in PEIA benefit plans is not automatic upon retirement; you must complete the proper enrollment forms. Enrollment authorizes PEIA to deduct the premiums from your annuity for the coverages you select. 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.

At present, you cannot initially enroll for retirement benefits on PEIA's online enrollment website, but once you are retired, you may make changes in your information by going to www.wvpeia.com and clicking on **"Manage My Benefits"**.

PEIA PPB Plan/PEIA's Medicare Advantage Plan

You may enroll for PEIA retiree benefits regardless of age, as long as you meet the eligibility requirements. Non-Medicare retirees have benefits through the PEIA PPB Plan A or B or the managed care plan of their choice. Most Medicare

eligible retirees receive their benefits from PEIA's Medicare Advantage plan, although some are enrolled in PEIA's Special Medicare Plan.

Managed Care Plans

As a retired employee, you may enroll in a managed care plan if you are not 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. Generally, Medicare or an MAPD plan 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

You may continue your basic, optional and dependent life insurance at the time of retirement. If you wish to elect new or increased life insurance as a retired employee, you must enroll and submit medical information during the calendar month of retirement or the two following calendar months. Coverage will be effective upon approval of PEIA's life insurance carrier. You may not elect or increase life insurance after this period. If your life insurance lapses after retirement for any reason, for example, for non-payment of premiums, you will not be permitted to reinstate that coverage; you will need to seek life insurance from another source.

Enrolling Your Dependents

You may enroll dependents for health coverage when you enroll as a retiree, and if you do, their coverage begins the same day as yours. You may enroll dependents for health coverage outside your initial enrollment period only if you experience a qualifying event. To make a change as a result of a qualifying event, you must do so during the month of the event or the following two calendar months or you will have to wait until the next Open Enrollment. If you enroll them at a later date, their coverage will become effective the first day of the month following enrollment. In the absence of a qualifying event, you may only enroll dependents for health coverage during Open Enrollment; coverage will be effective on the first day of the following plan year. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent. See page 26 for details.

If you are adding a dependent to your existing dependent life insurance policy at a date later than the two calendar months following a qualifying event, coverage will not become effective until medical information has been submitted to and approved by PEIA's life insurance carrier. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent. See page 26 for details.

Dependents may be removed from coverage during Open Enrollment or at the time of a qualifying event. To make a change as a result of a qualifying event, you must do so during the month of the event or the following two calendar months or you will have to wait until the next Open Enrollment. Qualifying events which end eligibility (such as divorce) must be reported immediately. The policyholder must provide documentation supporting the qualifying event to remove dependents. Coverage of removed dependents will terminate at the end of the month in which the policyholder removes them from coverage. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce.

PEIA PPB Plan/Special Medicare Plan/PEIA's Medicare Advantage Plan

For the PPB Plan, the Special Medicare Plan or PEIA's Medicare Advantage Plan, you must enroll new dependents during the calendar month of, or the two calendar months following, the date of the qualifying event that makes them eligible (i.e., date of marriage, date of birth or adoption) even if you already have family coverage. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent. See page 26 for details. In the absence of a qualifying event, coverage may be added for the employee and/or eligible dependents, only during PEIA's annual Open Enrollment period.

Life Insurance

Add newly acquired dependents to your existing dependent life insurance policy (Plan 1) 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). Coverage greater than Plan 1 requires you to submit medical information and be approved to obtain dependent life insurance coverage.

Special Rules for Newborn or Adopted Children

Newborn Child

When you have a child, you must:

- provide documentation;
- PEIA will accept the Certificate of Live Birth from the hospital as documentation to enroll the child initially, but you must provide the Birth Certificate as soon as you have it or PEIA will suspend the child's coverage until we receive it;
- 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 or to PEIA.

To enroll the child for health coverage you must:

- enroll your biological newborn child for health coverage during the calendar month of birth or the two following calendar months;
- coverage will be made effective retroactive to the date of birth;
- any premium increase associated with the addition of this child will also be retroactive to the month of birth; and
- if you do not enroll your newborn within this time frame, you cannot add the newborn child until the next Open Enrollment period.

To enroll the child for life insurance coverage you must:

- add a biological newborn child to your existing dependent life insurance policy during the calendar month of or two calendar months following the date of birth;
- coverage will be made effective retroactive to the date of birth;
- any premium increase associated with the addition of this child will also be retroactive to the month of birth;
- if you add the child later, you will have to submit medical information and be approved to obtain dependent life insurance coverage for your child.

Adopted Child

When you adopt a child, you must:

- provide documentation;
- PEIA requires a copy of the adoption papers to enroll the child;
- In the case of a foreign adoption, PEIA requires adoption papers in English, and may require entry visa and/or statement from the U.S. consulate in the country of origin recognizing the adoption.

To enroll the child for health coverage you must:

- enroll an adopted child during the calendar month the child is placed in your home or the two following calendar months;
- coverage will be effective retroactive to the date of placement;
- any premium increase associated with the addition of this child will also be retroactive to the date of placement;

- 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;
- if you do not enroll your child within this timeline, the adopted child cannot be added to your coverage until the next Open Enrollment period.

To enroll the child for life insurance coverage you must:

- add an adopted child to your existing dependent life insurance policy (Plans 1-4) during the calendar month of or the two calendar months following the date of placement in your home;
- coverage can be made effective retroactive to the date of placement;
- any premium increase associated with the addition of this child will also be retroactive to the date of placement;
- If you add the child later, or elect Plan 5, you will have to submit medical information and be approved to obtain dependent life insurance coverage for your adopted child.

Eligibility and Enrollment for Surviving Dependents

Who is Eligible

The surviving spouse or dependent of an active or retired public employee who was insured as a spouse or dependent under the policyholder's coverage by PEIA at the time of the policyholder's death, may elect to continue health coverage as a policyholder in his or her own right under the health plan using a Surviving Dependent enrollment form available from PEIA.

If you are such a surviving spouse and you choose not to enroll immediately for coverage, you may elect PEIA health coverage during a future Open Enrollment Period if you have not remarried. The surviving spouse's eligibility for PEIA coverage terminates upon remarriage. If a divorce occurs after the remarriage, re-enrollment as a surviving dependent is not allowed.

Dependent Children

- surviving dependent children are eligible to continue health coverage, if they were enrolled in the health coverage at the time of the policyholder's death, subject to the same age restrictions as other dependent children in the PEIA plan;
- the deceased policyholder's biological or adopted children and/or stepchildren may continue coverage to age 26;
- other children for whom the deceased policyholder was the court-appointed guardian to may continue coverage to age 18;
- surviving dependent biological children, adopted children, or stepchildren may be covered under the plan to age 26, regardless of their residency, marital status, or the availability of other insurance coverage. The dependent child's marriage is a qualifying event to cancel PEIA coverage. A married surviving dependent child may not enroll his or her spouse for PEIA coverage.

From time to time PEIA may conduct eligibility audits to verify that policyholders and dependents in the plan qualify for coverage. If you are audited, you will have to produce documentation for the dependent in question. If you cannot prove that the dependent qualifies for coverage, coverage will be terminated retroactively to the date the dependent would otherwise have been terminated, and PEIA will pursue reimbursement of any medical or prescription drug claims paid during the time the dependent was ineligible.

How to Enroll

To continue health coverage without interruption, surviving dependents must complete enrollment forms in the calendar month death occurs or the two following calendar months. In this case, 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.

In the event of the death of the employee spouse who is the policyholder in the PEIA Plan, when the surviving dependent is also an active or retired public employee who is benefit-eligible in his or her own right, the surviving dependent has a choice to make. He or she must choose whether to enroll in the PEIA Plan as a surviving dependent of the policyholder, or as an active or retired employee.

If you enroll as a surviving dependent before July 1, 2015, premiums will be based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium with 25 or more years of service, but the surviving dependent is not eligible for life insurance.

If you enroll as a surviving dependent on or after July 1, 2015, premiums will be based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium and the years of service, but the surviving dependent is not eligible for life insurance.

If enrolled as an active or retired employee, premiums will be based on the appropriate active employee premium chart or, if retired, the surviving employee's own years of service, and he or she will be eligible for life insurance.

If you need help evaluating which would be better, please contact PEIA's customer service unit at 1-888-680-7342.

Special Eligibility Situations

If You and Your Spouse are Both Public Employees

Two public employees who are married to each other and 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 same 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.

To qualify for the Family with Employee Spouse premium, both employees MUST have basic life insurance. For active employees, the premium for Family with Employee Spouse coverage is based on the average of the two employees' salaries. The Family with Employee Spouse discount is also offered when the 'employee spouse' is a retired public employee; the premium for this coverage is based on the active employee's salary.

Generally, since both spouses, as policyholders, are eligible to make independent benefit elections, both spouses receive the Shopper's Guide, Summary Plan Description, and other relevant benefit information.

It the employee spouse on an active employee's plan is retired and Medicare-eligible, that employee spouse may want to consider becoming a "policyholder only" in PEIA's Medicare Advantage plan. Doing so could reduce your total premium and cost-sharing, depending on your situation.

In the event of the death of the employee spouse who is the policyholder in the PEIA Plan, when the surviving dependent is also an active or retired public employee who is benefit-eligible in his or her own right, the surviving dependent has a choice to make. He or she must choose whether to enroll in the PEIA plan as a surviving dependent of the policyholder, or as an active or retired employee.

If you enroll as a surviving dependent before July 1, 2015, premiums will be based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium with 25 or more years of service, but the surviving dependent is not eligible for life insurance.

If you enroll as a surviving dependent on or after July 1, 2015, premiums will be based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium and the years of service earned by the deceased policyholder, but the surviving dependent is not eligible for life insurance.

If enrolled as an active or retired employee, premiums will be based on the appropriate active employee premium chart or if retired, the surviving employee's own years of service, and he or she will be eligible for life insurance.

If you need help evaluating which would be better, please contact PEIA's customer service unit at 1-888-680-7342.

Transfer from One Participating Agency to Another

If you transfer from one participating agency to another in the middle of a plan year without a lapse in coverage, that transfer does not constitute a qualifying event to change coverage. 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 Plans A, B and C have an unlimited enrollment area, you will not be permitted to transfer out of them during the plan year, even if you move. PEIA PPB Plan D is available only to WV residents, so if you move outside the state you will be required to change plans.

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. In this case, a plan change may be permitted, if the transfer creates a qualifying change in family status under the Premium Conversion Plan. Other transfers may permit a change in coverage based on documented financial hardship.

Disabled Child

Your dependent child may continue to be covered after reaching age 26 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 26;
- the child must have been covered by PEIA upon reaching age 26; and
- the child must be incapable of self-sustaining employment and chiefly dependent on you for support and maintenance. To continue this coverage, the WV PEIA Disabled Dependent Disability Application must be obtained from PEIA, completed by a licensed physician, and returned to PEIA with all supporting medical records, between 2-3 months prior to the dependent's 26th birthday, to prevent a potential lapse in coverage.

Court-Ordered Dependent (COD)

If a PEIA policyholder and his or her spouse divorce, and the policyholder 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 noncustodial 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 or the dependent of an active employee becomes eligible for Medicare and has no other insurance, the PEIA PPB Plan remains the primary insurer, except if the policyholder or dependent attains Medicare eligibility due to End Stage Renal Disease (ESRD). As long as you are an active employee, you and your Medicare-eligible dependents are not required to sign up for Medicare Part B and pay the premium. When you prepare to retire, you and your Medicare-eligible dependents must enroll for Medicare Part B. If you do not enroll in Medicare Parts A and B, your coverage may be terminated.

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, which means that once Medicare has paid, PEIA will pay the balance up to 100 % of Medicare's allowed amount.

When you or your dependent become eligible for Medicare, you must send a copy of the Medicare card to PEIA.

Medicare-eligible Members Who Reside Outside the U.S.

Medicare-eligible retirees who reside outside the United States will have benefits through PEIA's Special Medicare Plan. Medicare claims will be processed by UMR, and PEIA will pay only the amount we would have paid if Medicare had processed your claim and made a payment. Prescription drug claims will be processed by CVS Caremark.

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 the 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).

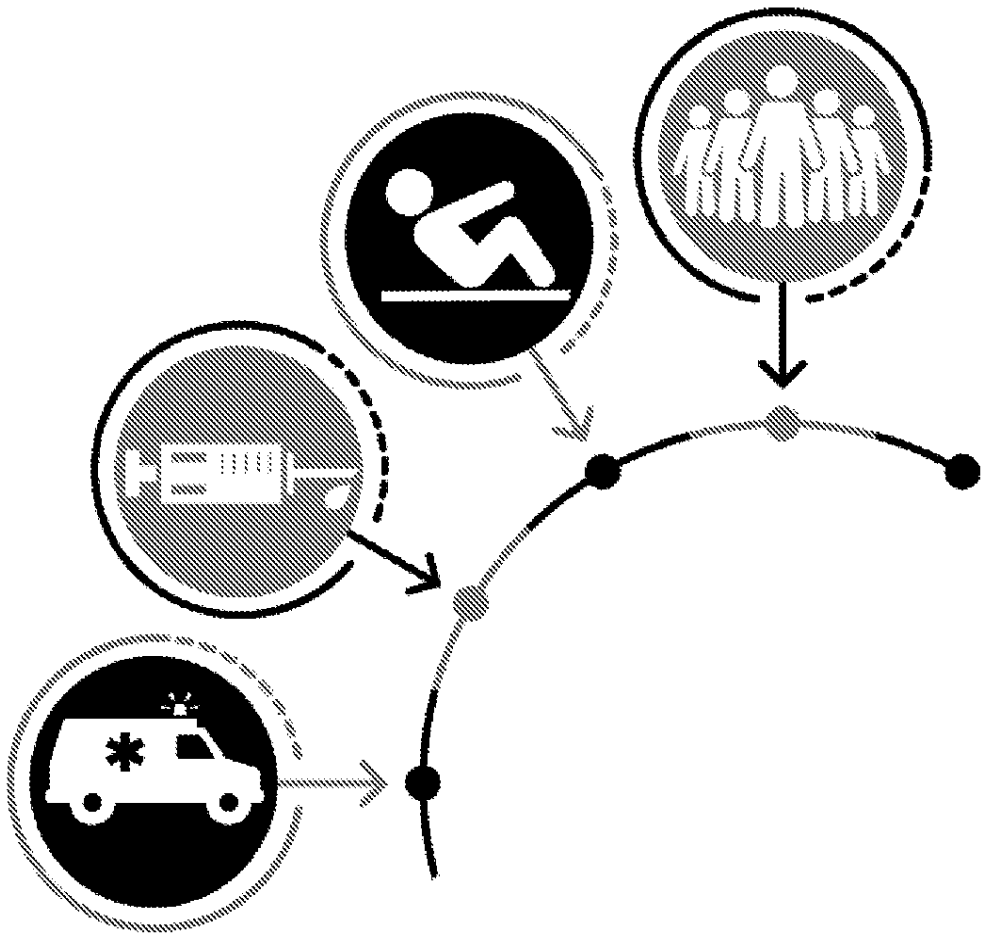
Military Leave

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 the 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

Qualifying Events

A qualifying event is a personal change in status which may allow you to change your benefit elections, whether you or your employer participate in an IRS Section 125 plan, or not. Qualifying events which end eligibility (such as divorce) must be reported immediately. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce.

All qualifying events require substantiating documentation, which must be provided in English, as detailed in the chart below:

Qualifying Event	Documentation Required
Divorce	Copy of the divorce decree showing that the divorce is final
Marriage (of policyholder or dependent)	Copy of a valid marriage license or certificate – the dependent child's marriage is a qualifying event for the policyholder to remove the dependent child from coverage. The policyholder MAY remove the child but is not required to do so.
Birth of Child	Copy of child's birth certificate
Adoption	Copy of adoption papers
Adding coverage for a dependent child	Copy of child's birth certificate
Adding coverage for any other child who resides with policyholder	Copy of court-ordered guardianship papers
Open Enrollment under spouse's or dependent's employer's benefit plan	Copy of printed material showing Open Enrollment dates and the employer's name
Death of spouse or dependent	Copy of death certificate
Beginning of spouse's or dependent's employment	Letter from the spouse's employer stating the hire date, effective date of insurance, what coverage was added, and what dependents are covered
End of spouse's or dependent's employment	Letter from the employer stating the termination or retirement date, what coverage was lost, and dependents that were covered
Significant change in health coverage due to spouse's or dependent's employment	Letter from the insurance carrier indicating the change in insurance coverage, the effective date of that change and dependents covered
Unpaid leave of absence by employee, spouse or dependent	Letter from your or your spouse's or your dependent's personnel office stating the date the covered person went on unpaid leave or returned from unpaid leave
Change from full-time to part-time employment or vice versa for policyholder, spouse or dependent	Letter from the employer stating the previous hours worked and the new hours worked and the effective date of the change

All documents used in support of eligibility transactions: birth certificates, adoption papers, marriage certificates, divorce decrees, and citizenship documents (Visas, permits, residency documents, etc.), must be in English or have a certified English translation.

If you experience a qualifying event, you have the month of the event and the two following calendar months to act upon that qualifying event and change your coverage. If you do not act within that timeframe, you cannot make the change until the next Open Enrollment. Qualifying events which end eligibility (such as divorce) must be reported immediately. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce.

Annual Open Enrollment

Each Spring PEIA holds an Open Enrollment period for active employees and non-Medicare retirees for health coverage. The period is typically the month of April. During Open Enrollment, current active employee and non-Medicare retiree participants may move between plans and make eligibility changes, such as adding or removing dependents or adding or dropping coverage. 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 any PEIA PPB Plan or any managed care plan, subject to the deadlines and rules in force for that enrollment period. 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 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.

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

Medical Identification Cards

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. New PEIA PPB Plan ID cards have been issued for all PPB members for Plan Year 2020 due to the transition to PEIA's new third-party administrator, UMR.

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. Members enrolled in the Comprehensive Care Partnership will receive individualized cards with provider information. All others will receive one card for individual coverage, and two cards for family coverage in the policyholder's name. If you want additional cards, or if you need to replace a lost card, please contact UMR at 1-888-440-7342.

If you enroll in a managed care plan or if you are in PEIA's MAPD 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 or PEIA immediately of any changes in your participation status or in your family situation and make the appropriate change to keep your PEIA coverage up to date. Examples of such changes include retirement or disability retirement, a change of address, a change in your marital status, or a dependent child no longer qualifying for coverage.

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

You can update your enrollment records at any time by logging on to the PEIA website at www.wvpeia.com and clicking on the green **"Manage My Benefits"** button. If you do not have internet access, you may update your records using a form available from your benefit coordinator or by calling PEIA. Completed forms should be returned to your benefit coordinator.

When Coverage Ends

Coverage for a policyholder and/or dependent(s) will end at the end of the month in which the individual is no longer enrolled for or eligible for coverage. In most cases when your coverage 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" on page 30.

Voluntary Termination of Employment

PEIA coverage for an active policyholder and any covered dependents terminates at the end of the month in which the employee voluntarily ceases employment. For employees on delayed payroll, coverage will terminate at the end of the month in which their employment terminates, although they may continue to receive paychecks due to their delayed payroll status.

Involuntary Termination of Employment

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 employer must continue to pay the employer's share of the premium during these three months. The policyholder will be responsible for paying the employee's share of the premium during these three months.

Termination for Misconduct

If an employee is discharged for misconduct and chooses to contest the charge, he or she may extend coverage for up to 3 months while available administrative remedies are pursued. If the discharge is upheld, the former employee must reimburse the employer's share of the premium cost for the extended coverage to the former employer.

Voluntary Termination of Benefits

PEIA coverage for an active policyholder and any covered dependents terminates at the end of the month in which the employee voluntarily terminates the coverage; provided that the employee has experienced a qualifying event that allows such termination. Qualifying events which end eligibility (such as divorce) must be reported immediately. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce. In the absence of a qualifying event, coverage cannot be terminated until the next Open Enrollment period.

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, provided that the retired employee has experienced a qualifying event that allows such termination. In the absence of a qualifying event, coverage cannot be terminated until the next Open Enrollment period.

For retiring employees, coverage will terminate at the end of the month in which the employee ceases active employment, unless forms have been completed to continue coverage. 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 PEIA's Medicare Advantage plan or the Special Medicare 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 his/her 26th birthday;
- surviving spouse remarries;
- child for which policyholder is legal guardian reaches his/her 18th birthday;
- disabled dependent no longer meets disability guidelines; or
- policyholder voluntarily removes dependent from coverage.

The policyholder is required to report these events online at www.wvpeia.com using the **"Manage My Benefits"** button, or by completing the appropriate forms to remove ineligible dependents. Qualifying events which end eligibility (such as divorce) must be reported immediately. If a policyholder fails to remove ineligible dependents (divorced spouse, etc.) the Plan may pursue reimbursement of any claims paid for the ineligible dependent from the employee. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce.

The policyholder may voluntarily terminate coverage for dependents when there has been a qualifying event to allow such a change. To make a change as a result of a qualifying event, you must do so during the month of the event or the following two calendar months or you will have to wait until the next Open Enrollment. Qualifying events which end eligibility (such as divorce) must be reported immediately. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce. Go to www.wvpeia.com and use the "Manage My Benefits" button or complete the appropriate forms. If coverage is terminated, it cannot be reinstated until the next Open Enrollment period, unless there is a qualifying event.

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 30 days following the due date, all coverage may be suspended. If payment is not received within 45 days following the due date, health and life insurance coverage will be cancelled, and all medical and prescription drug claims incurred will be your personal responsibility. Canceled life insurance cannot be reinstated, even if past-due premiums are paid. The cancellation is permanent, and you will need to seek life insurance from another provider. PEIA will also submit premiums over-due by 45 days to a collection agency.

Direct Pay

For non-Medicare policyholders who pay premiums directly to PEIA, if payment is not received by PEIA within 30 days following the due date, a termination notice containing the termination date will be mailed to the policyholder. All claims incurred following the termination date will be the policyholder's personal responsibility. The policyholder has the right to appeal the termination in writing within 60 days following the termination date.

- If the terminated policyholder appeals the termination in writing within 60 days from the date of termination, he or she must pay the past-due premiums, apply to pay premiums by direct draft from a bank account, and may be granted uninterrupted medical and prescription coverage at PEIA's discretion. Life insurance cannot be reinstated.
- If the terminated policyholder appeals the termination in writing more than 60 days following the date of termination, PEIA may only allow re-enrollment for health coverage if the policyholder enrolls as a new enrollee

and agrees to pay premiums by direct draft from a bank account. Two terminations for failure to pay within a 12-month period may result in permanent disqualification from coverage under the PEIA plan.

If extenuating circumstances prevent the policyholder from appealing within 60 days of the termination, the policyholder may send a written request, and the PEIA director may grant a waiver of the 60-day requirement, at his or her discretion.

For Medicare policyholders who pay premiums directly to PEIA, failure to pay premiums will result in termination from the plan consistent with applicable Medicare rules.

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. PEIA requires a written 30-day notice of a Non-State Agency's intent to terminate its contract with PEIA.

Eligible retirees may continue participation in PEIA. The withdrawn agency is billed a non-participating agency premium for these retirees. Retirees not eligible to participate in PEIA must look to their former employer for retiree coverage.

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 UMR, and all COBRA eligibility is maintained by UMR. New enrollees in any PEIA-sponsored health plan will receive a detailed notice of their COBRA rights from UMR.

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 starting from the latest of:

(1) the date on which the qualifying event occurs;
(2) the date on which you lose (or would lose) coverage under the plan due to the qualifying event; or
(3) the date on which you are informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and procedures for doing so.

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 UMR 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.

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 Securian Financial at 1-800-203-9515. The individual life insurance policy is issued by PEIA's life insurance carrier, Securian Financial. 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 Plans. 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. 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 5th. If payment is not received by PEIA within 30 days following the due date, all coverage may be suspended. If payment is not received within 45 days following the due date, coverage will be cancelled, and all claims incurred will be your personal responsibility. PEIA will also submit premiums overdue by 45 days to a collection agency.

Tobacco-free Premium Discount

All health and optional life insurance premiums are based on the tobacco-use status of insureds. Tobacco-free insureds receive the preferred monthly premium rate. 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. From time to time, the tobacco-free waiting period may be adjusted, and members will be notified in writing.

If your doctor certifies on a form provided by the PEIA, that it is unreasonably difficult due to a medical condition for you to become tobacco-free or it is medically inadvisable for you to become tobacco free, PEIA will work with you for an alternative way to qualify for the tobacco-free discount. Send all such doctors' certifications and requests for alternative ways to receive the discount to:

PEIA Discount Alternatives, 601 57th St., SE, Suite 2, Charleston, WV 25304-2345.

For family health 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 "Tobacco Cessation" on page 69 for details.

Once a member has submitted a tobacco affidavit, PEIA will rely upon that affidavit from year to year, unless the member submits a replacement. It is not necessary for members to submit a tobacco affidavit each year, although PEIA may, periodically, require policyholders to update their tobacco status during Open Enrollment. Instructions for updating tobacco status, if required, will be provided in the Shopper's Guide.

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. Apply online at www.wvpeia.com; click on the green **"Manage My Benefits"** button at the top right of the page. Affidavits completed online are processed immediately, and the discount becomes effective on the first day of the following month. When using a paper affidavit, 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 to future premiums and WILL NOT be applied retroactively. No refunds will be granted based on tobacco status.

Newly hired insureds must have been tobacco-free for 6 months prior to their effective date of coverage to qualify for the discount and must complete the tobacco affidavit online or on paper to receive the discount.

Advance Directive/Living Will

PEIA no longer offers an Advance Directive/Living Will discount. We encourage members to have an Advance Directive/Living Will and to discuss it with their family and health care providers, but the premium discount has been discontinued.

Determining Monthly Premiums

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.

If you are a member of the West Virginia Legislature, a member of the West Virginia Board of Education, or an elected member of a county board of education, you must pay 100% of the premium for any coverage you elect.

Retired Employees

Premiums for retired employees are determined based on a number of factors, including hire date and retirement date. See more information below. Premiums for most retired employees are deducted from their annuity on a monthly basis. Some retired employees pay premiums directly to 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 5th.

Employees Hired on or After July 1, 2010

Employees hired on and after July 1, 2010, will not receive any plan subsidy of their health insurance premiums at retirement. These employees may continue coverage in the plan at retirement but must pay the unsubsidized premium for the coverage of their choice. Two exceptions are made to this rule:

- Active employees hired before July 1, 2010, who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2010) hire date.
- Retired employees who had an original hire date prior to July 1, 2010, may return to active employment and retain their pre-July 1, 2010, original hire date for purposes of determining their eligibility for premium subsidy.

Retirees from non-state entities which employers joined the PEIA Plan on or after July 1, 2010, will also receive no premium subsidy and must pay the full cost of their participation in the plan. Such non-state retirees will be assigned a "hire date" in the PEIA systems which is the same as the date they enroll in PEIA as an active employee.

Regardless of any other discussion of premium subsidy later in this section, employees hired on or after July 1, 2010, who don't meet one of the two exceptions above, will not receive any premium subsidy for years of service or any other factor.

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, but NOT their years of service. These retirees are not subject to the "years of service" policy. For premium purposes, employees who retired prior to July 1, 1997, fall into the "25 or more" years of service category on PEIA's premium charts. 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. 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 the premium will be covered by your accrued leave. The amount of sick and/or annual leave accrued by the retiring employee will be reported by the benefit coordinator at the agency from which the employee is retiring. Disability retiree premiums are assessed on twenty-five (25) years of service.

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.

Premiums charged to surviving dependents are determined by when the surviving dependent enrolls:

- For surviving dependents enrolled before July 1, 2015, premiums are based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium for "25 or more years of service."
- For surviving dependents enrolled on or after July 1, 2015, premiums are based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium and the years of service earned by the deceased policyholder.

Premiums for surviving dependents are deducted from their annuity on a monthly basis or are paid directly to PEIA.

Extending Employer-Paid Insurance upon Retirement

You may be eligible to extend your employer-paid insurance upon retirement, but how you do that depends upon your employer. To take advantage of this benefit, you must move directly from active public employment into your respective retirement system. You must use your leave at the time of retirement. You may not save the leave for use later. If you choose to separate from employment and defer your retirement, you cannot defer your sick and/or annual leave or years of teaching service 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

If you are an employee of a PEIA-participating employer (State agency, county board of education, local agency, college or university) with coverage through PEIA and have accrued sick and/or annual leave when you retire, you may use that accrued leave to extend your employer-paid insurance coverage. You must be enrolled in a PEIA PPB plan or a PEIA-sponsored managed care plan or the group life insurance plan offered by PEIA prior to your retirement to qualify. This extended coverage must be for full months, and the leave must be used immediately at the time of retirement. 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.

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.

Calculating Your Benefit

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

Before July 1, 1988:

If you elected to participate in the plan before July 1, 1988, and have been continuously covered by PEIA since that time, then your extended employer-paid 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 elected to participate in the plan after July 1, 1988, and before July 1, 2001, or if you had a lapse in coverage during this period then your extended employer-paid 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 elected to participate in the plan 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

This benefit is not available to faculty hired on or after July 1, 2009.

Retired Employee Assistance Programs

Retired employees whose total annual income is less than 250% of the federal poverty level (FPL) 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 called the Retired Employee Premium Assistance program. Applicants must be enrolled in the PEIA PPB Plan, the Special Medicare Plan or PEIA's Medicare Advantage 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 retired employees with health coverage each spring. Medicare-eligible retirees with 15 or more years of service who qualify for Premium Assistance may also qualify for Benefit Assistance. Benefit Assistance reduces the medical and prescription out of pocket maximums and most copayments. It is described in detail in the Evidence of Coverage provided by PEIA's Medicare Advantage Plan. For additional detail or for a copy of the application, call PEIA's customer service unit at 1-888-680-7342.

The amount of assistance for which you are eligible is based on years of active service and percentage of FPL. For surviving dependents, it will be based on years of service earned by the deceased policyholder. Disabled retirees are considered to have twenty-five (25) years of service.

Following is a chart that shows the premium reductions provided under the Retired Employee Premium Assistance program.

Policyholder Only Monthly Premium Reduction				
This amount will be deducted from your monthly premium for Medicare or non-Medicare coverage. If the amount of the reduction is greater than the premium due, then the premium due will be $0.				
Years of Service	< 100% of FPL	100-150% of FPL	150-200% of FPL	200-250% of FPL
5-14	$51	$34	$19	$13
15-24	$65	$50	$31	$19
25+	$88	$74	$46	$24
Policyholder with Dependents Monthly Premium Reduction				
This amount will be deducted from your monthly premium for Medicare or non-Medicare coverage. If the amount of the reduction is greater than the premium due, then the premium due will be $0.				
Years of Service	<100% of FPL	100-150% of FPL	150-200% of FPL	200-250% of FPL
5-14	$76.50	$51	$28.50	$19.50
15-24	$97.50	$75	$46.50	$28.50
25+	$132	$111	$69	$36

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. 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 following example 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

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 include:

- 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
- 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/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.

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, use PEIA's online enrollment site, **"Manage My Benefits"** or get a Change-in-Status form from your benefit coordinator. ALL changes require additional documentation.

Health Care Benefits

Active employees may get health care benefits through PEIA from a managed care plan or from one of the PEIA PPB Plans. Non-Medicare retirees and surviving dependents may get health care benefits through PEIA from a managed care plan or from PEIA PPB Plan A or B, although Plan B is only available when all enrolled dependents are non-Medicare. Medicare-eligible members of the Special Medicare Plan also receive their benefits through PEIA. PEIA PPB Plans C and D are not offered to retirees. PPB Plan C is an IRS-qualified, High-Deductible Health Plan (HDHP). For more information about Plan C, download Summary Plan Description (Plan C) at www.wvpeia.com or call 1-888-680-7342.

Most Medicare-eligible retired employees and Medicare-eligible dependents of retired employees are covered by PEIA's Medicare Advantage plan, so the benefits described here do not apply to them.

If you choose to receive your benefits from a managed care plan, you must enroll with PEIA and choose a plan. Refer to the information provided by the managed care plan for details of your benefits.

If you choose the PEIA PPB Plan A, B or D, your benefits are described on the following pages. PEIA PPB Plan C is an IRS-qualified, High-Deductible Health Plan (HDHP). For more information about Plan C, download Summary Plan Description (Plan C) at www.wvpeia.com or call 1-888-680-7342.

PEIA PPB Plans A, B and D

The PEIA PPB Plans A, B and D pay 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 Plans A, B and D are identical. The difference is in the deductibles, coinsurance, and out-of-pocket maximums, and in Plan D's provider network.

Under the plans, 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:

Medical claims and benefits – UMR at 1-888-440-7342.

Precertification, pre-authorizations, case management or prior approval for out-of-state care and maternity management—UMR at 1-888-440-7342.

Prescription drug claims and benefits – CVS Caremark at 1-844-260-5894.

Common Specialty Medication claims and benefits – CVS Caremark Specialty Medication Program at 1-844-260-5894.

Specialty Injectable Drug claims and benefits – UMR at 1-888-440-7342.

PEIA's Networks

PEIA PPB Plans A & B

The PEIA PPB Plans provide care through several networks of providers, and the benefit level depends on whether the care is provided inside West Virginia, or out, and on whether the out-of-state care is approved in advance by UMR, if necessary. In West Virginia, any properly licensed 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, PEIA uses the

UnitedHealthCare Choice Plus PPO to provide care for members of PEIA PPB Plans A, B and C. The UnitedHealthCare Choice Plus PPO contracts with some out-of-state providers to serve PEIA PPB Plans A, B and C participants only. To locate a network provider, call UMR at 1-888-440-7342.

Care provided outside West Virginia, even by network providers, costs more. Outside West Virginia, even with the discount contracts we have with network providers, PEIA cannot control its costs as it can inside West Virginia. Therefore, your out-of-pocket costs will be higher if you use in-network providers outside the state of West Virginia.

Not all providers in the UnitedHealthCare Choice Plus PPO network may participate with PEIA. Kings Daughters Medical Center and Our Lady of Bellefonte hospitals in Kentucky remain out-of-network for PEIA, regardless of their network status with the PPO network. Also, PEIA does not use the PPO network in Washington County, Ohio, (including Marietta Memorial Hospital) or Boyd County, Kentucky. PEIA reserves the right to remove providers from the network, so not all providers listed in the network may be available to you.

PEIA PPB Plan D

PEIA PPB Plan D members have access to WV providers ONLY. For PEIA PPB Plan D, the only care allowed outside the State of West Virginia will be emergency care to stabilize the patient for transport back to a WV facility, and a limited number of procedures that are not available from any health care provider inside West Virginia. Plan D members must contact UMR when it appears that out-of-state care may be necessary. UMR will direct the patient to the appropriate facility to provide care – either in WV or out-of-state. Non-emergency care provided outside WV without approval from UMR IS NOT COVERED.

Sanctioned Providers

Providers, both in and out of state, who are under sanction by Medicare, Medicaid or both are excluded from PEIA's network for the duration of their sanction. Additionally, providers may be excluded from PEIA's network based upon adverse audit findings. If you have questions about a specific network provider, please contact UMR at 1-888-440-7342.

Resident PPB Plan A & B Participants

PEIA PPB Plans A & B 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:

- 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.

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

Non-Resident PPB Plan A & B Participants

For PEIA PPB Plans A & B 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 without obtaining prior approval. Care from network providers will be covered at the highest out-of-state benefit level. Precertification of inpatient stays and certain outpatient procedures is still required. See page 50 for details.

Non-Network Providers

Care provided by non-network providers is not covered except for the initial care in an emergency, or if those services are not available from a network provider.

What You Pay with the PEIA PPB Plans A, B & D

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, if out-of-state beyond the bordering counties, whether you have prior approval from UMR.

The family deductible is shared among the family members. No one member of the family will pay more than the individual deductible (see Employee Only in the chart). Once one person has met the individual deductible, the plan will begin paying on that person. When another member of the family meets the balance of the family deductible, then the plan will begin paying on the entire family. Alternatively, all members of the family may contribute to the family deductible with no one person meeting the individual deductible; once the family deductible is met, the plan pays on all members of the family.

The deductibles are listed 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 employees or retired employees.

Annual Deductibles

	Annual Salary	Employee Only	Employee & Child(ren)	Family	Family with Employee Spouse*
PEIA PPB Plan A & D (state agencies, colleges, universities and county boards of education)	$0 - $22,700	$325	$650	$650	$650
	$22,701 - $32,700	$375	$750	$750	$750
	$32,701 - $38,700	$425	$850	$850	$850
	$38,701 - $44,700	$450	$900	$900	$900
	$44,701 - $52,700	$475	$950	$950	$950
	$52,701 - $65,200	$600	$1,200	$1,200	$1,200
	$65,201 - $77,700	$625	$1,250	$1,250	$1,250
	$77,701 - $102,700	$650	$1,300	$1,300	$1,300
	$102,701 - $127,700	$725	$1,450	$1,450	$1,450
	$127,701 +	$825	$1,650	$1,650	$1,650
PEIA PPB Plan B (state agencies, colleges, universities and county boards of education)	$0 - $44,700	$725	$1,450	$1,450	$1,450
	$44,701 +	$1,225	$1,950*	$1,950*	$1,950*
Non-State Plan A	Not Applicable	$450	$900	$900	N/A
Non-State Plan B	Not Applicable	$725	$1,450	$1,450	N/A
Non-Medicare Retirees Plan A	Not Applicable	$525	N/A	$1,050	N/A
Non-Medicare Retirees Plan B	Not Applicable	$925	N/A	$1,850	N/A
Deputy Sheriff's Early Retirement Plan A	Not Applicable	$450	N/A	$900	N/A
Deputy Sheriff's Early Retirement Plan B	Not Applicable	$725	N/A	$1,450	N/A
State-funded Elected Officials Plans A and D	Not Applicable	$450	$900	$900	$900
State-funded Elected Officials Plan B	Not Applicable	$725	$1,450	$1,450	$1,450

*One family member may have to meet the 'employee only' deductible, which is $1,225. See Medical Deductible beginning above the chart.

OOSINNA: For in-network out-of-state care beyond the bordering counties, if not approved in advance, the deductible and out-of-pocket maximum amounts are doubled, and the plan pays only 60% of the allowed amount.

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, 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 OOSINNA deductible applies to the in-network deductible, but the in-network deductible does not satisfy the OOSINNA deductible. Please note that the amounts listed in the chart are for in-network deductibles. OOSINNA deductibles are twice the amount of the in-network deductibles listed above.

Prescription drug benefits are subject to a separate deductible. See the "Prescription Drug Benefit" section for details.

Coinsurance for In-Network and Out-of-Network Benefits for PEIA PPB Plans

	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	Plan A: 20% coinsurance Plan B: 30% coinsurance Plan D: 20% coinsurance	Plan A: 20% coinsurance Plan B: 30% coinsurance	Plan A: 20% coinsurance Plan B: 30% coinsurance
Access care in a bordering county of a surrounding state using PPO providers*	Plan A: 20% coinsurance Plan B: 30% coinsurance Plan D: Not Covered	Plan A: 20% coinsurance Plan B: 30% coinsurance	Plan A: 20% coinsurance Plan B: 30% coinsurance
Access care outside WV (beyond bordering counties) using PPO providers with prior approval*	Plan A: 30% coinsurance Plan B: 35% coinsurance Plan D: Not Covered	Plan A: 30% coinsurance Plan B: 35% coinsurance	Plan A: 30% coinsurance Plan B: 35% coinsurance
Access care outside WV (beyond bordering counties) using non-PPO providers with prior approval*	Plan A: 30% coinsurance + amounts that exceed the Reasonable and Customary amount. Plan B: 35% coinsurance + amounts that exceed the Reasonable and Customary amount.	Plan A: 30% coinsurance + amounts that exceed the Reasonable and Customary amount. Plan B: 35% coinsurance + amounts that exceed the Reasonable and Customary amount.	Plan A: 30% coinsurance + amounts that exceed the Reasonable and Customary amount. Plan B: 35% coinsurance + amounts that exceed the Reasonable and Customary amount.
Access care outside WV (beyond bordering counties) using PPO providers without prior approval* (OOSINNA)	Plan A: 40% coinsurance + up to a $500 copayment for unapproved out-of-state care. Plan B: 50% coinsurance + up to a $500 copayment for unapproved out-of-state care.	Plan A: 40% coinsurance + up to a $500 copayment for unapproved out-of-state care. Plan B: 50% coinsurance + up to a $500 copayment for unapproved out-of-state care.	Plan A: 30% coinsurance + amounts that exceed the Reasonable and Customary amount. Plan B: 35% coinsurance + amounts that exceed the Reasonable and Customary amount.
Access care outside WV using non-PPO providers without prior approval*	Not Covered. You are responsible for 100% of the provider's charges, except if the care is the result of a medical emergency.	Not Covered. You are responsible for 100% of the provider's charges, except if the care is the result of a medical emergency.	Not Covered. You are responsible for 100% of the provider's charges, except if the care is the result of a medical emergency.

*PEIA PPB Plan D has NO coverage for out-of-state services. Plan D members cannot receive services outside WV, except in a medical emergency or when UMR determines that a needed service is not available within WV. In these cases, out-of-state care is covered as in-network care.

*Prior approval is generally only provided if services are not available in West Virginia.

The PEIA PPB Plans A, B & D are 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, PEIA uses UnitedHealthCare Choice Plus Preferred Provider Organization.

Resident PPB Plan Participants

PEIA PPB Plan A & B 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 its portion of the contracted payment rate, and you will be responsible for any copayments, deductible, coinsurance, and non-covered services.

For services of out-of-state (beyond the contiguous counties) in-network providers without approval in advance from UMR, the plan will pay of its portion of PEIA's maximum allowance; you will be responsible for any deductible, a $500 copayment for unapproved out-of-state care, and coinsurance. These are OOSINNA services.

For services of out-of-state, non-network providers without prior approval, the plan will pay nothing, unless the services are provided as a result of a medical emergency or because the necessary care is not available from an in-network provider, in which case the services will be paid at the in-network benefit level. For non-emergent services of out-of-state non-network providers without prior approval, you will be responsible for 100% of billed charges, and those amounts are considered non-covered services, so they do not count toward the deductible or out-of-pocket maximum.

PEIA PPB Plan D members must be WV residents and may use ONLY WV providers. PEIA PPB Plan D participants may access care from any West Virginia health care provider who provides health care services or supplies to a PEIA participant, without prior approval. Services provided outside of West Virginia are not covered, except if provided as a result of a medical emergency to stabilize the patient for transport back to WV, or if provided outside the state because necessary care is not available within WV. For services of WV providers, the plan will pay its portion of the contracted payment rate, and you will be responsible for any copayments, deductible, coinsurance, and non-covered services.

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 UMR 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 Plans A and B only)

PEIA PPB Plan A & B 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 the higher level of benefit (see chart on page 47) based on the contracted payment rate. You will be responsible for any copayment, deductible, coinsurance, and non-covered services. PEIA PPB Plan D participants must be WV residents.

Care provided by non-network providers must be as a result of a medical emergency or have prior approval to be covered. Emergency or approved services of non-network providers will be paid at the in-network benefit level. Other out-of-state non-network services ARE NOT COVERED. Precertification requirements apply for inpatient stays and certain outpatient procedures. PEIA PPB Plans A & B members please consult the preceding chart to determine your level of coinsurance based on where you reside, where you receive your services, and whether or not you obtain prior approval. Charges for non-covered services and applicable plan penalties, such as precertification penalties are your responsibility.

Covered in Full

The following services are covered in full if in-network for all PEIA PPB Plans:

Type of Service Frequency	
Covered Preventive Services for Adults *AWV=Annual Wellness Visit	
Abdominal Aortic Aneurysm one-time screening for men aged 65-75 who have ever smoked	Once per lifetime
Alcohol Misuse screening and counseling	Included in AWV
Aspirin use for men and women of certain ages (requires a prescription; covered under prescription drug plan)	As Needed
Blood Pressure screening for all adults	Included in AWV
Cholesterol screening for men age 35 and older and women age 45 and older or others at higher risk	Included in AWV
Colorectal Cancer screening for adults over 50	See Colorectal Cancer Screening, page 55
Depression screening for adults	Included in AWV
Type 2 Diabetes screening for adults with high blood pressure	Included in AWV
Diet counseling for adults at higher risk for chronic disease	Included in AWV
Hepatitis B screening for people at high risk	As Needed
Hepatitis C screening for everyone born between 1945-1965 and people at high risk	As Specified
HIV screening for all adults at higher risk	Annually
Immunization vaccines for adults—doses, recommended ages, and recommended populations vary: Hepatitis A Hepatitis B Herpes Zoster Human Papillomavirus Influenza (Flu Shot) Measles, Mumps, Rubella Meningococcal Pneumococcal Tetanus, Diphtheria, Pertussis Varicella	As Recommended by the American Academy of Family Physicians
Lung cancer screening for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years	As Specified
Obesity screening and counseling for all adults	Included in AWV
Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk	Included in AWV
Tobacco Use screening for all adults and cessation interventions for tobacco users (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	See Tobacco Cessation, page 69
Syphilis screening for all adults at higher risk	Annually
Covered Preventive Services for Women, Including Pregnant Women	
Anemia screening on a routine basis for pregnant women	As Needed
Bacteriuria urinary tract or other infection screening for pregnant women	As Needed
BRCA counseling about genetic testing for women at higher risk	As Needed
Breast Cancer Mammography screenings every 1-2 years for women over 40	Every 1-2 years
Breast Cancer Chemoprevention counseling for women at higher risk	Once per lifetime
Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women	As Needed
Cervical Cancer screening for sexually active women	Annually
Chlamydia Infection screening for younger women and other women at higher risk	Annually
Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling (generic oral contraceptives require a prescription; covered under the prescription drug plan)	As Needed

Domestic and interpersonal violence screening and counseling for all women	Included in AWV
Folic Acid supplements for women who become pregnant (requires a prescription; covered under prescription drug plan)	As Needed
Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes	Once per pregnancy
Gonorrhea screening for all women at higher risk	Annually
Hepatitis B screening for pregnant women at their first prenatal visit	Once per pregnancy
Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women	Annually
Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older	Every 3 years
Osteoporosis screening for women over age 60 depending on risk factors	Annually after age 60
Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk	As Needed
Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	See Tobacco Cessation, page 69
Sexually Transmitted Infections (STI) counseling for sexually active women	Included in AWV
Syphilis screening for all pregnant women or other women at increased risk	Annually
Well-woman visits to obtain recommended preventive services	Annually
Covered Preventive Services for Children (*WCC=Well Child Care)	
Alcohol and Drug Use assessments for adolescents	Included in WCC
Autism screening for children at 18 and 24 months	Included in WCC
Behavioral assessments for children of all ages Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Blood Pressure screening for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Cervical Dysplasia screening for sexually active females	Annually
Congenital Hypothyroidism screening for newborns	Once, for newborn
Depression screening for adolescents	Included in WCC
Developmental screening for children under 3, and surveillance throughout childhood	Included in WCC
Dyslipidemia screening for children at higher risk of lipid disorders Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	As specified
Fluoride Chemoprevention supplements for children without fluoride in their water source (requires a prescription; covered under the prescription drug plan)	As Needed
Gonorrhea preventive medication for the eyes of all newborns	Once, for newborn
Hearing screening for all newborns	Included in WCC
Height, Weight and Body Mass Index measurements for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Hematocrit or Hemoglobin screening for children	Once per lifetime
Hemoglobinopathies or sickle cell screening for newborns	Once, for newborn
HIV screening for adolescents at higher risk	Annually
Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis — Haemophilus Influenzae type B — Hepatitis A Hepatitis B — Human Papillomavirus — Inactivated Poliovirus Influenza (Flu Shot) — Measles, Mumps, Rubella — Meningococcal Pneumococcal — Rotavirus — Varicella	As Recommended by the American Academy of Pediatrics
Iron supplements for children ages 6 to 12 months at risk for anemia (requires a prescription; covered under the prescription drug plan)	As Needed
Lead screening for children at risk of exposure	As Needed

Medical History for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Obesity screening and counseling	Included in WCC
Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years	Included in WCC
Phenylketonuria (PKU) screening for this genetic disorder in newborns	Once, for newborn
Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk	Included in WCC
Tuberculin testing for children at higher risk of tuberculosis Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	As specified
Vision screening for all children	Included in WCC

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 Plans A, B & D begin 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
Primary Care Physician Office Visits treat illness or injury	$20 copayment per visit with no deductible
Specialist Office Visit	$40 copayment per visit with no deductible
Out-of-State Primary Care Office Visits (In network)	$20 copayment per visit with no deductible
Second Surgical Opinions*	$40 copayment per visit with no deductible
Pain Management and Rehabilitative Outpatient Services Visits 1-20	$20 copayment per visit with no deductible

*No copayment if required by UMR.

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)	$100 copayment + deductible and coinsurance. An additional $500 copay will apply to claims for injuries resulting from high risk behaviors.
Non-emergency services at emergency room*	$100 copayment + deductible and coinsurance
Ambulatory surgery/Outpatient surgery (facility-based)	$100 copayment + deductible and coinsurance
Bariatric surgery and dental procedures	$500 copayment + deductible and coinsurance
Outpatient Therapy Services visits 1-20	$10 copayment + deductible and coinsurance
Outpatient Therapy Services visits 21 +	$25 copayment + deductible and coinsurance
Out-of-Network transplant services	Deductible + coinsurance + additional $10,000 deductible

* Non-emergency services received at the emergency room are very expensive to the PEIA Plans. Members who visit the emergency room for non-emergency services an excessive number of times may be placed on case management or otherwise have payment for their ER services restricted or terminated by the PEIA Plans.

Coinsurance and Deductible and Higher/Lower Level of Benefits

Services not listed in the three preceding charts are covered after the deductible is met. The coinsurance amounts are shown in the chart below:

	In WV and within contiguous counties*	In-Network Outside WV WITH Approval from UMR* Higher Level of Benefit	Out-of-State, In-Network Not Approved by UMR (OOSINNA) Lower Level of Benefit	Out-of-network Outside WV WITHOUT Approval from UMR
Plan A	80/20	70/30	60/40	Not Covered
Plan B	70/30	65/35	50/50	Not Covered
Plan D	80/20**	70/30	Not Covered	Not Covered

You pay your deductible, coinsurance, and any charges for services not covered by the plan directly to your health care provider.

* Boyd County, Kentucky, and Washington County, Ohio, are excluded.

** Contiguous counties are not covered in Plan D.

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 for details.

The family out-of-pocket maximum is divided up among the family members. No one member of the family will pay more than the individual out-of-pocket maximum (see the single out-of-pocket maximum in the chart below). Once one person has met the individual out-of-pocket maximum, the plan will pay 100% of that person's covered charges (less applicable copayments). When another member of the family meets the balance of the family out-of-pocket maximum, then the plan will pay 100% of covered charges (less applicable copayments) on the entire family for the balance of the plan year. Alternatively, all members of the family may contribute to the family out-of-pocket maximum with no one person meeting the individual out-of-pocket maximum; once the family out-of-pocket maximum is met, the plan will pay 100% of covered charges (less applicable copayments) on all members of the family.

Your out-of-pocket maximum amount depends on your employment status, your salary, your tier of coverage, where you receive your services, whether your provider is in the PEIA PPO network, and whether you have prior approval for out-of-network care.

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-network, out-of-pocket maximums are twice the amount of the in-network, out-of-pocket maximums. The following chart shows the out-of-pocket maximums.

Out-of-Pocket Maximum Amounts			
Employee Status	Employee's Annual Salary	Annual In-network Out-of-Pocket Maximum	Annual In-Network Out-of-State w/o Approval* Out-of-Pocket Maximum
PEIA PPB Plans A and D (Active, State Agency, Colleges and Universities, Boards of Education)	$0 - $22,700	$1,800/single; $3,600/family	$3,600/single; $7,200/family
	$22,701 - $32,700	$2,100/single; $4,200/family	$4,200/single; $8,400/family
	$32,701 - $38,700	$2,250/single; $4,500/family	$4,500/single; $9,000/family
	$38,701 - $44,700	$2,500/single; $5,000/family	$5,000/single; $10,000/family
	$44,701 - $52,700	$2,750/single; $5,500/family	$5,500/single; $11,000/family
	$52,701 - $65,200	$2,800/single; $5,600/family	$5,600/single; $11,200/family
	$65,201 - $77,700	$2,850/single; $5,700/family	$5,700/single; $11,400/family
	$77,701 - $102,700	$2,900/single; $5,800/family	$5,800/single; $11,600/family
	$102,701 - $127,700	$3,000/single; $6,000/family	$6,000/single; $12,000/family
	$127,701 +	$3,250/single; $6,500/family	$6,500/single; $13,000/family
PEIA PPB Plan B (state agencies, colleges, universities and county boards of education)	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family
Non-State Plans A & D	Not Applicable	$2,500/single; $5,000/family	$5,000/single; $10,000/family
Non-State Plan B	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family
Non-Medicare Retirees Plan A	Not Applicable	$1,500/single; $3,000/family	$3,000/single; $6,000/family
Non-Medicare Retirees Plan B	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family
Deputy Sheriff's Early Retirement Plan A	Not Applicable	$2,500/single; $5,000/family	$5,000/single; $10,000/family
Deputy Sheriff's Early Retirement Plan B	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family
State-funded Elected Officials Plans A and D	Not Applicable	$2,500/single; $5,000/family	$5,000/single; $10,000/family
State-funded Elected Officials Plan B	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family

*PEIA PPB Plan D has no out-of-network or out-of-state benefit, so this column does not apply to Plan D members.

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 catastrophic cases involving serious long-term illness or injury resulting in loss or impaired function requiring medically necessary therapeutic intervention, 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. All services listed below must be medically necessary; otherwise, they are not covered.

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*	20 visits (total amount allowed for all indicated therapies combined)
Pain Management and Rehabilitative Outpatient Services	20 visits (total amount allowed for all indicated therapies combined)
Inpatient Rehabilitation	150 Days
Skilled Nursing Facility	100 Days

Lifetime Maximum

The PEIA PPB Plans have no lifetime maximum.

PEIA PPB Plan Fee Schedules and Rates

The PEIA PPB Plans A, B & D pay 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.

Many outpatient hospital services are also paid on a prospective basis. PEIA has adopted a modified version of Medicare's Outpatient Prospective Payment System (OPPS). OPPS reimbursement is based on Ambulatory Payment Classification (APC) groups. APCs include groups of services that are similar clinically, and require similar resources. These rates are adjusted annually.

Pre-Service Decisions

The PEIA PPB Plans A, B & D require that certain services and/or items be reviewed in advance to determine whether they are medically necessary and being provided in the most appropriate setting by a network provider, if possible. PEIA has three different types of pre-service determinations: prior approval, precertification/notification and preauthorization which are described on the next few pages.

Important things to remember about pre-service decisions:

- Requests for pre-service decisions should be submitted to UMR, as early as possible, in advance of the service/item.
- Services or items may be approved or denied in whole or in part.
- One or more of the pre-service determinations may be required depending on the type of service or item.
- Check with UMR to see if your provider is in-network.

For example, a hospital admission, the procedure to be performed and/or each physician's services may require pre-service determinations, particularly if any of these is an out-of-state network provider, a non-network provider or the service is covered only under limited circumstances.

Each type of pre-service requirement is described below. If you have questions, please call UMR.

Prior Approval for Out-of-State Services in PEIA PPB Plans A & B (Mandatory)

If you are in PEIA PPB Plan A or B and 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 at the higher benefit level; you will be responsible for any deductible, copayments and coinsurance (see chart on page 47).

For services for all members provided by out-of-state, in-network providers without prior approval, the plan will pay the lower OOSINNA benefit . You will be responsible for any deductible, copayments, and 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.

Out-of-state, non-network services are covered only in the case of an emergency or if approved in advance by UMR. All other out-of-state, non-network services are **not covered**. You will be responsible for 100% of billed charges. 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 PEIA PPB Plans A & B participants who live more than one county beyond the borders of West Virginia. See "Non-resident PPB Plan Participants" on page 43 for more details.

PEIA Plan D members have no benefit for out-of-state or out-of-network services, except in the case of a medical emergency which occurs out-of-state, or for the limited number of services not available within West Virginia. For services not available in West Virginia, UMR will direct the member to an out-of-state network facility capable of providing the needed services.

Precertification/Notification Requirements

Precertification of certain services (Mandatory)

The PEIA PPB Plans A, B & D require 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 documented medical condition.

Precertification is required for the following:

1. All admissions to out-of-state hospitals/facilities
2. All admissions to rehabilitation or skilled nursing facilities
3. Ambulance Service for Non-Emergency transport, including air ambulance
4. Any potentially experimental/investigational procedure, medical device, or treatment
5. Autism Spectrum Disorder services
6. Chelation Therapy
7. Continuous glucose monitors
8. Durable medical equipment purchases and/or rentals of $500 per month rental or $1500 per purchase or more
9. Elective (non-emergent) facility to facility air ambulance transportation
10. Electroconvulsive shock therapy (ECT) and Trans magnetic stimulation (TMS)
11. Heart Perfusion Imaging
12. Home health care and/or IV therapy in the home
13. Hyperbaric Oxygen Therapy (HBOT)
14. Limited Molecular Diagnostic/Genetic Testing used to diagnose or treat disease. Examples include: Hereditary Non-Polyposis Colorectal Cancer (HNPCC) testing, BRCA gene testing, Oncotype DX breast cancer assay, Familial Adenomatous Polyposis (FAP) testing, Catecholaminergic Polymorphic Ventricular Tachycardia (FPVT) testing
15. Inpatient Mental Health and substance abuse treatment
16. Outpatient CTA (CT angiography)

17. Outpatient Dialysis Services
18. Outpatient IMRT (intensity modulated radiation therapy)
19. Outpatient MRI scan of the breast or spine (includes cervical, thoracic, and lumbar)
20. Outpatient PET Scans
21. Oxygen rental and supplies, with the exception of oxygen concentrators
22. Partial/day mental health or substance abuse treatment programs
23. Sleep studies, services and equipment. See section on "sleep management services" on page 66
24. Specialty drugs provided in a physician's office, by a pharmacy or mail order
25. SPECT (single photon emission computed tomography) of brain or lung
26. Stereotactic Radiation Surgery and Stereotactic Radiation Therapy
27. Surgeries
    a) artificial disc surgery
    b) bariatric surgery
    c) cochlear implants
    d) discectomy with spinal fusion surgery
    e) Potentially cosmetic surgeries including but not limited to abdominoplasty, blepharoplasty, breast reduction, breast reconstruction, panniculectomy, penile implants/vascular procedures, otoplasty, rhinoplasty, scar revision, testicular prosthesis, and surgery for varicose veins
    f) Endoscopic treatment of GERD
    g) hysterectomy
    h) implantable devices including, but not limited to: implantable pumps, spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators
    i) knee arthroscopy
    j) laminectomy, including laminectomy with spinal fusion surgery
    k) spinal fusion surgery
    l) total joint replacement
    m) transplants
    n) uvulopalatopharyngoplasty
    o) Vertebroplasty, Kyphoplasty, and Sacroplasty
28. Transplants and transplant evaluations (including but not limited to: kidney, liver, heart, lung and pancreas, small bowel, and bone marrow replacement or stem cell transfer after high dose chemotherapy)

Notification

Notification to UMR 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. Notification to UMR 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 pre-certify or notify UMR of an admission within the timeframes specified in the following chart 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 copayments, coinsurance, deductible, and amounts that exceed PEIA's maximum allowance.

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

Exception: It is the patient's responsibility to pre-certify inpatient stays and outpatient procedures when these services are received out-of-network. If you do not pre-certify 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 pre-certify services.

Timely Precertification Requirements	
Type of Admission	Advance Notice Required
Scheduled:	
Planned inpatient admission	3 business days in advance
Inpatient or outpatient elective surgery or procedure	3 business days in advance
Maternity (notify UMR during your first trimester)	
Term pregnancy	Within 48 hours of admission
Caesarean section (planned)	3 business days in advance
Caesarean section (emergency)	Within 48 hours of admission
Other Admissions	
Urgent/Emergency service or procedure	Within 48 hours of admission
Extended stay	Additional days may be recommended based on medical necessity

Preauthorization (Voluntary)

Preauthorization is a voluntary process which allows you to contact UMR in advance of a procedure to verify that the service is a covered benefit and medically necessary so that you can make an informed decision about the procedure. To obtain preauthorization, ask your provider to send your request to:

UMR, P.O. Box 30541, Salt Lake City, UT 84130-0541

Your provider should include your name, address, telephone number, your ID number, and all information about the procedure that's recommended. UMR may contact your physician for more information. Remember, if your request for preauthorization is denied, you will be responsible for paying for the service or procedure if you choose to have it.

Medical Case Management

If you are experiencing a serious or long-term illness or injury, UMR's 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 UMR can:

- arrange home care to prevent hospitalization;
- arrange services in the home to facilitate early hospital discharge;
- coordinate care and benefits for transplant services;
- 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.

For catastrophic cases involving serious long-term illness or injury resulting in loss or impaired function requiring medically necessary therapeutic intervention, the UMR case manager may, based on medical documentation, recommend additional treatment for certain therapy services. For details of these benefits, see "What Is Covered" later in this section beginning on page 54.

Transition of Care Program (New Participants Only)

If you are new to the PEIA PPB Plan and have been receiving medical treatment from an out of state provider, you may be concerned that your care will be interrupted in your move to this Plan. To assist participants receiving treatment for serious medical conditions from out-of-state or out-of-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 UMR 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, UMR 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 1-888-440-7343 and submit the completed form to UMR 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 UMR. You must apply for TOC within three months of your effective date of coverage in Plan A or B.

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 Plans.

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 Plans A, B & D 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;
- providing treatment within the scope or limitation of the license or certification;
- not under sanction by Medicare, Medicaid or both. Services of providers under sanction will be denied for the duration of the sanction; and
- not excluded by PEIA due to adverse audit findings.

Types of Services Covered

PEIA PPB Plans A, B & D cover 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 for PEIA PPB Plan A & B members only). If you have questions about coverage of services, call UMR at 1-888-440-7342. Special arrangements that have been made for participants in PEIA PPB Plans A & B who live more than one county beyond the borders of West Virginia are explained on page 43 under "Non-resident PPB Plan A & B Participants".

In this section, services marked with "X" require precertification in some or all circumstances.

● **Allergy Services.** Including testing and related treatment; in-network care covered with applicable coinsurance after the deductible is met.

✖ **Ambulance Services.** Emergency ground or air ambulance transportation, when medically necessary to the nearest facility able to provide needed treatment; in-network care covered with applicable coinsurance after the deductible. The PEIA allowance for air ambulance transportation is the current Medicare rural rate. The benefit limit for air ambulance services is $25,000. Non-medically necessary, non-emergency ground transportation is not covered. Non-emergency air ambulance transportation requires precertification and is generally not covered.

✖ **Ambulatory Surgery.** This benefit is subject to a $100 copayment and applicable coinsurance after the deductible has been met. See "Outpatient Surgery" on page 59.

- **Annual Routine Physical and Screening Examination.** The PEIA PPB Plans cover a routine physical and screening examination once every year for insureds age 16 and over. Exams may be provided more often if the patient's medical history indicates a need, but these additional visits are subject to copayments. The routine physical and screening examination includes history and physical (screening and counseling for alcohol and/or substance abuse, blood pressure, depression, diabetes, domestic violence, nutrition, obesity, physical activity, STD prevention and other health risk factors as appropriate and provided for by the Patient Protection and Affordable Care Act; review of medications; blood work including general health panel and lipid panel, and immunizations as recommended by the American Academy of Family Physicians). Any additional services, including lab work, diagnostic testing and procedures, that are provided to you during this visit will be subject to your deductible, coinsurance and copayments, if there is a diagnosis to support them. For more information, see page 43 for a complete list of services covered under the Annual Routine Physical and Screening. See page 109 for information you can take to your physician.

✖ **Autism Spectrum Disorder.** Applied behavior analysis (ABA) services, to the extent mandated by W. Va. Code §5-16-7(a)(8), when provided in-network are covered with applicable coinsurance after the deductible has been met.

✖ **Bariatric Surgery.** This benefit is subject to a $500 copayment and applicable coinsurance after the deductible has been met. Must meet plan guidelines.

- **Cardiac or Pulmonary Rehabilitation.** Benefits are limited to 3 sessions per week for 12 weeks or 36 sessions per year covered with applicable coinsurance after the deductible is met.

✖ **Chelation Therapy.** Benefits for these services are limited. If covered, in-network therapy is covered with applicable coinsurance after the deductible has been met.

- **Childhood Immunizations.** Immunizations, as recommended by the American Academy of Pediatrics, 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. See also Immunizations.

✖ **Chiropractic Services.** Services of a chiropractor for acute treatment of neuromuscular-skeletal conditions are included in the Pain Management and Rehabilitative Outpatient Services Benefit (see page 59). Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. Initial 20 visits require a $20 copayment per visit. Visits 21+, if approved by UMR, require a $25 copayment per visit and applicable coinsurance after the deductible is met. Office visits are subject to a copayment and x-rays are covered with applicable coinsurance after the deductible is met. See Pain Management and Rehabilitative Outpatient 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 with applicable coinsurance after the deductible is met. 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.

✖ **Colorectal Cancer Screenings.** Routine screening to detect colorectal cancer is covered at 100% in-network with no deductible or coinsurance required. This benefit is covered as follows:

- Fecal-occult blood test – 1 in 12 months/age 50 and over
- Flexible sigmoidoscopy – 1 in 5 years/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 5 years/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 when required as the result of accidental injury or disease, or when performed to correct birth defects are covered with applicable coinsurance after the 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 with applicable coinsurance after the $500 copayment and deductible are 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. The Least Expensive Professionally Acceptable Alternative Treatment (LEPAAT) for accident-related dental services will be covered. For example, the dentist may recommend a crown, but the Plan will only provide reimbursement for a large filling. Contact UMR 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 UMR within the initial six months.

- **Dental Services (impacted teeth).** Medically-necessary extraction of impacted wisdom teeth is covered with applicable coinsurance after the $500 copayment and deductible are met. Extractions for 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 with applicable coinsurance after the 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.** Services of a diabetes education program that meets the standards of the American Diabetes Association are covered with applicable coinsurance after the deductible is met. Coverage is limited to six (6) visits per patient, per lifetime: three visits with the dietician and three visits with a registered nurse. Contact UMR for specific benefit limitations.

- **Dietician Services.** Services of a licensed, registered dietician are covered with the appropriate office visit copayment. Coverage is limited to two visits per year when prescribed by a physician for adult members with chronic medical conditions. Diabetic patients see Diabetes Education above. Benefit may be extended to children who meet criteria.

- ✖ **Durable Medical Equipment (DME) and Prosthetics.** Coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices, and for the rental (at the plan's discretion) of standard DME, when prescribed by a physician. Prosthetics and DME purchases of $1,500 or more, or rentals of $500 or more for more than 3 months must be pre-certified by UMR. DME and prosthetics are covered with applicable coinsurance after the deductible is met. Omnipod and other disposable insulin delivery systems are not covered.

- **Emergency Services (including supplies; for the first six visits in a Plan Year).** Services received in an emergency room when the condition has been certified as an emergency are subject to a $100 copayment and applicable coinsurance after the deductible is met. Members who visit the emergency room for non-emergency services an excessive number of times may be placed on case management or otherwise have payment for their ER services restricted or terminated by the PEIA Plans. PEIA will assess an additional emergency room copay of $500 for emergency treatments received as a result of high-risk behaviors, such as:

  - Accidents while driving motorcycle or UTV/ATV without a helmet
  - DUI/DWI or drug-related accidents
  - Failure to wear seatbelt(s)

- **Emergency Room Treatment over six visits in a Plan Year (including ambulance transport, supplies, testing, consultation, and all associated costs).** Emergency Room treatment should be used only when there is an actual "Emergency Medical Condition" as defined by applicable State law: "Emergency Medical Condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected (by a prudent layperson) to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of a bodily part or organ." If you have such a condition, PEIA urges you to go immediately to a hospital emergency room.

  Because use of the emergency room for non-emergency care is inappropriate and very expensive for the member and the PEIA Plans, after the sixth emergency room visit by a policyholder and their dependent(s) in a Plan Year, any emergency room visits will be assumed to be non-emergency care and will not be covered (including associated costs). However, the member may appeal these claims and if, upon appeal, the claim is shown by the member to be for an actual emergency medical condition, the claim will be adjusted and paid the same as an emergency room claim for the first six visits per policyholder per plan year. (See "Appealing a Claim" in this Summary Plan Description).

✖ **Home Health Services.** Intermittent health services of a home health agency when prescribed by a physician are covered with applicable coinsurance after the 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 twelve (12) visits are necessary, precertification is required.

✖ **Hospice Care.** When ordered by a physician, hospice care is covered with applicable coinsurance after the deductible is met.

✖ **Hyperbaric Oxygen Therapy.** Covered with applicable coinsurance after the deductible is met.

- **Immunizations.** 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, 4-6 years, a booster at age 11-12, and a single dose at age 16-18.
  - Tetanus-Diphtheria (Td): At 11-18 years with booster every 10 years.
  - Measles-Mumps-Rubella (MMR): At 12-15 months and 4-18 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-2months, 1-4 months, and 6-18 months. If missed, get 3 doses starting at age 11 years.
  - Hepatitis A: Begin at 6 months, with second dose at least 6 months apart.
  - Pneumococcal disease (Prevnar™): At 2 months, 4 months, 6 months, and 12-15 months. If missed, talk to your health care provider.
  - Influenza: At 6 months and then annually.
  - Varicella: At 12-15 months and 4-6 years. Adults, if not previously immunized, 2 doses per lifetime
  - Meningococcal: At 2-10 years for certain children as recommended by the American Academy of Pediatrics, a booster at age 11-12, and a single dose at age 16-19.
  - Human Papillomavirus (HPV): At 11-26 years.
  - Rotavirus: At 2 months, 4 months, and 6 months depending on vaccine used.
  - Zoster: ages 60 and over

  For children through age 16, the plan covers immunizations and the associated office visit with no deductible, coinsurance, or copayment required. Also see "Well Child Care" on page 60.

  For adults and children over age 16, the plan covers immunizations provided and administered in a physician's office as recommended by the American Academy of Family Physicians at 100% in-network. The associated office visit is

subject to the applicable copayment unless it is administered at the time of an "Annual Routine Physical and Screening Examination." Other immunizations covered with applicable coinsurance after the deductible is met. If purchased at a pharmacy, the member will be reimbursed according to PEIA's fee schedule.

✖ **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 with applicable coinsurance after the $100 copayment and the deductible is met. Unapproved out-of-network inpatient admissions are not covered.

✖ **Inpatient Medical Rehabilitation Services.** When ordered by a physician, coverage is subject to the $100 copayment and applicable coinsurance after the deductible is met and is limited to 150 days per plan year. Unapproved out-of-network inpatient admissions are not covered.

✖ **Intensive Modulated Radiation Therapy (IMRT).** Covered with applicable coinsurance after the deductible is met.

● **Mammogram.** A routine mammogram every 1-2 years for women over 40 to detect breast abnormalities is covered at 100% in-network with no coinsurance or deductible required. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and is covered with applicable coinsurance after the deductible is met.

✖ **Massage Therapy.** Therapeutic services by a provider licensed to perform massage therapy for treatment of neuromuscular-skeletal conditions are covered under the Outpatient Therapy Benefit when ordered by a physician. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. Initial 20 visits require a $10 copayment and applicable coinsurance per visit. Coverage may be extended beyond the 20-visit limit for members in case management due to a catastrophic illness or injury, if approved in advance by UMR. Visits 21 +, if approved by UMR, require a $25 copayment and applicable coinsurance per visit. Maintenance services are not covered. Combined coverage for all therapies is limited to a maximum of 20 visits per person, per plan year. See Outpatient Therapy Services for more information.

✖ **Mastectomy and Follow-up.** 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;
- 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 lymphedemas.

● **Maternity Services.** See "Maternity Benefits" on page 63 for details.

✖ **Mental Health Services.**

- Inpatient programs and outpatient 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. Cases requiring more than 20 visits 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 with applicable coinsurance after the $100 copayment and the deductible is met. Unapproved out-of-network inpatient admissions are not covered.
- 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 with applicable coinsurance after the deductible is met.

- **MRA.** Magnetic Resonance Angiography services when performed on an outpatient basis are covered with applicable coinsurance after the deductible is met.

✖ **MRI.** Magnetic Resonance Imaging services when performed on an outpatient basis, are covered with applicable coinsurance after the deductible is met. MRI of the knee and spine, including cervical, thoracic and lumbar require precertification.

✖ **Neuromuscular stimulators and bone growth stimulators,** when criteria are met, are covered with applicable coinsurance after the deductible is met.

- **Oral Surgery.** Coverage is limited and pre-authorization is recommended. Services are limited to extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction. This benefit requires a $500 copayment, then is covered with applicable coinsurance after the deductible is met. Dental implants are not covered.

✖ **Organ Transplants.** See "Organ Transplant Benefits" on page 65 for more details.

- **Outpatient Diagnostic and Therapeutic Services.** Laboratory, diagnostic tests, and therapeutic treatments, when ordered by a physician, are covered with applicable coinsurance after the deductible is met.

✖ **Outpatient Surgery.** This benefit is subject to a $100 copayment with applicable coinsurance after deductible, when performed in a hospital or alternative facility.

✖ **Outpatient Therapies.** Coverage for the following outpatient therapies is combined into one benefit and is available with applicable coinsurance after the deductible is met. The benefit is limited to a maximum of 20 visits per person per plan year for all the therapies combined. Coverage may be extended beyond the 20-visit limit for members in case management due to a catastrophic illness or injury, if approved in advance by UMR. Maintenance services are not covered. Initial 20 visits require a $10 copayment per visit. Visits 21+, if approved in advance by UMR, require a $25 copayment per visit.

- **Massage Therapy.** When ordered by a physician, therapeutic massage therapy services by a provider licensed to perform massage therapy are covered with applicable coinsurance after the deductible and $10 or $25 copayment (details above) are met.
- **Outpatient Speech Therapy.** When ordered by a physician, this benefit is covered with applicable coinsurance after the deductible and $10 or $25 copayment (details above) are met.
- **Vision Therapy.** This benefit is covered, up to age 18, with applicable coinsurance after the deductible and $10 or $25 copayment (details above) are met.

✖ **Pain Management and Rehabilitative Outpatient Services.** Coverage for the following outpatient therapies is combined into one. The benefit is limited to a maximum of 20 visits per person per plan year for all the therapies combined. Coverage may be extended beyond the 20-visit limit for members in case management if approved in advance by UMR. Initial 20 visits require a $20 copayment per visit. Visits 21+, if approved in advance by UMR, require a $25 copayment per visit and applicable coinsurance after the deductible is met.

- **Chiropractic Treatment.** Services of a chiropractor for treatment of neuromuscular-skeletal conditions are covered with the cost-sharing described above. Office visits are subject to a copayment and x-rays are covered with applicable coinsurance after the deductible is met.
- **Occupational Therapy.** This benefit is covered with the cost-sharing described above.
- **Osteopathic Manipulations.** Services of an osteopathic physician to eliminate or alleviate somatic dysfunction and related disorders are covered with the cost-sharing described above.
- **Outpatient Physical Therapy.** This benefit is covered with the cost-sharing described above.

- **Pap Smear.** An annual Pap smear and the associated office visit to screen for cervical abnormalities are covered. The screening is covered in full if conducted as a part of the Routine Physical and Screening Exam. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and covered with applicable coinsurance after the deductible is met.
- **Physician's Office Visits (treatment for illness, injury, or medical condition).** These visits are subject to a copayment for in-network services. See page 46.
- **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 to a primary care or specialty care physician are subject to the applicable copayment (see chart on page 46). Other physician services are covered with applicable coinsurance after the deductible is met.
- **Prostate Cancer Screening.** For men age 50 and over. The screening is covered in full if conducted as a part of the Routine Physical and Screening Exam. The PSA blood test associated with this screening, when ordered by a physician, is covered at 100% with no deductible or coinsurance in-network.
- **Second Surgical Opinions.** Office visits for second surgical opinions are subject to a copayment per visit. Second surgical opinions are paid at 100% if required by UMR.
- ✖ **Specialty Injectable Medications.** Coverage is provided for treatments utilizing specialty drugs through a program managed by CVS Caremark. Specialty medications covered under the medical benefit plan are subject to applicable coinsurance after the deductible is met. Specialty medications covered under the prescription drug program are covered with a $100 copay if on the WV Preferred Drug List and a $150 copay if not on the WV Preferred Drug List, after the prescription drug deductible is met.
- ✖ **SPECT.** Single Photon Emission Computed Tomography is covered with applicable coinsurance after the deductible is met. SPECT of brain or lung requires precertification.
- ✖ **Skilled Nursing Facility Services.** Confinement in a skilled nursing facility including semi-private room, related services and supplies is covered with applicable coinsurance after the $100 copayment and the deductible is met. Confinement must be prescribed by a physician in lieu of hospitalization. Coverage is limited to 100 days per plan year. Unapproved out-of-network inpatient admissions are not covered.
- ✖ **Sleep Management Services.** All sleep testing, equipment and supplies for resident PPB Plan members are covered through a network of West Virginia providers and require precertification through CareCentrix, if determined to be otherwise covered. Non-resident PPB Plan members should call UMR for precertification of sleep management services. See further details under Sleep Management Services later in this section.
- **Smoking Cessation.** See "Tobacco Cessation" on page 69 for details.
- **Telehealth.** Services of a telehealth physician provided through PEIA's telehealth vendor, iSelectMD, are covered at 100% after a $10 copayment.
- **Travel Benefits.** Members are eligible for some reimbursement for travel benefits (mileage and tolls). See Travel Benefits on page 67.
- **Urgent Care.** Services from an urgent care center are covered with a $50 copayment.
- **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.

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, 30 months, 3 years and 4 years.
- Late childhood: Annually from ages 5 through 12.
- Adolescence: Annually from ages 13 through 16.

Adolescents over the age of 16 receive the Annual Routine Physical and Screening Examination benefit described on page 55.

Comprehensive Care Partnership (CCP) Program

PEIA offers a healthcare program that allows you to receive primary care services while paying less. This program, called the Comprehensive Care Partnership (CCP) program, is designed to promote quality of care, preventive services and appropriate use of health services to identify health problems early and maintain control of chronic conditions. This benefit option is available to PEIA PPB Plan A, B and D insureds.

Members who enroll in the CCP Program will pay less for specified services at their CCP provider. CCP providers are expected to provide primary care services, coordination of care, and some CCP locations also provide specialty care services and/or laboratory services. If a CCP member uses any provider outside the CCP, including another primary care provider, the copayment for the office visit will be $40.

The purpose of the CCP is to promote the use of health services to keep the patient well, identify health problems early, maintain control of chronic conditions and to promote efficient utilization of healthcare resources. As such, the following is required of the CCP provider:

- Remind you when services are due;
- Perform an initial evaluation to include an assessment of your preventive health care services and overall health status;
- Provide the information you need to care for yourself;
- Maintain an electronic medical record, which includes a summary of key health and preventive care history, medicines, and a provision for delivering such information to you as needed;
- Provide 24-hour telephone access to a medical provider;
- Coordinate with specialists to ensure that all information and treatment plans are consistent;
- Notify you of any changes to covered services;
- Notify PEIA of non-compliant members who should be removed from the program.

Members enrolled in the CCP program agree to receive their primary healthcare from the CCP provider. Enrolled members pay less for specified services provided at their CCP location. The success of the program requires a working partnership between the CCP provider and the patient/member. Participating members agree to:

- Use their chosen CCP provider for all health care available at their designed CCP.
- Contact their CCP provider before receiving medical care from providers with the exception of emergency cases.
- Participate in initial and regular health assessment at least every two years. The purpose of the assessment is to collect the health history and clinical data needed to identify the preventive services needed, plan the patient's care, and address all healthcare questions.
- Members who do not comply with the requirements of the program may be dis-enrolled.

NOTE: If you want to continue using other primary care providers and/or specialists for much of your health care, the CCP may not be for you.

To enroll in the CCP program, simply:

- Review the Provider Directory on UMR's website at www.umr.com and choose the provider location to serve as your CCP provider;
- Click on the green "Manage My Benefits" button in the upper right corner, register on the site or use your existing credentials to log-in and choose your CCP provider;
- Or complete the CCP program enrollment form from the website, note the CCP location of choice and the seven-digit provider ID number, then sign it and return it to PEIA at the address provided, or you may give it to a receptionist at one of the health centers;

Your CCP will be effective the first day of the month following receipt of your completed enrollment form, if it is received no later than the 25th. If the form is received after the 25th, then enrollment may be delayed a month.

Disease Management Program

The Disease Management Program identifies those individuals who have certain chronic diseases and would benefit from this program. Specially trained nurses work telephonically with members to help them improve their chronic diseases and maintain quality of life. UMR identifies individuals with one or more of the seven targeted chronic conditions:

1. Asthma,
2. coronary artery disease,
3. congestive heart failure,
4. chronic obstructive pulmonary disease,
5. diabetes,
6. hypertension, and
7. depression as a comorbidity linked to another chronic managed condition.

Identified members are invited to participate in the appropriate Disease Management program, and then work with specially trained nurses through phone calls and printed materials to learn more about their condition and how to manage it.

In addition to the telephonic services, UMR Disease Management also provides HealtheNotes. These targeted mailings are sent to members' homes and to their health care providers. They identify chronic condition gaps in care and include information on ways to prevent long-term issues and avoid health care costs.

HealtheNotes provide useful, personalized information based on an individual member's health care utilization, including information on provider visits, prescriptions, and health screenings. HealtheNotes is an educational tool in the Disease Management Program for managing a member's chronic condition(s).

Hemophilia Disease Management Program

To provide quality care at a reasonable cost, PEIA has partnered with the Charleston Area Medical Center (CAMC) and West Virginia University Hospitals (WVUH) to provide a Hemophilia Care Program to PEIA PPB Plan members. Members who participate in the program will be eligible for the following benefits:

- An annual evaluation by specialists in the Hemophilia Disease Management Program which will be paid at 100% with no deductible, copay or coinsurance. (This evaluation is not intended to replace, or interrupt care

provided by your existing provider or specialists. This evaluation does not include routine or sick care visits with your doctor or ER).

- Hemophilia factor expenses incurred at CAMC or WVUH will be paid at 100% with no deductible, copay or coinsurance.
- Reimbursement for travel and lodging for an annual evaluation
    1. Child and 1 or 2 parents
    2. Adult and an accompanying adult
    3. Lodging will be at an approved hotel for a maximum of two (2) nights for one room only.
    4. Gas will be reimbursed at the federal rate for one vehicle only.
    5. Receipts for food will be paid at 100% for the child and parents or for the 2 adults.

Lodging and Travel Expenses:

Lodging expenses include:

1. a) Expenses incurred by the patient traveling between his or her home and the participating facility to receive services in connection with the Hemophilia Disease Management Program.
2. b) Expenses incurred by the patient's companion to enable the patient to receive services from the Hemophilia Disease Management Program.
3. For children under the age of 18, lodging will be covered for one (1) or two (2) parents.
4. For patients over the age of 18, lodging will be covered for one (1) companion.

Lodging will be covered at 100% of the charge at an approved hotel.

Travel expenses (gas & meals) include:

1. Expenses incurred while traveling with the patient between the patient's home and the medical facility to receive services in connection with the Hemophilia Disease Management program.
2. Gas receipts are required for reimbursement.
3. Reimbursement of meal expenses up to $30 per day per person. Receipts are required for the reimbursement of meals.

All claims must be submitted within the six-month timely filing period, including the submission of all lodging and travel expenses.

For more information about this program please contact: UMR at 1-888-440-7342.

Maternity Benefits

The PEIA PPB Plans A, B & D provide coverage for maternity-related professional and facility services, including prenatal care, midwife services and birthing centers. Maternity related services are covered for the employee and covered dependents.

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

You will need to contact UMR 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.

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of long-term hospital stays for both mothers and babies. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the member's risk level and educational needs. The program uses incentives in order to increase participation and encourage program completion.

UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they are pregnant. Members self-enroll in the pre-pregnancy coaching program by calling UMR's toll-free number. They are then contacted by nurse case managers who have extensive clinical backgrounds in obstetrics/gynecology. The nurses complete pre-pregnancy assessments to determine risk levels, if any, and provide members with education and materials based on their needs.

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 under a global fee after the deductible has been met. Other maternity services, including hospital charges and anesthesia services, are paid with applicable coinsurance 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, PEIA PPB Plans A, B & D 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 UMR and request a Maternity Pre-payment form.

High-Risk Birth Score Program

For infants identified at birth as being at risk for health problems, PEIA PPB Plans A, B & D 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. UMR 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 or online at www.wvpeia.com under **"Manage My Benefits".**

Nursery Charges

If the baby is enrolled for coverage under the PEIA PPB Plan A,B, or D, charges for the newborn nursery care will be paid in the baby's name. If the baby is not enrolled for coverage under the Plan, only charges for a normal, healthy newborn's nursery care will be covered if billed as part of the mother's maternity benefit, and all other claims will be denied. 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 UMR. You should contact UMR as soon as your doctor determines you or a member of your family covered by PEIA PPB Plans A, B or D may need a transplant. All transplants require precertification for determination of medical necessity. You should advise your physician that UMR 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 a network of providers for organ transplant services. This helps to control health care costs for both you and the plan. PEIA's primary OTN facilities are:

- University of Kentucky's UK HealthCare
- Cleveland Clinic
- WVU Hospital for bone marrow
- Charleston Area Medical Center (CAMC) for kidney

For services not available at these facilities, PEIA uses the Optum transplant network. UMR will work with patients and physicians to determine which 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 46 will still apply.

Travel Allowance: Because network facilities may be located some distance from the patient's home, reimbursement benefits include up to $5,000 per transplant for patient travel, lodging and meals related to visits to the transplant facility or physician. 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 of meals and lodging; cost estimates are not acceptable. No alcoholic beverages will be reimbursed. Mileage will be reimbursed at the federal mileage rate for medical expenses.

NOTE: To seek reimbursement for transplant-related travel expenses, use the Medical Claim Form on www.wvpeia.com and submit the form to UMR, the third-party administrator. All claims must be submitted within the six-month timely filing period, including the submission of all lodging and travel expenses.

Medical Case Management: UMR 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 UMR at 1-888-440-7342.

You should contact UMR as soon as you learn that you or a member of your family covered by PEIA PPB Plans A, B or D may need a transplant. All transplants must be pre-certified through UMR.

Out-of-Network Organ Transplant Benefits

For patients who choose to use a non-network facility for transplant services, there is no coverage for out-of-network facilities, unless approved in advance by UMR. No travel benefits will be provided for out-of-network transplants (except medically necessary ambulance transport).

Transplant-Related Prescription Drugs

PEIA PPB Plans A, B & D cover transplant-related immunosuppressant prescription drugs at 100%, after you have met your prescription drug deductible. Transplant-related immunosuppressants are a specialty medication and must be purchased through the CVS Specialty Pharmacy. PEIA will allow a one-time initial fill of the medication at a retail pharmacy.

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

Sleep Management Services

The PEIA PPB Plans cover services for the diagnosis and treatment of sleep apnea and other sleep-related conditions that can affect your health. To ensure compliance and to administer prescribed sleep services at the highest quality, UMR, the third-party administrator for PEIA, has contracted with CareCentrix to provide sleep diagnostic and therapy management services for PPB Plan members. A precertification process has been established to qualify services as medically necessary and appropriate. PEIA requires that the ordering physician request approval from CareCentrix prior to a member receiving sleep services that include sleep testing, sleep therapy or sleep therapy supplies and services out of state.

Using evidence-based guidelines, CareCentrix will review your request for a sleep study and make recommendations for those studies that can be performed in the member's home. If the member is appropriate for a diagnostic home sleep study, the member will be directed to a CareCentrix-contracted home sleep testing provider.

In addition to managing sleep testing services, CareCentrix also manages PAP therapy services by providing prior approval for PAP therapy and supply requests. CareCentrix directs the member to a CareCentrix-contracted DME provider. In addition, CareCentrix provides comprehensive support for members' prescribed PAP therapy to provide assistance with adherence to therapy through the iComply program.

To obtain prior authorization for sleep services, you may call CareCentrix at 1-888-49-SLEEP (75337), or you may fax your request to 1-888-571-8816 using the Prior Authorization Fax Form found at http://help.carecentrix.com/ProviderResources/PEIA_Health_Fax_Request_form.pdf. Non-resident PPB Plan members must call UMR for precertification of sleep management services.

Specialty Drug Program

PEIA's Specialty Drug Program has two components:

1. Specialty Injectable Drugs are administered by injection or infusion, and are managed by UMR through the medical benefit.
2. Common Specialty Medications are self-administered, and are managed by CVS Specialty Pharmacy

Specialty Injectable Drugs are prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring. The PEIA PPB Plans cover specialty injectable drugs through a program managed by UMR. The program provides comprehensive direction to policyholders and their dependents for treatments utilizing specialty drugs. If your physician prescribes a specialty drug, that physician, you, or the pharmacist must call UMR at 1-888-440-7342. The Specialty Injectable Drug list is located at https://hs.umr.com/print/UM1428.pdf. To obtain a paper copy, call 1-888-680-7342. UMR will review the drug for medical necessity If denied, UMR will contact your physician for additional information which may allow approval of the requested medication.

Common Specialty Medications are self-administered specialty injectable drugs through the CVS Specialty Pharmacy. Through the CVS Specialty Pharmacy, you will be assigned a dedicated CareTeam with specialists in your condition. These specialists will check in to see what you need and how they can help moving forward. They'll also make arrangements for injection training, as needed. If your physician prescribes a common specialty drug, they can call 1-800-237-2767, fax 1-800-323-2445, or e-prescribe the specialty drug to the CVS Specialty Pharmacy. CVS Specialty will then work with your doctor to obtain prior authorization for the specialty medication. Once approved, you can have your specialty medications delivered directly to you.

Many specialty medications have manufacturer programs which will financially assist patients in the purchase of the medication. PEIA requires that if a financial assistance program is available, you must participate in the program. Only your actual out-of-pocket payments will count toward your drug deductible and annual out-of-pocket maximum; not amounts discounted off the price by the manufacturer or seller of the specialty medication.

Travel Benefits

If a covered PEIA participant travels more than 60 miles, one-way, from their home, to receive care in West Virginia, the PPB Plan will reimburse the policyholder some of the travel expenses related to their medical care.

Limitations and requirements:

- Only mileage and tolls are covered.
- Mileage will be reimbursed at the federal mileage rate for medical expenses in effect for the time period.
- You must provide receipts for tolls.
- Travel must be on the same day as the medical procedure.
- Other travel related expenses are not covered.
- Benefit is only for care and services received at providers in West Virginia. Travel to providers outside of West Virginia is not covered except as specified in the Summary Plan Description.
- Maximum reimbursement shall not exceed $250 per benefit year.

NOTE: To seek reimbursement for travel expenses, use the Medical Travel Expense Reimbursement Request Form on www.wvpeia.com, and submit the form to PEIA, 601 57th St., SE, Suite 2, Charleston, WV 25304-2345. All claims must be submitted within the six-month timely filing period, including the submission of all travel expenses.

Healthy Tomorrows

The Healthy Tomorrows Initiative

As a part of its financial plan for Plan Year 2020, the PEIA Finance Board voted to suspend the Healthy Tomorrows bloodwork and reporting requirements. If you submitted a Healthy Tomorrows form for Plan Year 2020, thank you for your efforts. PEIA will destroy any forms that have already been submitted. New wellness programs, initiatives, and training will be rolled out during Plan Year 2020, including several pilot programs for chronic disease management. For the latest news and updates, please make sure your email is current on Manage My Benefits, connect with PEIA on Facebook, visit our website, or talk to your Workplace Wellness Coordinator.

NOTE: PEIA still covers an annual physical for members at no cost (state and network rules apply). Take the Adult Annual Physical and Screening Examination Form on page 109 to your doctor. This form explains what is covered in full, and how the physician's office needs to bill to have the visit reimbursed correctly.

Face-to-Face (F2F) Diabetes Program

PEIA's F2F Diabetes Program is a statewide, two-year program for PPB Plan members (subject to the availability of providers) open to active employees and non-Medicare retirees who have diabetes.

Under the program, members and/or their dependents with diabetes or gestational diabetes agree to make regular visits to a participating provider of their choosing for counseling and health education services. The provider works with each member over the course of the two-year program to ensure he/she gets the best diabetes care possible by monitoring:

1. recommended testing and treatment of diabetes;
2. the member's currently prescribed medicines and knowledge about how to take them; and
3. physical activity and nutrition plan to assist the member in achieving optimal health.

New members enrolling in the F2F Diabetes program will have 12 months from the date of enrollment to get their HbA1c at a value of 8 or below (or provide a physician's statement of why they cannot). Members benefit from participating in the F2F Diabetes program by improving their health and quality of life, and by saving money, since copayments are waived for generic and brand-preferred diabetes related prescription drugs, and/or supplies. Copayments are waived only at retail pharmacies, not mail order. Copayments are not waived on brand non-preferred prescription drugs. PEIA benefits from the member's better management of their disease through fewer health care costs from the disease or its complications.

Members participating in the F2F Diabetes program must be tobacco free and must be eligible for the tobacco-free premium discount, which means they must have been tobacco free for a minimum of six months prior to enrollment in the program. F2F is a twice-in-a-lifetime benefit (with the exception of gestational diabetes). Members who either failed to comply or dropped out of the program may re-enroll after a 12-month waiting period, which begins on the date PEIA disenrolls you from the program. Prior bariatric surgery will make the member ineligible to participate in F2F.

For more information or an application, check the PEIA website, www.wvpeia.com, or the F2F Care Management Program website, www.peiaf2f.com, or call PEIA Customer Service at 1-888-680-7342.

Weight Management Program

PEIA offers a facility-based weight management program for PEIA PPB members who meet the program qualifications and are willing to make the necessary commitment to the program. Members will be subject to monthly program compliance checks and must meet certain goals to continue in the program. To participate in the PEIA Weight Management Program, PPB Plan Members must have a Body Mass Index of 30 or greater; or a waist circumference of 35 inches or greater (for women) or 40 inches or greater (for men). The program includes comprehensive services from registered and licensed dietitians, degreed exercise physiologists and personal trainers at approved fitness centers. The

current list of participating facilities is on PEIA's website at www.wvpeia.com. This is a twice per lifetime benefit with a maximum of 24 months. The program requires a copayment of $20 per month. Members who previously participated in the PEIA Weight Management Program for fewer than 18 months may be eligible for a second program attempt. Members who have exhausted the lifetime benefit, have undergone bariatric or lap band surgery within the last 10 years, or are under age 18, are not eligible for this benefit.

To enroll, you must complete the online application, which includes some medical information. For more information, or to enroll in the program, go to www.wvpeia.com.

Tobacco Cessation

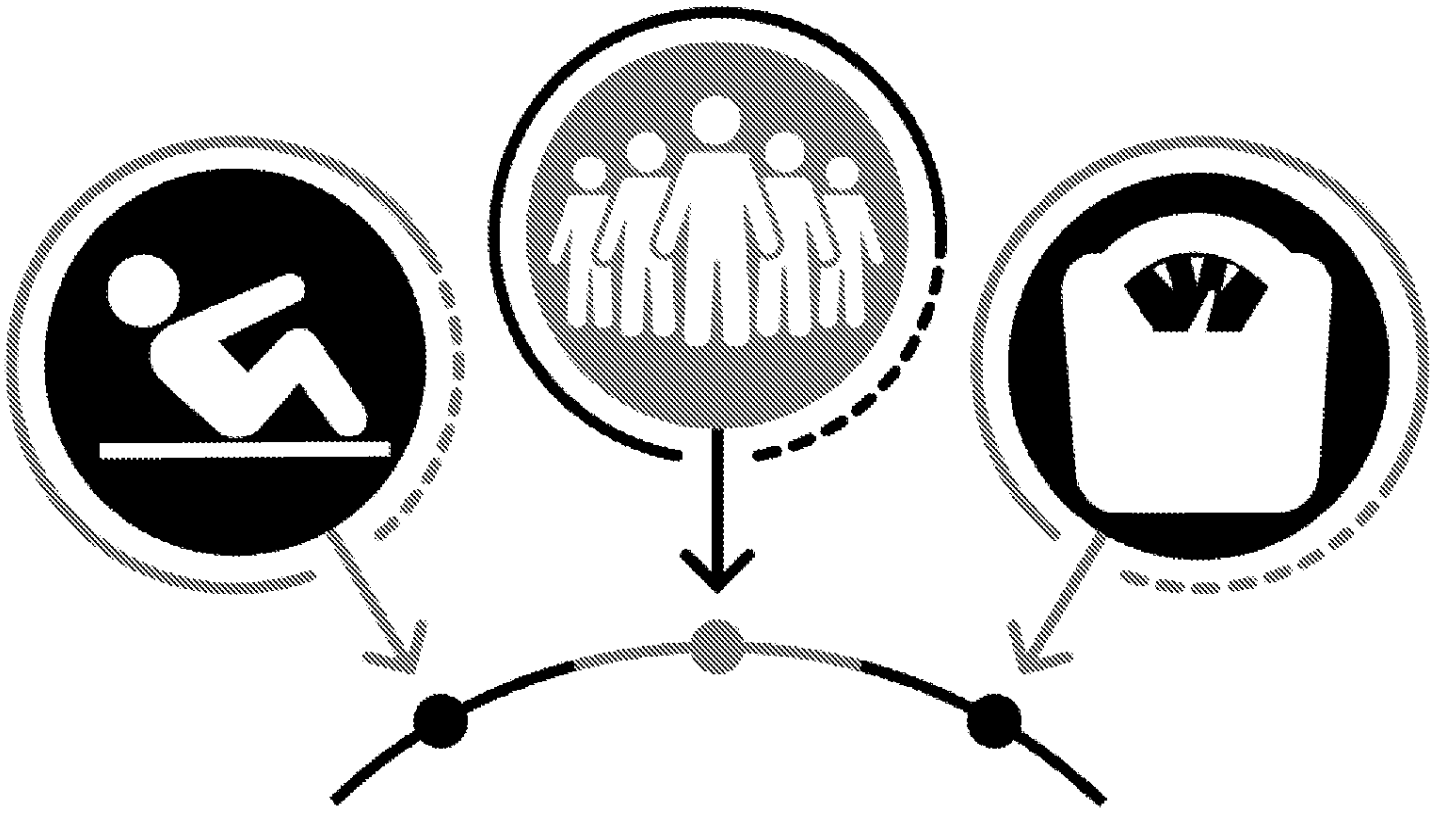
PEIA PPB Plans A, B & D provide benefits for participants who wish to quit smoking or using smokeless tobacco products. Only those members who have been paying the Standard (tobacco-user) premium are eligible for the Tobacco Cessation benefit. If you signed an affidavit claiming to be tobacco-free, you will be declined the Tobacco Cessation benefit.

To access the benefits, simply visit your primary care provider. PEIA will cover an initial and follow-up visit to your physician or nurse practitioner. PEIA covers both prescription and non-prescription tobacco cessation medications if they are dispensed with a prescription. PEIA will cover two 12-week cycles of drug therapy, even if more than one type of therapy is used. If extended therapy is required, the provider must submit a written appeal to the Director of PEIA with proof of medical necessity.

You can use the benefit (office visits and prescriptions) twice per year (rolling 12-month period). For pregnant participants, PEIA will provide 100% coverage for the tobacco cessation benefit during any pregnancy.

Payment Level

PEIA will cover an initial and follow-up visit to your physician or nurse practitioner at no cost to the member. Tobacco-cessation products are available at no cost to the member; both the deductible and the copayment are waived when prescribed by a physician and purchased at a network pharmacy.



What Is Not Covered

Some services are not covered by the PEIA PPB Plans regardless of medical necessity. Some specific exclusions are listed below. If you have questions, please contact UMR at 1-888-440-7342. The following services are not covered:

1. Acupuncture
2. Aqua therapy
3. Autopsy and other services performed after death, including transportation of the body or repatriation of remains
4. Biofeedback
5. Chemical dependency treatments when a patient leaves the hospital or facility against medical advice
6. Cologuard
7. Coma stimulation
8. Cosmetic or reconstructive surgery when not required as the result of accidental injury or disease, or not performed to correct birth defects. Services resulting from or related to these excluded services also are not covered
9. 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, including applied behavior analysis (ABA), except to the extent ABA is mandated to be covered for treatment of autism spectrum disorder by W.Va. Code §5-16-7(a)(8)
10. Dental implants, whether medically indicated or not
11. Dental services including dental implants, routine dental care, x-rays, treatment of cysts or abscesses associated with the teeth, dentures, bridges, or any other dentistry and dental procedures
12. Daily living skills training
13. Duplicate testing, interpretation or handling fees
14. Education, training and/or cognitive services, unless specifically listed as covered services
15. Elective abortions
16. Electronically controlled thermal therapy
17. Emergency evacuation from a foreign country, even if medically necessary
18. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts
19. Expenses incurred as a result of the commission of a felony, while incarcerated or while under the control of the court system
20. Experimental, investigational or unproven services, unless pre-approved by UMR
21. Fertility drugs and services
22. Foot care. Routine foot care including:
    - Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or 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
23. Genetic testing for screening purposes is generally not covered, unless specifically mandated by the Patient Protection and Affordable Care Act. See Precertification on page 50 for exceptions
24. Glucose monitoring devices or test strips, except Accu-Chek Aviva Plus, Accu-Chek Nano and Accu-Chek Guide models covered under the prescription drug benefit
25. Homeopathic medicine
26. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery
27. Hypnosis

28. Incidental surgery performed during medically necessary surgery
29. 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, including the workup for infertility treatment
30. Maintenance outpatient therapy services, including, but not limited to:
    - Chiropractic
    - Massage Therapy
    - Occupational Therapy
    - Osteopathic Manipulations
    - Outpatient Physical Therapy
    - Outpatient Speech Therapy
    - Vision Therapy
31. Marriage counseling
32. Medical equipment, appliances or supplies of the following types:
    - Augmentative communication devices
    - Bariatric beds and chairs
    - Bathroom scales
    - Educational equipment
    - Environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters
    - 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 (including Hoyer lifts); recliners; contour chairs; adjustable beds; or tilt stands
    - Support devices which are widely available over the counter such as prophylactic wrist, ankle and knee supports
    - Exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines
    - Hearing aids of any type
    - Hygienic equipment such as bed baths, commodes, and toilet seats
    - Motorized scooters
    - Nutritional supplements, over-the-counter (OTC) formula (with the exception of amino acid-based formula for the treatment of severe protein allergic conditions or absorption disorders or infant formula administered through a feeding tube), food liquidizers or food processors
    - Omnipod, V-go, Finesse and other disposable insulin delivery systems
    - Orthopedic shoes, unless attached to a brace
    - Professional medical equipment such as blood pressure kits or stethoscopes
    - Replacement of lost or stolen items
    - Supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags
    - Standing/tilt wheel chairs
    - Traction devices
    - Vibrators
    - Whirlpool pumps or equipment
    - Wigs or wig styling
33. Medical rehabilitation and any other services that are primarily educational or cognitive in nature
34. Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning

35. Optical services:
    - Routine eye examinations, refractions, eye glasses, contact lenses and fittings
    - Glasses and/or contact lenses following cataract surgery
    - Low-vision devices, including magnifiers, telescopic lenses and closed-circuit television systems
36. Oral appliances, including, but not limited to, those treating sleep apnea
37. Orientation therapy
38. Orthodontia services
39. Orthotripsy
40. Physical examinations and routine office visits except those covered under the Periodic Physicals benefit
41. 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
42. 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
43. 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
44. Provider charges for phone calls, prescription refills, or physician-to-patient phone consultations
45. Radial keratotomy, Lasik procedure and other surgery to correct vision. Surgery to prevent legal blindness or restore vision from legal blindness is covered, if not correctable by lenses or other more conservative means
46. Reversal of sterilization and associated services and expenses
47. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities
48. Screenings, except those specifically listed as covered benefits
49. Service/therapy animals and the associated services and expenses, including training
50. 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
51. Services rendered outside the scope of a provider's license
52. Surgical or pharmaceutical treatments associated with gender dysphoria or any physical, psychiatric, or psychological examinations, testing, treatments or services provided or performed in preparation for, or as a result of, sex transformation surgery
53. Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit
54. Sensory stimulation therapy
55. Take-home drugs provided at discharge from a hospital or any facility
56. 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
57. The difference between private and semi-private room charges
58. Therapy and related services for a patient showing no progress
59. Therapies rendered outside the United States that are not medically recognized within the United States
60. Transportation other than medically-necessary emergency ambulance services, or as approved under the Organ Transplant Network benefit or the Travel Benefit

61. War-related injuries or illnesses. Treatment in a State or Federal hospital for military or service-related injuries or disabilities
62. 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 the Weight Management Program offered by PEIA
63. Work-related injury or illness

How to File a Claim

Filing a Medical Claim

Medical claims are processed by UMR and should be submitted to:

UMR, P.O. Box 30541, Salt Lake City, UT 84130-0541

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

To process a medical claim, UMR 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 which is primary, you need to submit an Explanation of Benefits (EOB) from the other insurance which shows the amount the primary insurance paid 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, 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 receive from PEIA. See "Subrogation" on page 104 for details.

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 UMR 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 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 UMR or the prescription drug administrator.

PEIA is a Covered Entity under 45 CFR 160.103 and is required to be compliant with any and all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as other Privacy and Security laws, rules, ands regulations enacted by the State of West Virginia or the United States, and not rules of the European Union. The European Union's GDPR (General Data Protection Regulation) does not apply to PEIA or its operations.

UMR 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 plan you're enrolled in.

Appealing a Claim

PEIA PPB Plans

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 94) all appeals must be initiated within one hundred and twenty (120) days of claim payment or denial.

Type of Error	Who to Call	Where to Write
Pre-Service Medical claim or case management denial	UMR Appeals 1-800-808-4424 Ext. 15227	UHC Appeals – UMR P.O. Box 400046 San Antonio, TX 78229 Fax: 1-888-615-6564 Attn: UMR Appeals
Post-Service Medical claim	UMR 1-888-440-7342	UMR P.O. Box 30541 Salt Lake City, UT 84130-0541
Out-of-state care denial or denial of precertification	UMR 1-888-440-7342	UMR P.O. Box 30541 Salt Lake City UT 84130-0541
Prescription drug claim	CVS Caremark 1-844-260-8884	CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-2084
Common Specialty Medications claim	CVS Caremark 1-844-260-8884	CVS Caremark Specialty Appeals Department 800 Biermann Court Mount Prospect, IL 60056
Specialty Injectable Drugs	UMR 1-888-440-7342	UMR P.O. Box 30541 Salt Lake City, UT 84130-0541

If your medical claim or service has been denied, or if you disagree with the determination made by one of the Third-Party Administrators, the second step is to appeal in writing within 120 days of the denial to the Third-Party Administrator at the address listed above. Explain what you think the problem is, and why you disagree with the decision.

Please have your physician provide any additional relevant clinical information to support your request. Third-Party Administrator 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 the Third-Party Administrator. Facts, issues, comments, letters, Explanations of Benefits (EOBs), and all pertinent information about the case should be included and mailed to:

Director, Public Employees Insurance Agency, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345

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 sixty (60) days of the date of the letter. If the additional information is not received, the case will be closed.

External Review: If we have denied your request for the provision of or payment for a health care service or course of treatment, our decision may be reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. An external review may be initiated by us or requested by you. You may submit a request for external review within four (4) months after receipt of the notice of denial to the PEIA Clinical Unit, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345. For standard external review by your request, a decision will be made within forty-five (45) days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may request an expedited external review of our denial. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may request for an external review of our denial. External review is the final level of appeal, regardless of whether the external review was initiated by us or requested by you. External review is not available for items or treatments that are simply not covered by the Plan or for out-of-state benefit level appeals.

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 120 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, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345.

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 sixty (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.

Prescription Drug Benefits

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

1. The Retail Pharmacy Program gives you access to local participating pharmacies to get your prescription filled;
2. The CVS Caremark 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;
3. The CVS Caremark Specialty Medication Program provides access to 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 whether you purchase generic or brand name drugs.

What You Pay

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 or D	PPB Plan B
Policyholder Only	$75	$150
Policyholder & Child(ren)	$150	$300
Family	$150	$300
Family with Employee Spouse	$150	$300

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 or coinsurance based on the amount and type of drug you're taking. The following chart shows the copayments and coinsurance.

Copayments and Coinsurance

Once you meet your deductible, you pay a copayment or coinsurance to obtain drugs. Copayments and coinsurance 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 or coinsurance.

Prescription Drug Copayments and Coinsurance		
PEIA PPS Plan A or B		
	Up to a 30-day supply	90-day supply*
Generic Drug	$10	$20
Brand-name drug on the WV Preferred Drug List	$25	$50
Brand-name drug not listed on the WV Preferred Drug List#	75% Coinsurance	75% Coinsurance
Common Specialty Medications on WV Preferred Drug List	$100	Not Available
Common Specialty Medications NOT on WV Preferred Drug List†	$150	Not Available
PEIA PPS Plan S		
Generic Drug	$10	$20
Brand-name drug listed on the WV Preferred Drug List	$30	$60
Brand-name drug listed on the WV Preferred Drug List#	75% Coinsurance	75% Coinsurance
Common Specialty Medications on WV Preferred Drug List	$100	Not Available
Common Specialty Medications NOT on WV Preferred Drug List†	$150	Not Available

*For maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. You must purchase all medications on the Maintenance Drug List in 90-day supplies through a Retail Maintenance Network pharmacy or through Mail Service. Read on for details.

†Should your doctor prescribe, or you request the brand-name Specialty Medication when a generic drug is available, you must pay 75% coinsurance.

#Should your doctor prescribe, or you request the brand-name drug when a generic drug is available, you must pay 75% coinsurance.

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 member and the 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 copayment structure works:

- **Highest Cost:** You will pay a 75% coinsurance for brand-name drugs that are not listed on the WVPDL.
- **Middle Cost:** You will pay a mid-level copayment for brand-name drugs that are listed on the WVPDL.
- **Lowest Cost:** You will pay the lowest copayment for 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, a CVS Caremark 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 CVS Caremark 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, please call CVS Caremark Customer Care at 1-844-260-5894.

Non-Preferred Drugs

Non-preferred (tier 3) drugs are brand name drugs that do not appear on the WVPDL. Non-preferred drugs require 75% coinsurance after the prescription drug deductible.

If your doctor prescribes a non-preferred brand name drug, and you have tried and failed on the generic and preferred brand name alternatives offered by CVS Caremark, your provider may file an appeal to lower your out-of-pocket cost. To file the appeal, your provider must submit medical justification, in writing, to:

CVS Caremark
Attn: Exceptions Dept
1300 E. Campbell Rd.
Richardson, Tx 75081

Or fax to: 1-888-487-9257

Your tier appeal, if approved by CVS Caremark, will lower your out-of-pocket cost from 75% of the cost of the drug to the $25 preferred drug monthly copay. The decision by CVS Caremark is final. There is no further level of appeal for a tier exception.

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 and co-insurance, not deductibles or other charges, and is separate from your medical out-of-pocket maximum.

Getting Your Prescriptions Filled

Using a Retail Network Pharmacy

CVS Caremark has a nationwide network of pharmacies. To get a prescription filled, simply present your medical/prescription drug ID card at a participating CVS Caremark network pharmacy. You can purchase acute medications at any CVS Caremark network pharmacy. Maintenance medications must be purchased from a Retail Maintenance Network pharmacy or using the CVS Caremark Mail Service Pharmacy Program (see below for details). You may refill your prescription when 75% of the medication is used up or 80% of a controlled substance is used up.

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 a CVS Caremark network 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. All applicable management, such as prior authorization, step therapy, and quantity limits still apply. You may submit the receipt with a completed claim form to CVS Caremark 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, and your deductible (if applicable). This reimbursement is usually less than you paid for the prescription.

If you need claim forms, call CVS Caremark Customer Care at 1-844-260-5894 or visit their website at www.caremark.com.

To find the participating pharmacies nearest you, call CVS Caremark Customer Care at 1-844-260-5894 and use the voice-activated Pharmacy Locator System. If you have Internet access, you can find a pharmacy online at www.caremark.com.

Using the Retail Maintenance Network

If you take a drug on a long-term basis, you MUST purchase a 90-day supply of that drug if it is on the maintenance list (see the Maintenance Drug List later in this section) from a Retail Maintenance Network pharmacy. Check with your local pharmacist to verify participation.

Maintenance Drug Copayments

	PEIA PPB PLAN A or C		PEIA PPB Plan B	
	Up to 30-day supply†	90-day supply*	Up to 30-day supply†	90-day supply*
Generic medication	Not Covered	$20	Not Covered	$20
Brand-name medication listed on the WV Preferred Drug List	Not Covered	$50	Not Covered	$60
Brand-name medication not listed on the WV Preferred Drug List#	Not Covered	75% Coinsurance	Not Covered	75% Coinsurance

*For maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. You must purchase all medications on the Maintenance Drug List in 90-day supplies 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 75% coinsurance.

† For initial start on a new drug, patient may receive up to 2 30-day fills to be sure the drug is tolerated. After these two initial fills, the drug must be purchased in a 90-day supply to be covered.

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 CVS Caremark. 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 and your deductible (if applicable). This reimbursement is usually less than you paid for the prescription. All applicable management, such as prior authorization, step therapy, and quantity limits still apply.

If you purchase a Maintenance Medication at a non-network pharmacy, you will not be reimbursed for your purchase. Maintenance Medications must be purchased from Retail Maintenance Network pharmacies or using the CVS Caremark Mail Service Pharmacy Program.

If you need claims forms call CVS Caremark Customer Care at 1-844-260-5894 or visit their website at www.caremark.com.

Using the CVS Caremark Mail Service Pharmacy Program

CVS Caremark 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 must order a 90-day supply of a medication on the maintenance list, as prescribed by your doctor, and pay the member cost share indicated above. You may refill your prescription when 75% of the medication is used up. CVS Caremark's 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 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 in 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 e-prescribe or fax your order to 1-800-378-0333. 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.
    a) Refills online: Log on or register at CVS Caremark's website at www.caremark.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.
    b) Refills by phone: Call 1-844-260-5894 and use the automated refill system. Have your member ID number, refill slip with the prescription number, and your credit card ready.
    c) 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, American Express, electronic check, or PayPal. 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.

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. All prior authorization requests must be reviewed annually.

The medications listed below require prior authorization:

1. acitretin (Soriatane®)
2. adapalene (Differin®)
3. amphetamines (Adderall XR®, Vyvanse®)

4. anabolic steroids (Anadrol, Oxandrin)
5. armodafinil (Nuvigil®)
6. atomoxetine (Strattera®)
7. becaplermin (Regranex®)
8. buprenorphine (Subutex®)
9. buprenorphine/naloxone (Suboxone®, Bunavail™, Zubsolv®)
10. Butrans Patch
11. Calcitonin gene-related peptide (CGRP) receptor antagonists (Aimovig™, Ajovy™, Emgality™)
12. ciclopirox topical solution (Ciclodan®, Penlac®)
13. chenodiol (Chenodal™)
14. cinacalcet (Sensipar®)
15. Compounded Medications
16. cyclosporine ophthalmic emulsion (Restasis®)
17. dextromethorphan hydrobromide/quinidine sulfate (Nuedexta®)
18. diclofenac sodium gel (Solaraze®, Voltaren®)
19. diclofenac sodium topical solution (Pennsaid®)
20. edoxaban tosylate (Savaysa™)
21. enfuvirtide (Fuzeon®) *
22. Sacubitril/Valsarten (Entresto)
23. fentanyl oral and topical (Abstral®, Actiq®, Duragesic®, Fentora®, Lazanda®, and Subsys™)
24. fluocinonide 0.1% (Vanos®)
25. Hydrocodone Extended Release (Zohydro ER)
26. linezolid (Zyvox®)
27. lidocaine patch (Lidoderm®)
28. lifitegrast (Xiidra®)
29. metformin ext-rel (Fortamet/Glumetza)
30. modafinil (Provigil®)
31. naltrexone extended-release injectable suspension (Vivitrol®)
32. naproxen sodium extended release (Naprelan®)
33. omeprazole sodium bicarbonate (Zegerid)
34. Oral Acne medications (Absorica, Clavaris)
35. PCSK-9 Inhibitors (Praluent®, Repatha®)
36. select medical devices (e.g. Avenova®, Beau Rx, Eletone®, Epiceram®, Gelclair®, HPR Plus™, PromiseB®)
37. select medical devices – artificial saliva (e.g. NeutraSal®, SalivaMAX®)
38. sodium oxybate (Xyrem®)
39. Specialty medications*
40. stimulants (Concerta®, Focalin XR®, methylphenidate)
41. tazarotene (Tazorac®, Fabior®)
42. testosterone products (oral, topical, injectable products)
43. tiopronin (Thiola®)
44. tolvaptan (Samsca®)
45. Topical Antifungals (Jublia, Kerydin)
46. tretinoin cream (e.g. Retin-A) for individuals 35 years of age or older
47. vacation supplies of medication for foreign travel (allow 7 days for processing)

48. vitamin D analogs, topical (Calcipotriene, Calcitrene, Dovonex®, Enstilar®, Sorilux®, Taclonex®, Vectical®)
49. vorapaxar (Zontivity®)

*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 in writing. 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:

1. Angiotensin II Receptor Antagonists (Benicar, Benicar HCT, Tekturna, Tekturna HCT, Edarbi, Edarbyclor)
2. Anti-depressants (Pristiq®, Aplenzin®, Khedezla®, Fetzima™, Irenka)
3. Antifungal, topical (Ecoza™, Ertaczo®, Exelderm®, Loprox®, Lotrisone®, Luzu™, Mentax®, Naftin®, Oxistat®, Vusion®, Xolegel®)
4. Benign Prostatic Hypertrophy (Cardura/XL®, Rapaflo®)
5. Bisphosphonates (Fosamax Plus D™, Binosto®)
6. Cholesterol-lowering medications (Altoprev®, Crestor®, Vytorin®, Livalo™, Liptruzet™)
7. crisaborole (Eucrisa®)
8. Dermatologicals (doxepin Cr, Prudoxin®, Zonalon®)
9. Insulins (Apidra, Humalog, Humalog Mix, Humulin 70/30, Humulin N, Humulin R, Novolin R Relion, Novolin N Relion, Novolin 70/30 Relion)
10. Febuxostat (Uloric®)
11. Fenofibrates (Triglide®, Fenoglide®)
12. Lyrica®, Gralise®, Horizant®
13. Migraines (Sumavel Dosepro™, Alsuma, Treximet®, Onzetra Xsail, Zembrace)
14. Nasal Steroids (Beconase AQ®, Veramyst®, Omnaris®, Dymista®, Qnasl®, Zetonna®)
15. Non-Steroidal Anti-inflammatory Drugs (brand-name NSAID e.g., Cambia®, Duexis, fenoprofen 200mg, Fenortho 200 mg, Flector®, Pennsaid®, Nalfon, Tivorbex, Vivlodex, Zipsor, Zorvolex)
16. Ophthalmic prostaglandins (Lumigan®, Travatan/Z®, Zioptan®)
17. Opioid pain medications
18. Overactive Bladder: (Oxytrol, Toviaz®, Vesicare®, Enablex®, Gelnique®, Myrbetriq®)
19. Proton Pump Inhibitors (e.g., Dexilant®, Prilosec/Protonix/Zegerid Powder packets, compounding kits for PPI suspension formulations)
20. Sedative Hypnotics (Belsomra, Rozerem™, Edluar™, Zolpimist™, Silenor®)
21. Selective Serotonin Reuptake Inhibitors (e.g., Pexeva, Viibyrd®, Trintellix)
22. Tetracyclines (e.g., Adoxa®, Doryx®, Oracea®, Solodyn®, Oraxyl®, Vibramycin®)
23. Topical Acne products, kits and cleansers (e.g., Acanya, Aczone, Akne-Mycin, Azelex, Clindagel, Fabior, Panoxyl, Riaz, Tretin-X)
24. Topical immunomodulators (Elidel®, Protopic®)

This list is subject to change during the plan year, if circumstances arise which require adjustment. Changes will be communicated to members in writing. 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 (QL)

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. 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. Acetaminophen and Aspirin containing pain reliever medications are limited to quantities not to exceed 4 grams of acetaminophen or aspirin per day.
2. Amphetamines, methylphenidate and stimulant products to treat ADHD or narcolepsy are subject to limits on quantity within FDA approved doses.
3. Antipsychotic Drugs (Abilify® 30 units, Abilify Discmelt® 60 units, Fanapt™ 60 units, Geodon® 60 units, Invega® varies, Risperdal® 60 units, Saphris® 60 units, Seroquel/XR® varies, Zyprexa® 30 units, and Zyprexa Zydis® 30 units, Latuda® 30 units)
4. Antiemetics:
   - Aloxi® is limited to 2 vials per 21 days.
   - Anzemet® is limited to 6 tablets per 21 days.
   - Anzemet 100/5 & 12.5/0.625 injection is limited to 15ml per 180 days.
   - Akynzeo is limited to 2 capsules per 21 days.
   - Cesamet® is limited to 18 capsules per 30 days.
   - Emend® 40 mg is limited to 3 capsules per 6 months.
   - Emend® 80 mg is limited to 4 capsules per 21 days.
   - Emend® 150 mg vial is limited to 2 vials per 21 days.
   - Emend® 125 mg is limited to 2 capsules per 21 days.
   - Emend® Tri-fold Pack is limited to 2 packages per 21 days.
   - Kytril® is limited to 12 tablets per 21 days.
   - Kytril® 0.1mg/ml is limited to 2ml per 21 days.
   - Kytril® 1mg/ml is limited to 2ml per 21 days.
   - Kytril® 4mg/4ml (1mg/ml) injection is limited to 2ml per 21 days.
   - Marinol is limited to 60 capsules per 25 days.
   - Netupitant-Palonosetron is limited to 2 capsules per 21 days.
   - Sancuso® is limited to 2 patches per 21 days.
   - Varubi is limited to 4 tablets per 21 days.
   - Zofran® 24 mg is limited to 2 tablets per 21 days.
   - Zofran® 4mg and 8mg are limited to 18 tablets per 21 days.
   - Zofran® ODT 4mg and 8mg are limited to 18 tablets per 21 days.
   - Zofran® Solution is limited to 200ml per 21 days.
   - Zofran® 2mg/ml injection is limited to 20ml per 21 days.
   - Zofran® 40mg/20mg (2mg/ml) is limited to 20ml per 21 days.
   - Zuplenz® is limited to 18 films per 21 days.
5. Abstral®, Actiq®, Fentora®, Onsolis, Subsys® Coverage is limited to 120 units per 30 days; Lazanda®: Coverage is limited to 30 bottles per 30 days.

6. Benzodiazepines (excluding insomnia) (alprazolam, Ativan®, chlordiazepoxide, clonazepam, diazepam, Klonopin®, lorazepam, Niravam®, oxazepam, Tranxene®, Valium®, Xanax®, Xanax® XR)
7. Buprenorphine/naltrexone containing products (Bunavail™, Suboxone®, Subutex®, and Zubsolv®) is limited to 24mg in initial 60-day period then 16mg.
8. Cholesterol Lowering Medications. (Advicor® varies, Caduet® 30 units, Vytorin® 30 units, Altoprev® 30 units, Crestor® 30 units, Lescol® varies, Lipitor® 30 units, lovastatin varies, Mevacor® 30 units, Pravachol® 30 units, pravastatin sodium 30 units, Simcor® 30 units, simvastatin 30 units, Zocor® 30 units and Livalo® 30 units)
9. Diabetic test strips (204/month)
10. Enbrel®: Coverage is limited to 4 syringes or 8 vials per 28 days.
11. Estrogen patches: Alora®, Estraderm®, Minivelle®, Vivelle/Dot® limit is 8 patches/28 days. Climara/Pro and Menostar® limit is 4 patches per 28 days.
12. Gabepentin (Neurontin). Coverage is limited to 3,600mg per day.
13. Humira®: Coverage is limited to 2 syringes/pens per 28 days.
14. Lidocaine/Lidocaine topical products is limited to one tube/pack every 25 days.
15. Migraine medications. Coverage is limited to quantities listed below:

Generic name	Brand name	Quantity Level Limit for 30-day Period
Almotriptan tablets 6.25 mg	Axert®	12 tablets
Almotriptan tablets 12.5 mg	Axert®	12 tablets
Diclofenac potassium, 50 mg powder packet	Cambia	9 packets
Dihydroergotamine nasal spray vials, 4mg/mL vial	Migranal®	1 kit=8-unit dose sprayers
Eletriptan 20mg, 40mg	Relpax®	12 tablets
Frovatriptan tablets 2.5mg	Frova®	18 tablets
Naratriptan tablets 1mg, 2.5mg	Amerge®	12 tablets
Rizatriptan tablets 5mg, 10mg	Maxalt®	18 tablets
Rizatriptan tablets 5mg, 10mg, orally disintegrating tablets	Maxalt-MLT®	18 tablets
Sumatriptan injection pre-filled auto-injectors, 6mg/0.5ml	Alsuma®	6 kits (12 syringes)
Sumatriptan auto-injectors 3mg/0.5ml	Zembrace Symtouch	24 injectors (12ml)
Sumatriptan injection syringes, 6mg/0.5ml	Imitrex® Statdose System	6 kits=12 injections
Sumatriptan injection vials, 4mg/0.5 ml	Generics	18 vials
Sumatriptan injection vials, 6mg/0.5 ml	Imitrex®, generics	12 vials
Sumatriptan nasal spray 20 mg	Imitrex®, generics	2 boxes=12-unit dose spray devices
Sumatriptan nasal spray 5mg	Imitrex®, generics	4 boxes= 24-unit dose spray devices
Sumatriptan nasal spray 11mg	Onzetra Xsail	1kit=8 pouches
Sumatriptan needle-free injection vial 4mg/0.5ml	Sumavel™ DosePro™	3boxes=18 needle-free devices
Sumatriptan tablets 25mg, 50mg, 100mg	Imitrex®, generics	12 tablets
Sumatriptan (85mg) naproxen sodium (500mg) tablets	Treximet™	9 tablets

Sumatriptan (10mg) and naproxen sodium (60mg) tablets	Treximet™	9 tablets
Zolmitriptan nasal spray 5mg	Zomig®	2 boxes=12-unit dose spray devices
Zolmitriptan tablets 2.5 mg, 5mg, orally disintegrating	Zomig-ZMT®	12 tablets
Zolmitriptan tablets 2.5 mg, 5mg	Zomig®	12 tablets

16. Multiple Sclerosis: Avonex® 4 units per 30 days, Betaseron®/Extavia 14 or 15 units per 30 days, Copaxone® 1 kit per 30 days, Rebif® 1 pkg/12 syringes per 30 days.
17. Nuvigil®: Coverage limit varies.
18. Opioid pain medications have a quantity limit (QL) for all medications in the opioid class. Additional quantities require Prior Authorization. Long-acting Opioids and immediate-acting Opioids – quantities vary based on strength of medications. Medications in this class include, hydrocodone products, Avinza, Nucynta, Nucynta ER, Xartemis XR, Kadian, Embeda, morphine products, Oxycontin, Hysingla ER, Zohydro ER, Opana, Opana ER, methadone, codeine products, hydromorphone products, oxycodone products, Meperidine products, Exalgo, Vicoprofen, Talwin NX, Tramadol and Tramadol-containing products, Soma and Soma-containing products. Initial prescription is limited to a 7-day supply only.
19. Other Antidepressants (Budeprion SR® 60 units, Budeprion XL ® 30 units, Bupropion HCL SR® 60 units, Forfivo® XL 30 units, Wellbutrin SR® 60 units, and Wellbutrin XL® 30 units, Aplenzin® 30 units).
20. Provigil®: Coverage limit varies.
21. Respiratory/Asthma inhalers, nasal steroid inhalers, and COPD inhalers are limited to quantity in accordance with FDA-approved dosing.
22. Sedative Hypnotics (Ambien®, Ambien CR™, Doral®, estazolam, flurazepam, Intermezzo®, Lunesta™, Restoril®, Rozerem™, Sonata®, Edluar™, Silenor®, temazepam, triazolam). Coverage is limited to 15 units per 30 days. Zolpimist™, coverage is limited to 1 bottle.
23. Selective Serotonin Reuptake Inhibitors (Celexa® 30 units, citalopram HBR 30 units, fluoxetine HCL varies, fluvoxamine maleate varies, Lexapro® 30 units, Luvox CR® varies, paroxetine HCL® varies, Paxil® varies, Paxil CR® 60 units, Pexeva® varies, Prozac Weekly® 5 units, Sarafem® 30 units, Selfemra™ varies, sertraline HCL® varies, Viibyrd® 30 units, and Zoloft® varies).
24. Serotonin and Norepinephrine Reuptake Inhibitors (Cymbalta® varies, Effexor® varies, Effexor XR® varies, Pristiq® 30 units, Savella® varies, venlafaxine ER® varies, Viibryd® 1 pack).
25. Sprix: Coverage is limited to 5 days of therapy per prescription.
26. Tamiflu® and Relenza®: Coverage is limited to one course of treatment every 90 days. Additional quantities require prior authorization from RDT.
27. Topical steroids (120gm or ml/month)
28. Toradol: Coverage is limited to 20 tables per prescription.

Maintenance Medications

All Maintenance Medications must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through CVS Caremark mail service. You must receive a 90-day supply of the medications and classes listed below. Maintenance medications dispensed in quantities less than 90 days are not covered by the plan. If you are starting on a new maintenance medication, you may receive up to two 30-day fills to be sure you tolerate the medication and that your dosage is correct. After the second 30-day fill, the maintenance medication will be covered only in a 90-day supply, and only when filled at a Retail Maintenance Network pharmacy or using the CVS Caremark Mail Service Pharmacy Program.

1. Allergies
2. Alzheimer's Disease
3. Antipsychotics
4. Blood Modifiers/Thinners
5. Cancer (non-specialty)
6. Contraceptives/Hormone Replacement
7. Depression
8. Diabetes
9. Accu-Chek test strips/lancets
10. Digestive Enzymes
11. Diuretics
12. Enlarged Prostate
13. Gastrointestinal agents
14. Glaucoma
15. Gout
16. High Blood Pressure & Heart Disease
17. High Cholesterol
18. Immune Disorders (non-specialty)
19. Inflammatory Bowel Disease (non-specialty)
20. Irritable Bowel Disease
21. Kidney Disease
22. Osteoporosis
23. Overactive Bladder
24. Parkinson's Disease
25. Respiratory Agents
26. Rheumatoid Arthritis
27. Seizure Disorders
28. Thyroid
29. Ulcer/GERD

Specialty Drug Program

PEIA's Specialty Drug Program has two components:

1. Specialty Injectable Drugs are administered by injection or infusion, and are managed by UMR through the medical benefit.
2. Common Specialty Medications are self-administered, and are managed by CVS Specialty Pharmacy

Specialty Injectable Drugs are prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring. The PEIA PPB Plans cover specialty injectable drugs through a program managed by UMR. The program provides comprehensive direction to policyholders and their dependents for treatments utilizing specialty drugs. If your physician prescribes a specialty drug, that physician, you, or the pharmacist must call UMR at 1-888-440-7342. The Specialty Injectable Drug list is located at https://hs.umr.com/print/UM1428.pdf. To obtain a paper copy, call 1-888-680-7342. UMR will review the drug for medical necessity If denied, UMR will contact your physician for additional information which may allow approval of the requested medication.

Common Specialty Medications are self-administered specialty injectable drugs through the CVS Specialty Pharmacy. Through the CVS Specialty Pharmacy, you will be assigned a dedicated CareTeam with specialists in your condition. These specialists will check in to see what you need and how they can help moving forward. They'll also make arrangements for injection training, as needed. If your physician prescribes a common specialty drug, they can call 1-800-237-2767, fax 1-800-323-2445, or e-prescribe the specialty drug to the CVS Specialty Pharmacy. CVS Specialty will then work with your doctor to obtain prior authorization for the specialty medication. Once approved, you can have your specialty medications delivered directly to you.

Many specialty medications have manufacturer programs which will financially assist patients in the purchase of the medication. PEIA requires that if a financial assistance program is available, you must participate in the program. Only your actual out-of-pocket payments will count toward your drug deductible and annual out-of-pocket maximum; not amounts discounted off the price by the manufacturer or seller of the specialty medication.

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

After you have met your prescription drug deductible, the copayment on these medications will generally be $100 for any Common Specialty Medications on the WV Preferred Drug List and $150 for any Common Specialty Medications not on the WV Preferred Drug List; however, certain specialty medications are subject to variable copayments, depending on the availability of programs. Only your actual out-of-pocket payments will count toward your drug deductible and annual out-of-pocket maximum, not amounts discounted off the price by the manufacturer or seller of the specialty medications. Contact CVS Caremark to verify copayments. These drugs are not available in 90-day supplies. If you are prescribed one of these common specialty medications, call CVS Caremark at 1-844-260-5894.

Common Specialty Medications

Drug Name	Category	Drug Name	Category
Acthar® HP [QLL]	Multiple Sclerosis	Nexavar [QLL]	Anti-Neoplastic, Immunosuppressant
Actimmune	Anti-Neoplastic	Norditropin®	Growth Hormone
Adcirca® [QLL]	Pulmonary Hypertension	Nutropin®	Growth Hormone
Afinitor [QLL]	Anti-Neoplastic	Octreotide Acetate	Endocrine disorders
Ampyra [QLL]	Multiple Sclerosis	Pegasys®	Hepatitis C
Aranesp®	Anemia	Peg-Intron® [QLL]	Hepatitis C
Avonex [QLL]	Multiple Sclerosis	Procrit®	Anemia
Betaseron® [QLL]	Multiple Sclerosis	Pulmozyme® [QLL]	Cystic Fibrosis
Boniva®	Osteoporosis	Rebif® [QLL]	Multiple Sclerosis
Cerezyme® [QLL]	Gaucher Disease	Revatio® [QLL]	Pulmonary Arterial Hypertension
Copaxone® [QLL]	Multiple Sclerosis	Revlimid® [QLL]	Anti-Neoplastic, Immunosuppressant
Eligard	Anti-Neoplastic	Riba pak	Hepatitis
Enbrel® [QLL]	Inflammatory Conditions	Ribavirin®	Hepatitis C
Epclusa* [QLL]	Hepatitis C	Sandostatin LAR [QLL]	Endocrine disorders
Epogen®	Anemia	Simponi® [QLL]	Rheumatoid Arthritis
Forteo® [QLL]	Osteoporosis	Sprycel [QLL]	Anti-Neoplastic
Genotropin	Growth Hormone	Sutent® [QLL]	Anti-Neoplastic
Gilenya® [QLL]	Multiple Sclerosis	Tarceva® [QLL]	Anti-Neoplastic
Gleevec® [QLL]	Anti-Neoplastic	Tasigna [QLL]	Anti-Neoplastic
Harvoni* [QLL]	Hepatitis C	Temodar®	Anti-Neoplastic
Humatrope®	Growth Hormone	Tev-Tropin®	Growth Hormone
Humira® [QLL]	Inflammatory Conditions	Thalomid® [QLL]	Anti-Neoplastic
Incivek	Hepatitis	Thyrogen® Kit	Diagnostic
Inlyta® [QLL]	Cancer	Tobi® [QLL]	Cystic Fibrosis
Intron A®	Interferons	Tracleer® [QLL]	Pulmonary Arterial Hypertension
Jakafi® [QLL]	Cancer	Tykerb [QLL]	Anti-Neoplastic
Kalydeco® [QLL]	Respiratory conditions	Tyvaso® [QLL]	Pulmonary Arterial Hypertension
Kineret® [QLL]	Inflammatory Conditions	Victrelis [QLL]	Hepatitis
Kuvan	Enzyme deficiencies	Votrient [QLL]	Anti-Neoplastic
Letairis® [QLL]	Pulmonary Arterial Hypertension	Xalkori® [QLL]	Cancer
Leukine	Hematopoietic	Xeloda® [QLL]	Anti-Neoplastic
Lupron Depot®	Endometriosis, Anti-Neoplastic, Precocious Puberty	Xenazine® [QLL]	CNS Disorders
Lupron Depot®-Ped	Precocious Puberty	Zarxio	Neutropenia
Lupron®	Anti-Neoplastic	Zoladex®	Anti-Neoplastic
Neulasta® [QLL]	Neutropenia	Zolinza [QLL]	Anti-Neoplastic
Neupogen®	Neutropenia	Zytiga® [QLL]	Anti-Neoplastic

All Common Specialty Medications require Precertification from CVS Caremark.

[QLL] This drug is subject to Quantity Level Limits (QLL). This list is not all-inclusive and is subject to change throughout the Plan Year.

*Coverage of this drug is limited to a once-in-a lifetime course of treatment.

Diabetes Management

PEIA covers diabetes management items under its Maintenance Medication benefit, which means that needles, syringes, lancets and test strips must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through CVS mail service. For patients just starting use of needles, syringes, lancets or test strips, PEIA will permit two 30-day fills of the new prescription at a network pharmacy, but after that, all items must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through CVS mail service.

Blood Glucose Monitors: Covered diabetic insureds can receive a free Accu-Chek Aviva Plus, Accu-Chek Nano, or Accu-Chek Guide blood glucose monitor with a current prescription. All major chain pharmacies and some doctor's offices have vouchers for the Accu-Chek meters. Take your prescription to them or call the CVS Caremark Diabetic Meter Program at 1-800-588-4456 to request a meter.

Glucose Test Strips: The plan covers only Accu-Chek Aviva Plus test strips, Accu-Chek Nano test strips, and Accu-Chek Guide test strips at the preferred copayment of $50 per 90-day supply for PPB Plans A and D, and $60 per 90-day supply for PPB Plan B. Other brands require a 100% copayment.

Needles/Syringes and Lancets: The plan covers only BD needles and syringes. You can obtain a supply of disposable needles/syringes and lancets for the copayments listed below.

Diabetes Management Copayments				
	PEIA PPB Plan A or D		PEIA PPB Plan B	
	Up to 30-day supply	90-day supply*	Up to 30-day supply	90-day supply*
Accu-Chek test strips, as noted above	Not Covered	$50	Not Covered	$60
BD needles/syringes	Not Covered	$20	Not Covered	$20
Lancets	Not Covered	$20	Not Covered	$20

*You must purchase all Diabetes Management items in 90-day supplies through a Retail Maintenance Network pharmacy or through Mail Service.

Tobacco Cessation Program

PEIA has a tobacco cessation program that includes coverage for both prescription and over-the-counter (OTC) tobacco cessation products. For a full description of the benefits, please see "Tobacco Cessation" on page 69. The drugs are covered under your prescription drug program.

What is Covered?

PEIA will cover prescription and over-the counter (OTC) tobacco cessation products if they are dispensed with a prescription. Toll-free numbers are provided by the manufacturers of most of these products for phone coaching and support.

Coverage is limited to two twelve-week cycles per rolling twelve-month period. Tobacco-cessation products are available at no cost to the member; both the deductible and the copayment are waived when prescribed by a physician and purchased at a network pharmacy.

Who is Eligible for Tobacco Cessation?

Only those members who have been paying the Standard (tobacco-user) premium are eligible for this benefit. If you have signed an affidavit claiming to be tobacco-free, and then you attempt to use the tobacco cessation benefit, you will be declined services. 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. Abortifacient (i.e., Mifeprex)
2. Anorexiants (any drug used for the purpose of weight loss)
3. Anti-wrinkle agents (e.g. Renova®)
4. Arestin
5. Bleaching agents (e.g., Eldopaque®, Eldoquin Forte®, Melanex®, Nuquin®, Solaquin®)
6. Bulk ingredients (i.e. bulk chemicals, bulk powders, bulk compounding ingredients, hormone replacement bulk ingredients, high cost bases, compound kits, etc.)
7. Charges for the administration or injection of any drug
8. Compounds containing one or more ingredients which are commercially available in alternate medications, are an over-the counter (OTC) product or lack clinical evidence in compounded dosage forms. This list is subject to change throughout the Plan Year.
9. Contraceptive devices and implants
10. Diagnostic agents
11. Drugs dispensed by a hospital, clinic or physician's office
12. Drugs excluded from the formulary by CVS Caremark. You can find a list of these medications at https://pcia.wv.gov/prescription_drug_lists/Documents/Formulary_Exclusions.pdf
13. 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.
14. Drugs requiring prior authorization when prescribed for uses and quantities not approved by the FDA
15. Drugs requiring a prescription by State law, but not by federal law (State controlled) are not covered
16. Erectile dysfunction medications
17. Fertility drugs
18. Fioricet® with Codeine (butalbital/acetaminophen caffeine with codeine)
19. Fiorinal® with Codeine (butalbital/aspirin caffeine with codeine)
20. Hair growth stimulants
21. Homeopathic medications
22. Hypoactive Sexual Desire Disorder (HSDD) Agents
23. Immunizations, biological sera, blood or blood products, Hyalgan®, Synvisc®, Remicade®, Synagis®, Xolair®, Amevive®, Raptiva®, Vivitrol®, (these are covered under the medical plan)
24. Latisse™
25. Medical or therapeutic foods
26. 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
27. Medications 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.
28. Newly released prescription medications that have been on the market less than 12 months
29. Non-legend drugs
30. Nutritional Supplements (that require a prescription, i.e., Metanx, Limbrel, Deplen)
31. Omnipod V-go®, Finesse® or other disposable insulin delivery systems
32. Pentazocine/Acetaminophen (Talacen®)

33. 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.
34. Replacement medications for lost, damaged or stolen drugs
35. Requests for less than a 90-day supply of maintenance medications, or requests for more than a 30-day supply of short-term medications.
36. Respiratory Therapy Supplies: Nebulizers
37. Respiratory Therapy Supplies: Peak Flow Meters
38. Stadol® Nasal Spray (butorphanol)
39. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those listed above.
40. Unit dose medications
41. Vacation supplies, unless leaving the country. If you are leaving the country, and want PEIA to cover a vacation supply, you must submit documentation (copy of an airline ticket, travel agency itinerary, etc.) to substantiate your international travel arrangements. Please allow seven (7) days for processing.

Other Important Features of Your Prescription Drug Program

Your prescription drug program is designed to provide the care and services 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.

CVS Caremark 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 CVS Caremark's 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. CVS Caremark's 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 CVS Caremark 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 CVS Caremark mails. Your retail pharmacy may also provide you with drug information. By visiting www.caremark.com, you also can access other health-related information. Click on Health Resources 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.caremark.com. Any written health information cannot replace the expertise and advice of health care practitioners who have direct contact with a patient. All CVS Caremark 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, CVS Caremark may provide information to you on one or more of CVS Caremark's 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 a CVS Caremark pharmacist or nurse. CVS Caremark 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 CVS Caremark to have the secondary claim processed:
   - a completed CVS Caremark claim form;
   - the receipt from the pharmacy; and
   - 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 30 days from receipt of your claim form.

If you need claim forms, call CVS Caremark's Member services at 1-866-260-5894 or visit their website at www.caremark.com.

2. Medicare Part B: 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. UMR 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 1-888-680-7362. These classes of drugs are usually covered by Medicare Part B:
   a) Immunosuppressants
   b) Oral Chemotherapeutic medications
   c) Drugs for nausea associated with chemo meds
   d) Diabetic testing supplies
   e) Limited Inhalation therapies

How to File a Claim

Filing a Prescription Drug Claim

Prescription drug claims are processed by CVS Caremark and should be submitted to:

CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-2084

To process a prescription drug claim, CVS Caremark requires a prescription receipt/label which includes:

- Pharmacy Name/Address
- Date Filled
- Drug Name, Strength and NDC
- Rx Number
- Quantity
- Days' Supply
- Price
- Patient's Name

Claims received missing any of the above information may be returned or payment may be denied or delayed.

Cash register receipts and canceled checks are not acceptable proof of your claim.

If you have other insurance which is primary, you need to submit an Explanation of Benefits (EOB) from the other insurance which shows the amount the primary insurance paid 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 prescription claim. If PEIA is your secondary insurer, 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.

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 receive from PEIA. See "Subrogation" on page 104 for details.

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 must use your I.D. card at a participating pharmacy to receive prescription benefits.

Claims Incurred Outside of the U.S.A.

If you or a covered dependent incur prescription drug expenses while outside the United States, you will 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 CVS Caremark.

CVS Caremark will determine, through a local banking institution, the currency exchange rate and you will be reimbursed according to the terms of PEIA PPB Plans A, B & D.

Appealing a Drug 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 CVS Caremark 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 CVS Caremark 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 (for Physician's offices or pharmacists ONLY)	RDT 1-800-847-2859	Rational Drug Therapy Program WVU School of Pharmacy P.O. Box 9511 HSCN Morgantown, WV 26506
Prescription drug claim payment error or denial	CVS Caremark 1-844-260-5894	CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-2084
Appealing a Specialty Drug Claim	CVS Caremark Call: 1-844-260-5894 Fax: 1-855-230-5548	CVS Caremark Specialty Appeals Department 800 Biermann Court Mount Prospect, IL 60056

CVS Caremark or RDT will respond in writing to you and/or 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 CVS Caremark or RDT.

Mail third step appeals to:

Director, Public Employees Insurance Agency, 601 57th St. SE, Charleston, WV 25304-2345.

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, considering 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 CVS Caremark at 1-844-260-5894.

External Review: If we have denied your request for the provision of or payment for a health care service or course of treatment, our decision may be reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. An external review may be initiated by us or requested by you. You may submit a request for external review within 4 months after receipt of the notice of denial to the PEIA Clinical Unit, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345. For standard external review by your request, a decision will be made within 45 days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may request an expedited external review of our denial. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may request an external review of our denial. External review is the final level of appeal, regardless of whether the external review was initiated by us or requested by you. External review is not available for drugs, services or items which are simply not covered by the Plan. External review is also not available for out-of-state benefit level appeals or for a change in drug cost-sharing tier.

How to Reach CVS Caremark

On the Internet: Reach CVS Caremark at www.caremark.com. Visit CVS Caremark's 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 CVS Caremark via the Internet, you can learn more about your program by calling CVS Caremark Customer Care at 1-844-260-5894, 24 hours a day, 7 days a week.

Special Services: CVS Caremark continually strives to meet the special needs of PEIA's insureds: You may call a registered pharmacist at any time for consultations at 1-844-260-5894.

PEIA's hearing-impaired insureds may use CVS Caremark's TDD number at 1-800-863-5488.

Visually impaired insureds may request that their mail service prescriptions include labels in Braille by calling 1-844-260-5894.

Controlling Costs

Prohibition of Balance Billing

All PEIA health plans are 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 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 UMR for details.

Preferred Provider Organizations

For services provided outside the State of West Virginia, UMR utilizes several networks. 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 UMR uses, see "PEIA's Networks" on page 39.

After you receive medical attention, your claim will be routed to UMR Benefit Solutions. 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). UMR Benefit Solutions will send you an Explanation of Benefits (EOB).

Out-of-State Provider Waiver (PEIA PPB Plans A & B ONLY)

To assist participants in PEIA PPB Plans A & B who receive medical treatment outside of West Virginia from providers who do not participate in the UnitedHealthCare Choice Plus PPO, 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 OOSINNA 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:
    a) an emergency arises; or
    b) the insured lives or is traveling out-of-state;
    c) the medically necessary service is not available in West Virginia (or within a reasonable travel time); or
    d) 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 OOSINNA 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, 601 57th St. SE, Charleston, WV 25304-2345.

You may obtain a PEIA Out-of-State Waiver Form from our website at www.wvpeia.com or 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.

The Out-of-State Waiver program is NOT available for members of PEIA PPB Plans C or D. The program is also not available for air ambulance fees.

PPB Plan C is an IRS-qualified, High-Deductible Health Plan (HDHP). For more information about Plan C, download the Summary Plan Description (Plan C) at www.wvpeia.com or call 1-888-680-7342.

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:

1. charges for services not received; and
2. overcharges or overpayments resulting from clerical error or miscalculation.
3. Any claim for a condition not present on admission, such as a hospital acquired infection or fall.

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 UMR or CVS Caremark 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

Healthcare Fraud and Abuse

By law, PEIA must report suspected fraud to the WV Insurance Commission. In addition, PEIA works with the US Attorney's office in the investigation of potential fraud and/or abuse.

Examples of Provider Fraud:

- waiving member copays;
- balance billing members for services;
- billing for services not provided;
- billing for a non-covered service as a covered service (e.g. billing a "tummy tuck" (non-covered) as a hernia repair (covered);
- billing that appears to be a deliberate claim for duplicate payments for the same services;
- misrepresenting dates, services or identities of members or providers;
- intentional incorrect reporting of diagnoses or procedures to maximize payment (up-coding);
- billing for separate parts of a procedure rather than the whole (unbundling);
- accepting or giving kickbacks for member referrals;
- prescribing additional and unnecessary treatments (over-utilization).

Examples of Member Fraud:

- providing false information when applying for PEIA coverage;
- forging or selling prescription drugs;
- "loaning" or using another's insurance card.

How to Report Healthcare Fraud and Abuse

If you suspect healthcare fraud, please call the PEIA toll-free number (1-888-680-7342) and ask to speak with a member of the Special Investigations Team or complete the Health Care Fraud and Abuse Form on PEIA's website. You will be asked to provide as much information as possible. PEIA will investigate your concern(s) and, if appropriate, refer the information to the appropriate legal authorities.

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.

UMR, 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, 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:
    a) the policy covers a specified disease, accident only, disability, or other limited benefits;
    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.

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 an active employee's dependent who has coverage as a retired employee from his or her former employer and is also covered by Medicare, benefits are determined in this order:
    1) the plan which covers the individual as a dependent of an active employee will pay first;
    2) Medicare will pay next;
    3) the plan which covers the person as a retired employee will pay last.

D. 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.

E. 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.

F. 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 "D" Above will apply;

G. 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 "D" above will apply;

H. for a dependent child who has coverage under either or both parents' plans and also has coverage as a dependent under a spouse's plan, the Plan which has covered the dependent the longest will be primary;

I. in the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under the parent's plans, the order of benefits shall be determined by applying the birthday rule to the dependent child's parent and the dependent's spouse;

J. 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;

K. 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 the person's dependent) will be primary;

   2) the benefits under the continuation coverage will be secondary;

L. 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.

"Carve-out" 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 mental health benefits with the same cost-sharing as other medical benefits with no limit when services are pre-certified.
- **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, if the services are covered by PEIA.

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

For most retirees and their Medicare-eligible dependents covered by PEIA and Medicare, regardless of age (see exception below), PEIA's Medicare Advantage plan is the primary insurer.

When you become an eligible beneficiary of Medicare, you must enroll in Medicare Parts A and B and send a copy of your Medicare card to PEIA. 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 requires payment of a monthly premium. You MUST NOT enroll in a separate Medicare Part D plan, since PEIA will provide prescription drug coverage for retirees with Medicare.

If you do not enroll in Medicare Parts A & B, your coverage may be terminated.

If you or your dependents have other coverage in addition to PEIA and Medicare, contact UMR 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 UMR or PEIA to determine who the primary insurer will be.

Whenever you or your covered dependents become eligible for Medicare, you should send a copy of your Medicare card to PEIA.

Members enrolled in an HMO when they become Medicare-eligible will be transferred to the Special Medicare Plan.

Special Medicare Plan

PEIA created the Special Medicare plan to accommodate the needs of two specific groups of Medicare-eligible members:

1. Members who are unable to access medical care through the PEIA's Medicare Advantage Plan due to provider limitations are permitted, on a case-by-case basis, to move into PEIA's Special Medicare Plan.
2. Employees who retire after the beginning of a plan year, and retired employees who become eligible for Medicare during the Plan year. Retired members who are enrolled in an HMO when they become Medicare-eligible will be transferred to PEIA's Special Medicare Plan. These members in the Special Medicare Plan will be moved to PEIA's Medicare Advantage Plan at the beginning of the next plan year (the following January).

Most members are enrolled in the Special Medicare Plan for less than a year. Those who become eligible for Medicare in the middle of a plan year, move into the Special Medicare Plan, and are transferred to the PEIA Medicare Advantage Plan at the beginning of the next Medicare plan year.

Under the Special Medicare plan, the member purchases traditional Medicare Parts A and B, and their secondary medical and prescription claims are paid by UMR and CVS Caremark, respectively. Medical and Prescription Drug benefits under the Special Medicare Plan are generally the same as those provided under the PEIA's Medicare Advantage plan.

The Medicare retiree's plan year is from January 1 to December 31 of each year. Below are the benefits for Plan Year 2019:

Service Description	Medicare Retiree Benefit Plan Year 2018 January – December 2018
Annual Deductible	$150
Primary Care Office Visit	$20
Specialty Office Visit	$40
Emergency Room	$50
Hospital Inpatient care	$100 per admission
Outpatient and Office Surgery	$100
Other services (testing, etc.)	$0
Medical Out-of-Pocket Maximum	$1,200
Prescription Drug Deductible	$75
Generic Drugs Copayment	$5
Preferred Drug Copayment	$15
Non-preferred Drug Copayment	50% coinsurance
Specialty Drug Copayment	$100 preferred/$150 non-preferred
Prescription Drug Out-of-Pocket Maximum	$1,750

The benefits described in the "What is Covered" section beginning on page 54 will be provided to members of the Special Medicare plan with no deductible and no coinsurance, but with the copayments and out-of-pocket maximum detailed in the chart above.

There are two main differences between the Special Medicare Plan and the Humana Medicare Advantage and Prescription Drug (MAPD) plan.

1. The non-preferred drug costs - in the Special Medicare Plan, the non-preferred drug cost-sharing is 75% coinsurance; in the MAPD plan, the non-preferred drug coinsurance is 50%.
2. The MAPD plan offers a free gym membership through a program called SilverSneakers. SilverSneakers is not available in the Special Medicare Plan.

Those who become eligible for the Special Medicare plan during a plan year have the right to request immediate enrollment in the Humana plan. Call PEIA for details.

If you have questions about the benefits of the Special Medicare plan, please contact PEIA's customer service unit at 1-888-680-7342.

Medicare for Active Employees

For PEIA PPB Plan active employees and their dependents that 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 and your Medicare-eligible dependents do not need to sign up for Medicare Part B and pay the premium. When you prepare to retire, you and any Medicare-eligible dependents must enroll for Medicare Part B. If you do not enroll in Medicare Parts A & B, your coverage may be terminated.

You DO NOT need to enroll in Medicare Part D as an active employee or upon retirement.

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, you must 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.

Benefit Assistance Program

Medicare-eligible retired employees with 15 or more years of service whose annual household income falls below 250% of the federal poverty level, and who are members of the PEIA PPB Plan can qualify for benefit assistance. 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. The details of the Benefit Assistance Program are described in the Evidence of Coverage produced by Coventry. Since Benefit Assistance is not available to non-Medicare retirees, there is no further discussion of it here. If you are interested in the details of the program, you can find more information online at www.wvpeia.com. If you qualify, contact PEIA for an application, or you can print a copy at www.wvpeia.com.

Medicare Part D

Medicare offers prescription drug coverage through Medicare Part D. **Please be aware that you DO NOT have to purchase Medicare Part D coverage.**

PEIA's Medicare Advantage Plan: Humana provides prescription drug coverage for retirees in the Medicare Advantage Plan through a Medicare Part D plan.

Special Medicare Plan: PEIA continues to provide creditable prescription drug coverage to our members in the Special Medicare Plan, and Medicare Part D will be of little or no use to you. If you enroll in a Medicare Part D plan, PEIA will reject your prescription at the pharmacy, and require the pharmacy to bill the Medicare Prescription Drug Plan first.

For those "dual eligible" that have both Medicare and Medicaid, you will be automatically enrolled in a Medicare Part D plan. Using the Medicare Part D plan will be to your benefit, since it is a better benefit to the "dual eligible" member.

Medicare Part D Creditable Coverage Notice

The coverage you have now through West Virginia PEIA is considered by Medicare to be creditable coverage, or coverage as good as or better than that offered under Medicare's standard Part D benefit. If you are eligible for Medicare and decide to opt out of this plan's coverage, you should consider joining another plan as soon as possible to avoid having to pay a late enrollment penalty. If you choose to leave this plan and do not join another plan within 63 days of the termination date of this coverage, you will be charged a late enrollment penalty of at least 1% per month you went without coverage as good as or better than that offered under Medicare Part D.

When can you change to a different plan?

Generally, Medicare-eligible members can change plans during the yearly enrollment period (called the "annual coordinated election period"). Generally, this is the only time of year to choose a different Medicare plan. Certain individuals, such as those with Medicaid, those who get "Extra Help" paying for their drugs, or those who move out of the geographic service area, can make changes at other times.

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:

1. 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;
2. 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
3. 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:

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

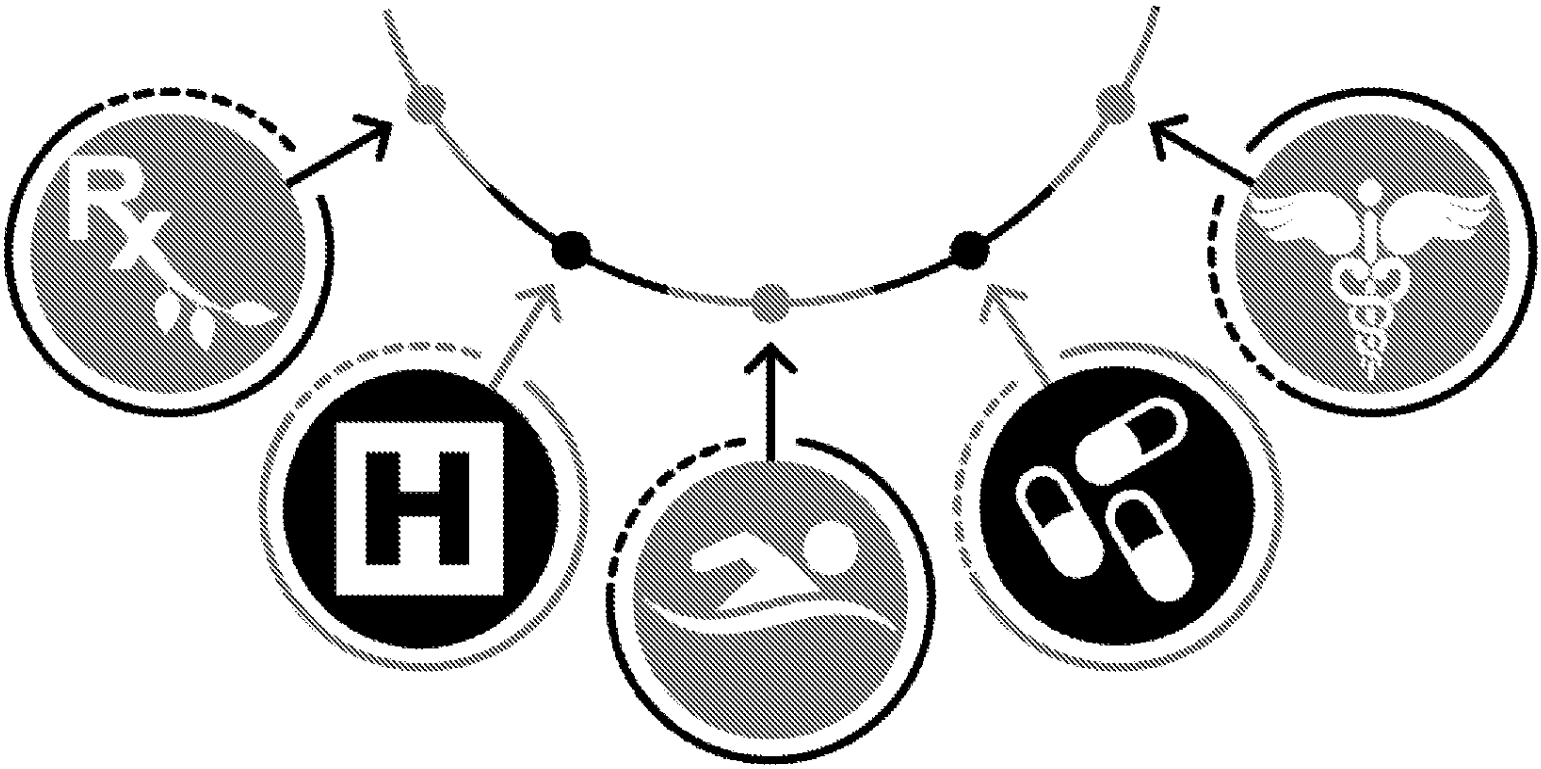
By acceptance of benefits paid under the plan, the PEIA insured agrees that PEIA's rights of subrogation and reimbursement shall have a priority lien and the right of first recovery against any settlement or judgment obtained by or on behalf of an insured. This right shall exist without regard to allocation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

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.



HIPAA Notice of Privacy Practices

Effective date of this notice: September 23, 2013

If you have questions about this notice, please contact the person listed under "Who to Contact" 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, pharmacies, 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 that is created, received, used, or maintained by PEIA or its Business Associates that relates to the past, present, or future physical or mental health, healthcare, or payment for the healthcare of an individual.

Who Must Abide by This Notice

- PEIA
- All employees, staff, students, volunteers, contractors, and other personnel who work for and/or 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 the purpose(s) of treatment, and as necessary for payment and healthcare operations activities as described below.

Our Legal Duties

- We are required by law to maintain the privacy and security 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 respond to your requests or concerns within a timely manner.
- 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.

This notice describes how we may use your personal, protected health information, or disclose it to others, for a number of different 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 and use the results to discuss with your health issues. 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 administrators 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 that 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. These third-parties are called "Business Associates" and are held to the same standards as PEIA with regard to ensuring the privacy, security, integrity, and confidentiality of your personal information. If, in the course of healthcare operations, your confidential information is transmitted electronically, PEIA requires that information to be sent in a secure and encrypted format that renders it unreadable and unusable to unauthorized users.
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. We will only disclose the minimum amount of health information necessary to fulfill the legal requirement.

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. We will only disclose the minimum amount of health information necessary to fulfill the investigation request.

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.

11. 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.

12. Research. We may disclose your health information in an appropriately de-identified format in connection with approved medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.

13. 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.

14. 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.

15. PEIA will not release, disclose, exchange, and/or sell your health information for use in marketing or for-profit ventures by third parties.

Your Rights

1. Authorization. We may not 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. We will only disclose the minimum amount of health information necessary to fulfill the authorization request. 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 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 and certain specific exclusions do apply. 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 will accept electronic request for releases of information in the form of e-mails or other electronic means. If you choose, you may receive your records in an electronic format but PEIA has the right to make sure that electronic information is delivered in a safe, secure, and confidential format. We may charge a fee for the cost of copying, mailing and/or e-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 including the change. The new notice will include an effective date. We will make the new notice available 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 have any questions about the privacy and security of your records, 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, 601 57th St. SE, Charleston, WV 25304-2345, 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.Help@wv.gov.

June 1, 2004

Revised: August 2, 2013

Effective date: September 23, 2013

Tear this page out and take it to your doctor!

PEIA Adult Annual Routine Physical and Screening Examination Form

Primary Care Visit

You are entitled under the Patient Protection and Affordable Care Act (PPACA) to an annual primary care visit that is covered at 100% with no deductible, copayment or coinsurance once per plan year. * We recommend your Annual Routine Physical and Screening examination be provided by your CCP or primary care physician. This visit includes the following:

☐ History & Physical to include:

⊕ Screening and counseling for

- Alcohol and/or substance abuse
- Depression
- Domestic violence
- Obesity
- STD prevention
- Blood pressure
- Diabetes
- Nutrition
- Physical activity
- Other health risk factors as appropriate and provided for by PACA

⊕ Review of medications

☐ Blood Work to include:

⊕ General Health Panel

⊕ Lipid Panel

☐ Immunizations as recommended by the American Academy of Family Physicians

Any additional services, including lab work, diagnostic testing and procedures with the appropriate diagnosis, that are provided to you during this visit will be subject to your deductible, coinsurance and copayments. This may result in additional out-of-pocket costs!

To the Provider:

☐ Bill one of the following codes for this visit:

⊕ 99381-99397 for the annual adult preventative care visit

☐ The most commonly used diagnosis code for this visit is:

⊕ Z00.00

☐ If you are CLIA certified, you may process labs in your office. You can bill the following for the lab work:

Panel Code	Component Code	Code Description
80061		Lipid Panel
80050	-	General Health Panel -- includes the following component:
-	80053	Comprehensive Metabolic Panel -- includes the following component code:
-	84443	Thyroid Stimulating Hormone (TSH) plus ONE of the following CBC or combination of CBC component codes for the same patient on the same date of service:
-	85025	Blood Count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
-	85027 + 85004	Blood Count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) AND Blood count; automated differential WBC count
-	85027 + 85007	Blood count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) AND Blood count; blood smear, microscopic examination with manual differential WBC count
-	85027 + 85009	Blood count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) AND Blood count; manual differential WBC count, buffy coat

☐ If you are not CLIA certified, labs must be performed and billed by a CLIA certified provider.

☐ Bill appropriate immunization codes.

*More details are available in the PEIA Summary Plan Description What Is Covered section.


WEST VIRGINIA
PEIA
PUBLIC EMPLOYEES INSURANCE AGENCY
Rx

Public Employees Insurance Agency

601 57th Street, SE / Suite 2
Charleston, WV 25304-2345

JOIN PEIA!

WHO	WHY	PHONE	WEBSITE
PEIA	Answers to questions about the PEIA PPB Plans	888-680-7342 (toll-free)	www.wvpeia.com
UMR	Answers to questions about eligibility, benefits and network.	888-440-7342 (toll-free)	www.UMR.com
The Health Plan of West Virginia, Inc. HMOs & POS	Answers to questions about The Health Plan of West Virginia, Inc.'s Benefits	800-624-6961 (toll-free) or 888-847-7902	www.healthplan.org
Securian Financial	Answers to questions about life insurance or to file a life insurance claim	800-203-9515 (toll-free)	www.securian.com
Mountaineer Flexible Benefits	Dental, vision, disability insurance, flexible spending accounts, etc.	844-559-8248 (toll-free)	www.myfbmc.com

Summary Plan Description
PPB Plan C
Plan Year 2020

July 1, 2019-June 30, 2020



JOIN PEIA

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

Group health plans sponsored by state and local government employers must generally comply with federal law requirements in the title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. PEIA has elected to exempt the PEIA PPB Plans from item two of the following requirements:

1. Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.
2. Protections against having benefits for mental health and substance-use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.
3. Certain requirements to provide benefits for breast reconstruction after a mastectomy.
4. Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these federal requirements will be in effect for the 2020 plan year, beginning July 1, 2019 and ending June 30, 2020. The election may be renewed for subsequent plan years.

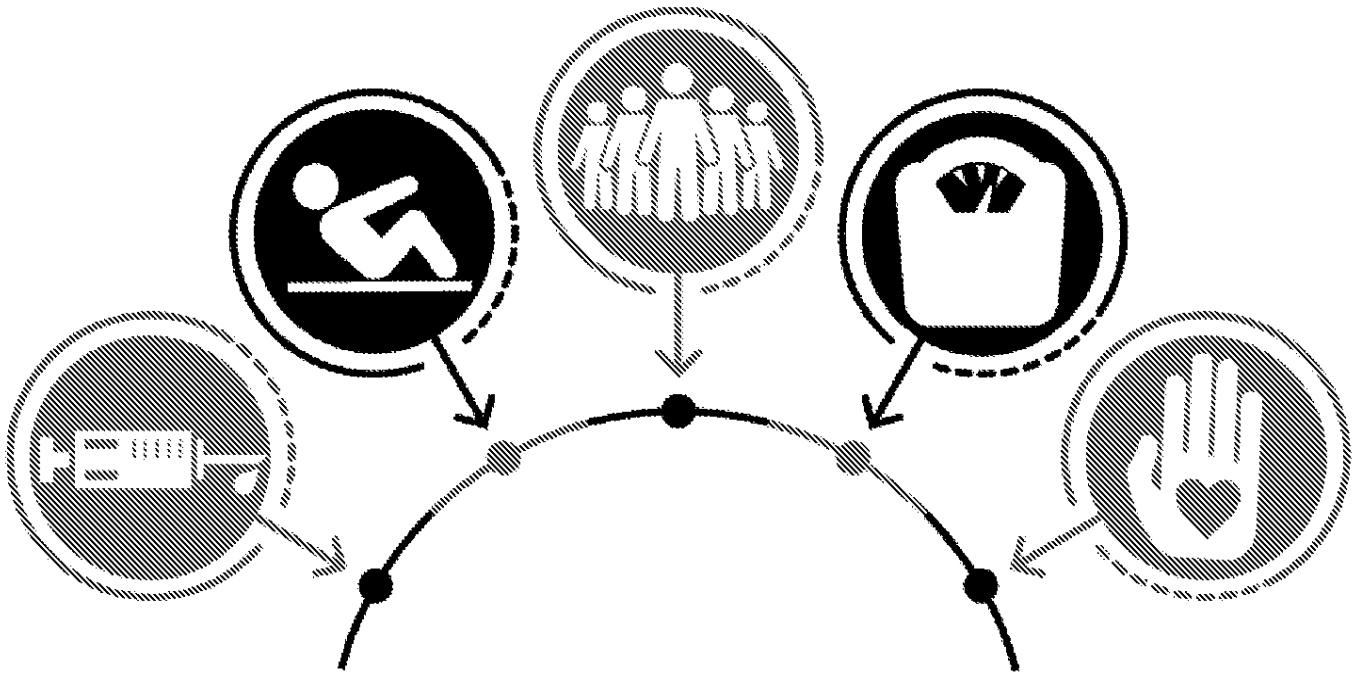
Medicare Part D Notice

If you (and/or your covered dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 95 for details.

Summary of Benefits and Coverage

Want to compare all of the plans offered by PEIA? There's an easy way! Go to www.wvpeia.com and click on Members, then Active Members, then scroll down to choose the "Summary of Benefits and Coverage" link. This link allows you to enter a bit of information and receive customized comparisons of the PEIA PPB Plans. If you don't have internet access, you can call PEIA's customer service unit at 1-888-680-7342 and we can generate the SBCs for you!

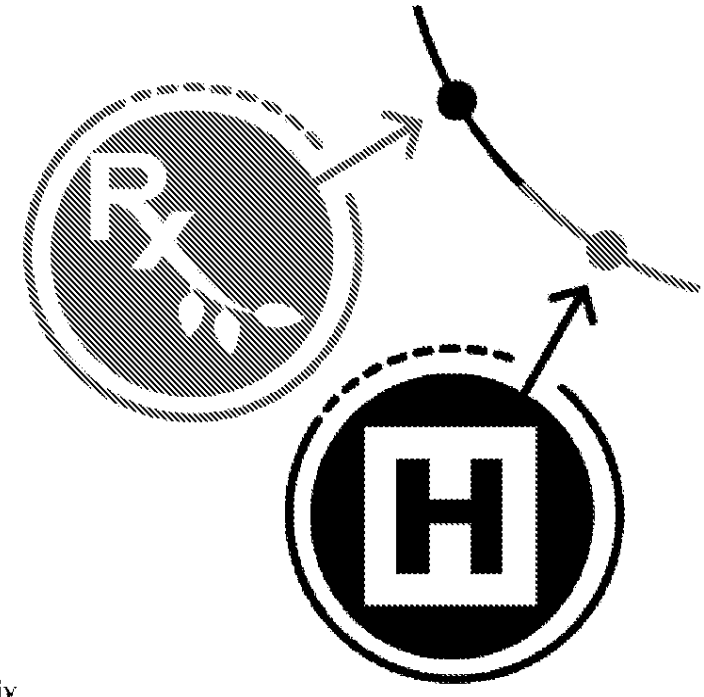
NOTE: PEIA also offers PPB Plans A, B and D; for more information, download the Summary Plan Description (Plans A, B and D) at www.wvpeia.com or call 1-888-680-7342.



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Introduction

Welcome to your PEIA Plan C Summary Plan Description. This booklet describes the benefits provided for PEIA insureds in PEIA PPB Plan C for Plan Year 2020 (July 1, 2019- June 30, 2020).

PPB Plan Participants

This booklet includes many details of the Preferred Provider Benefit (PPB) Plan C, which is PEIA's IRS-qualified High Deductible Health Plan. It is important to review this information closely so that you may familiarize yourself with all aspects of the plan. Please keep this booklet close at hand and refer to it often if you have questions about your health care benefits.

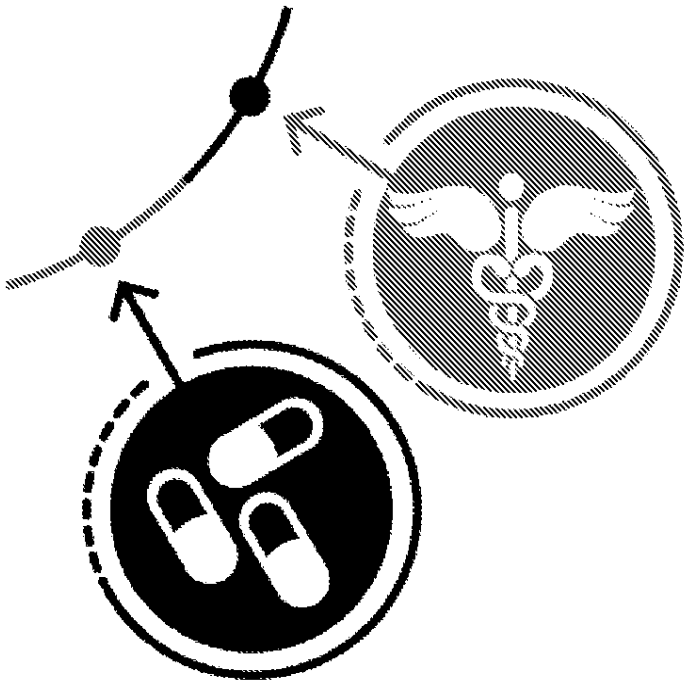
This Summary Plan Description (SPD) provides PPB Plan C participants with an easy-to-read description of benefits available through the Plan and instructions on how to use these benefits. The SPD is a summarized version of a portion of PEIA's Plan Document. The Plan Document describes, in detail, all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

PEIA contracts with third party administrators (TPAs) to process health and drug claims for Plan C. 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 also offers PPB Plans A, B and D. PPB Plan A is PEIA's most popular plan. PEIA PPB Plan B is similar to the standard PPB Plan A, but offers lower premiums with higher deductibles, higher out-of-pocket maximums, a greater co-insurance requirement, and higher copayments for prescription drugs. The medical coverage is the same as in PPB Plan A. Plan D is the West Virginia ONLY plan whose benefits mirror those of Plan A, but with no out-of-state benefits except for medical emergencies and a few services that are not available within WV. For more information about Plans A, B and D, download the Summary Plan Description (Plans A, B & D) at www.wvpeia.com or call 1-888-680-7342.

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. 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 and Benefits, Precertification, Pre-authorization, Prior Approval of Out-of-State Care and Utilization Management

UMR at 1-888-440-7342 (toll-free) or on the web at www.uhc.com.

Provider Network Administration

UMR with UnitedHealthCare Choice Plus PPO at 1-888-440-7342(toll-free).

Prescription Drug Benefits and Claims

CVS Caremark at 1-844-260-5894 (toll-free) or on the web at www.caremark.com.

Common Specialty Medications

CVS Caremark Specialty Medication Program at 1-844-260-5894 (toll-free).

Sleep Testing, Equipment, and Supplies

CareCentrix at 1-888-497-5337

Subrogation and Recovery

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

PEIA

Answers to questions about eligibility and third-level claim appeals. Contact WV Public Employees Insurance Agency at 1-304-558-7850 or 1-888-680-7342 (toll-free) or on the web at www.wvpeia.com.

Humana

Medical and prescription drug benefits for Medicare-primary members. Answers to questions about eligibility, health claims, benefits, and claim appeals: Call Humana at 1-800-783-4599.

Securian Financial

Answers to questions about life insurance or to file a life insurance claim. Call Securian Financial at 1-800-203-9515.

Mountaineer Flexible Benefits

Dental, vision, disability insurance and flexible spending accounts. Contact FBMC Benefits Management at 1-844-559-8248 (toll-free) or on the web at www.myfbmc.com.

PEIA Face-to-Face Diabetes Management Program

For information call 1-888-680-7342 or visit www.peiaf2f.com.

PEIA Weight Management Program

For information about the program, call 1-866-688-7493. To enroll, visit www.wvpeia.com.

The Health Plan of West Virginia, Inc. HMOs & POS

1-800-624-6961 (toll-free), 1-888-847-7902 or on the web at www.healthplan.org.

Terms & Definitions

Affordable Care Act (ACA) Out-of-Pocket Maximum: The Affordable Care Act places a limit on how much you must spend for healthcare in any plan year before your plan starts to pay 100% for covered essential health benefits. This limit includes deductibles (medical and prescription), coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not include premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing or spending for non-essential health benefits.

The maximum out-of-pocket cost for Plan Year 2020 can be no more than the rates set by the federal government for individual and family plans. Because PEIA's plans have out-of-pocket maximums that are substantially lower than the ACA required limits, the ACA out-of-pocket maximum should never come into play for most PEIA PPB Plan members.

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. Only the Allowed Amounts for covered expenses will be applied to your 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 Plans. For more information, read the "Recovery of Incorrect Payments" section.

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

Case Management: A program from UMR to identify catastrophic and complex illnesses, transplants, and trauma cases, and work with members to maximize their benefits.

Claims Administrator: UMR adjudicates health claims for the PEIA PPB plans.

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

Common Specialty Medications: Self-administered specialty drugs that are provided through CVS Specialty Pharmacy. All Specialty medications require prior authorization.

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

Copayment: This is the set dollar amount that you pay for prescription drugs once you have met your annual deductible.

CVS Caremark: PEIA's prescription drug benefit manager (PBM). CVS Caremark processes and pays prescription drug claims and helps manage the prescription drug benefit.

Deductible: The amount of eligible expenses you are required to pay before the plan begins to pay benefits. See Annual Deductible above.

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

Disease Management: A program from UMR to identify individuals who have certain chronic diseases and would benefit from working with specially trained nurses to manage those chronic diseases and maintain quality of life.

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: A condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of a bodily part or organ.

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 your benefits, contact the benefit coordinator at your payroll location or call the PEIA.

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

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 is 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. Phase 2 and 3 Clinical Trials for terminal cancer and other life-threatening conditions which meet certain statutory criteria will be covered despite being experimental.

Explanation of Benefits (EOB): A form sent to the policyholder 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.

Health Maintenance Organization (HMO): 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 that 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.

Health Savings Account (HSA): A health savings account (HSA) is a tax-exempt trust or custodial account that members of PEIA PPB Plan C may set up with a qualified HSA trustee to pay or reimburse certain medical expenses. The HSA works in conjunction with a High Deductible Health Plan. For a full description of PEIA's HDHP, see the section entitled PEIA PPB Plan C on page 39.

HealtheNotes: UMR provides targeted mailings to members and providers. HealtheNotes provide useful, personalized information to help members manage their health.

Healthy Tomorrows: A coordinated lifestyle and disease management program for all PEIA PPB Plan members.

High Deductible Health Plan (HDHP): A High Deductible Health Plan (HDHP) is a plan that includes a higher annual deductible than typical health plans, and an out-of-pocket maximum that includes amounts paid toward the annual deductible and any coinsurance that the member must pay for covered expenses. The HDHP deductible includes both medical services and prescription drugs under a single deductible. Out-of-pocket expenses include copayments and other amounts, but do not include premiums.

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 Plans, a managed care plan, or life insurance only. Insured refers to anyone who has coverage under any plan offered by PEIA.

Legal Guardianship: A legal relationship created when a person or institution is named by the Court to take care of minor children. Eligibility for guardianship requires an Order from a Court of Record. Notarized documents signed by parents assigning "guardianship" are not sufficient to establish eligibility. The term "guardian" may also refer to someone who is Court-appointed to care for and/or handle the affairs of a person who is incompetent or incapable of administering his/her affairs. Sometimes a separate person is appointed to handle the financial matters of the child(ren) or the adult and that relationship is called a conservatorship.

Maternity Management: A program from UMR that provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term.

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. 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 D (drug coverage) IS NOT required for members of the PEIA Plans.

Medicare Advantage and Prescription Drug (MAPD) Plan: A type of Medicare benefits that combines Medicare Parts A, B and D into one comprehensive benefit package. PEIA provides benefits to Medicare-eligible retired employees and Medicare-eligible dependents of retired employees almost exclusively through the Humana MAPD plan offered by PEIA.

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

Non-Resident PPB Plan Participants: A PEIA PPB Plan participant who resides outside WV and beyond the bordering counties.

Notification: The required process for reporting an inpatient stay to UMR. 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, freestanding facility, or physician's office but who is not admitted as a bed patient.

Participant: A policyholder or dependent enrolled in one of the PEIA PPB Plans.

PEIA PPB Plan A: The most expensive PEIA PPB Plan offered to all eligible active employees and non-Medicare retirees. For more information about Plan A, download the Summary Plan Description (Plans A, B & D) at www.wvpeia.com or call 1-888-680-7342.

PEIA PPB Plan B: A lower-cost PEIA PPB Plan offered to all eligible active employees and most non-Medicare retirees. Plan B offers lower premiums with higher deductibles, higher out-of-pocket maximums, increased coinsurance, and higher copayments for prescription drugs. The medical coverage is the same in Plans A, B and D. For more information about Plan B, download the Summary Plan Description (Plans A, B & D) at www.wvpeia.com or call 1-888-680-7342.

PEIA PPB Plan C: The IRS-qualified High Deductible Health Plan (HDHP) offered by PEIA to all eligible active employees. The plan offers lower premiums, but a high deductible that must be met before the plan begins to pay. The plan is designed to work with either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). The benefits are described in full later in this document.

PEIA PPB Plan D: PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, and the premiums are much lower than Plan A. The difference is that the only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia.

For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia. For more information about Plan D, download the Summary Plan Description (Plans A, B & D) at www.wvpeia.com or call 1-888-680-7342.

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 properly licensed WV providers who provide health care services or supplies to any PEIA participant, as well as most out-of-state providers in the UnitedHealthCare Choice Plus Preferred Provider Organization. For services provided outside of the State, contact UMR to find a network provider.

Pharmacy Benefits Manager (PBM): A company with which PEIA has a contract to administer the prescription drug benefit component of PEIA PPB Plans. The PBM processes and pays prescription drug claims and helps manage the prescription drug benefit.

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 for active PEIA participants. January 1 to December 31 for participants in the Special Medicare Plan.

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 contact UMR in advance of a procedure to verify that the service is a covered benefit and medically necessary.

Precertification: The required process of reporting any out-of-state inpatient admission, any mental health inpatient admission, in-state admissions for certain procedures and certain outpatient procedures in advance to UMR to obtain approval for the admission or service.

Premium: The payment required to keep coverage in force.

Primary Care Provider: A general practice doctor, family practice doctor, internist, pediatrician, geriatrician, OB/GYN, nurse practitioner or physician assistant working in collaboration with such a physician, who, generally, provides basic diagnosis and non-surgical treatment of common illnesses and medical conditions.

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

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

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.

Qualifying Event: A qualifying event is a personal change in status which may allow you to change your benefit elections. Examples of qualifying events include, but are not limited to, the following:

1. Change in legal marital status – marriage or divorce of policyholder or dependent
2. Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship
3. Change in employment status of the employee's spouse or employee's dependent – switching from part-time to full-time employment status or from full-time to part-time, termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in employee/dependent becoming ineligible for coverage
4. Dependent satisfies or ceases to satisfy eligibility requirements

If you experience a qualifying event, you have the month in which the event occurs and the two following calendar months to act upon that qualifying event and change your coverage. If you do not act within that time frame, you cannot make the change until the next Open Enrollment. **Qualifying events which end eligibility (such as <u>divorce</u>) must be reported immediately.** For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce

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 Plans.

Reasonable and Customary: The usual, customary and reasonable amount determined by the plan, for a geographic area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill or experience to treat successfully.

Resident PPB Plan Participants: PEIA PPB Plan participants who live in West Virginia or a bordering county of a surrounding state.

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 93.

Special Medicare Plan: The Plan created by PEIA to provide benefits to retirees unable to access providers in the Medicare Advantage plan and those retirees who become eligible for Medicare benefits during a plan year. Medical claims under this plan are paid by Medicare first, then by UMR and prescription claims are paid by CVS Caremark. The medical benefits are identical to those provided to members of the Humana MAPD plan, including a plan year that runs from January through December.

Specialty Injectable Drugs: These are prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring. The PEIA PPB Plans cover specialty injectable drugs through a program managed by UMR.

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. Some specialty medications are covered under the medical benefit and are managed by UMR, and some are covered under the prescription drug benefit and administered by CVS Specialty Pharmacy. Those covered under the prescription drug benefit, have a two-tier copay; after meeting your deductible, preferred specialty drugs have a $100 copay, non-preferred specialty drugs have $150 copay. Specialty Injectable drugs managed by UMR require 20% coinsurance after deductible. All specialty medications covered under the prescription benefit (oral and self-injectable) require prior authorization through CVS Caremark. PEIA will allow a one-time initial fill of the medication at a retail pharmacy.

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.

UMR: The third-party administrator that handles medical claim processing, case management, utilization management, precertification, prior approval and customer service for the PEIA PPB Plans.

UnitedHealthCare Choice Plus PPO: PEIA's out-of-state Preferred Provider Network. Not all providers in the UnitedHealthCare Choice Plus PPO network may participate with PEIA. Kings Daughters Medical Center and Our Lady of Bellefonte hospitals in Kentucky remain out-of-network for PEIA, regardless of their network status with the PPO network. Also, PEIA does not use the PPO network in Washington County, Ohio, or in Boyd County, Kentucky. PEIA reserves the right to remove providers from the network, so not all providers listed in the network may be available to you.

Utilization Management: A process by which PEIA controls health costs and saves money for plan members. 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 UMR.

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 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 four PEIA PPB Plans. Read on to see who is eligible to enroll in each plan.

1. Plan A is the most expensive plan available to all eligible enrollees, including active employees and non-Medicare retirees.
2. Plan B offers lower premiums with higher deductibles, higher out-of-pocket maximums, increased coinsurance, and higher copayments for prescription drugs. The medical coverage is identical in PPB Plans A, B & D. Plan B is available to all active employees and to non-Medicare retirees whose dependents do not have Medicare.
3. Plan C is an IRS-qualified High-Deductible Health Plan (HDHP). The medical and prescription benefits of Plan C are detailed later in this book. Plan C is available to active employees only.
4. Plan D is the West Virginia ONLY plan. Insureds enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-network coverage, except as noted above. Plan D is available to active employees only.

For more information about Plans A, B & D, download the Summary Plan Description (Plans A, B & D) at www.wvpeia.com or call 1-888-680-7342.

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 for information about the managed care plans 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 93 for a complete description of this provision. The PEIA PPB Plans may be of little or no value to you as secondary insurance on your dependents.

Life Insurance

As an active or retired employee, you may be eligible for basic decreasing term life insurance. This policy includes accidental death and dismemberment (AD&D) benefits for active employees only. If you enroll for health benefits as an active employee, you must also enroll for basic life insurance. If you choose not to enroll for health benefits, you may still 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.

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

Retired employees are eligible for dental, hearing, and vision coverage and the group legal plan on a post-tax basis. Enrollment materials are mailed to all eligible retired employees prior to the April enrollment period. If you have questions about these benefits, contact Fringe Benefits Management Company at 1-844-559-8248.

Open Enrollment for Mountaineer Flexible Benefits is held each Spring for ALL active and retired employees. The current information about these benefits and associated premiums 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 1-844-559-8248.

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
Hearing Benefits	Coverage for hearing examination, diagnostic testing and hearing aids
Medical Flexible Spending Account	Deposit up to $2,700 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.

For a more complete description of benefits, see the Mountaineer Flexible Benefits Plan booklet.

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);
- a member of the West Virginia Board of Education (must pay 100% of the premium);
- a permanent full-time substitute teacher working on a contract of 90-days or more per school year;
- an elected member of a county board of education (must pay 100% of the premium); or
- a school service employee eligible under W.Va. Code, Chapter 18A.

Dependents: If you elect PEIA coverage, you may also enroll the following dependents with proper documentation:

- your legal spouse;
- your biological children, adopted children, or stepchildren under age 26;
- other children for whom you are the court-appointed guardian to age 18.

A child may not be enrolled for health coverage as both a policyholder (as a public employee in his or her own right) and as a dependent child. Dependent biological children, adopted children, or stepchildren may be covered under the plan to age 26, regardless of their residency, marital status, or the availability of other insurance coverage. The dependent child's marriage is a qualifying event for the policyholder to remove the dependent child from coverage. The policyholder MAY remove the child, but is not required to do so.

From time to time PEIA may conduct eligibility audits to verify that policyholders and dependents in the plan qualify for coverage. If you are audited, you will have to produce documentation for the dependent in question. If you cannot prove that the dependent qualifies for coverage, coverage will be terminated retroactively to the date the dependent would otherwise have been terminated, and PEIA will pursue reimbursement of any medical or prescription drug claims paid during the time the dependent was ineligible.

How to Enroll or Make Changes

You may enroll for or make changes to PEIA health and life benefits using PEIA's online enrollment site, "**Manage My Benefits**," or by contacting your benefit coordinator. 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 enroll yourself and your dependents. Enrollment will authorize your employer or retirement system to deduct the premiums for the coverages you select from your salary or 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.

New Employees

New employees 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 in which you are hired and the following two calendar months. This is your "initial enrollment period." To enroll your dependents, you will need to provide documentation substantiating their eligibility for benefits. The chart on page 26 shows the documentation required.

As an active employee, if you enroll for health insurance, you must enroll for basic life insurance, as well. If you enroll for basic life insurance, then you may enroll for optional life insurance if you so choose. No medical information is required for up to $100,000 of optional life insurance elected during this initial enrollment period. Medical information is always required for optional life insurance in excess of $100,000. You may also enroll for optional life insurance for your dependents up to $20,000. Dependent life insurance in excess of $20,000 requires medical information.

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. Your health care plan selection will remain in effect for a full plan year unless you move outside the service area of your plan or have a qualifying event that enables you to change or cancel coverage.

If you choose not to enroll for life insurance during this initial enrollment period, but want life coverage later (basic, optional or dependent) for you or your dependents, you may apply for that coverage at any time, but you will have to submit medical information 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 during an Open Enrollment period or if you have a qualifying event, in accordance with guidelines in effect at the time you choose to enroll. To enroll as a result of a qualifying event, you must do so during the month of the event or the following two calendar months or you will have to wait until the next Open Enrollment period.

Employees hired on and after July 1, 2010, will not receive any plan subsidy of their health insurance premiums at retirement. These employees may continue coverage in the plan at retirement but must pay the unsubsidized premium for the coverage of their choice. Two exceptions will be made to this rule:

1. Active employees hired before July 1, 2010, who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2010) hire date.
2. Retired employees who had an original hire date prior to July 1, 2010, may return to active employment and retain their pre-July 1, 2010, original hire date for purposes of determining their eligibility for premium subsidy.

Employees of non-state agencies that join the PEIA Plan after July 1, 2010, will be assigned a "hire date" in the PEIA systems that is the same as their effective date of coverage under the PEIA Plan. Upon retirement, these employees will be treated as those hired on or after July 1, 2010, and will be required to pay the full cost of coverage as noted above.

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

PEIA has no pre-existing condition limitation. PEIA will provide coverage for all eligible medical conditions from the effective date of coverage. Managed care plans also 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:

1. have completed a full day of active work on that date; and
2. 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, coverage will become effective on the date you return to active work. Active work and actively at work mean performing regular duties for a full work day for the policyholder.

Existing Employees

Existing employees may make changes in their coverage as follows:

Health Coverage

Existing employees who choose not to take health coverage at the time of employment may enroll for health coverage by using PEIA's online enrollment site, "**Manage My Benefits**" or completing a Health Insurance Enrollment Form, provided that they have experienced one of the qualifying events shown in the chart on page 26.

To enroll as a result of a qualifying event, you must do so during the month of the event or the following two calendar months or you will have to wait until the next Open Enrollment. Coverage will be effective on the first day of the month following enrollment. In the absence of a qualifying event, coverage may be added for the employee and/or eligible dependents, only during PEIA's annual Open Enrollment period.

Life Insurance

Existing employees may add or increase the amount of life insurance at any time by using PEIA's online enrollment site, "**Manage My Benefits**" or completing an Optional Life Insurance Enrollment Form, submitting medical information, 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. You must meet the following requirements on the effective date of coverage:

1. have completed a full day of active work on that date; and
2. 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, 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.

Dependents

You may enroll eligible dependents for health and life coverage during your initial enrollment period, and if you do, their coverage begins the same day as yours. To enroll dependents, you must provide documentation substantiating their eligibility for benefits. See page 26 for details. You may enroll dependents for health coverage outside your initial enrollment period only if you experience a qualifying event. If you enroll them at a later date, their coverage will become effective the first day of the month following enrollment. In the absence of a qualifying event, you may only enroll dependents for health coverage during Open Enrollment. Coverage will be effective on the first day of the following plan year. To add a dependent to your coverage, you must submit documentation to prove the dependent's eligibility. See page 26 for details.

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 medical information has been submitted to, and approved by, PEIA's life insurance carrier. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent. See page 26 for details.

To enroll or add dependents, you must use PEIA's online enrollment site, "**Manage My Benefits**" or complete paper forms available from your benefit coordinator. Coverage is not automatic, even if you have an existing family plan.

Dependents may be removed from coverage only during Open Enrollment or at the time of a qualifying event. To make a change as a result of a qualifying event, you must do so during the month of the event or the following two calendar months or you will have to wait until the next Open Enrollment. Qualifying events which end eligibility (such as divorce) must be reported immediately. The policyholder must provide documentation supporting the qualifying event to remove dependents. Coverage of removed dependents will terminate at the end of the month in which the policyholder removes them from coverage. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce.

Medicare for Active Employees

For PEIA PPB Plan active employees or dependents of active employees who are 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, neither you nor your Medicare-eligible dependent need to sign up for Medicare Part B and pay the premium. When you prepare to retire, you and your Medicare-eligible dependent must enroll for Medicare Part B.

If you do not enroll in Medicare Parts A & B, you will not be eligible for PEIA's Medicare Advantage plan, and your PEIA coverage may be terminated.

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, you must send a copy of your Medicare card to PEIA. This notification will make the claims payment process go much more smoothly.

Newly Eligible Active Employees

Employees who become eligible to enroll for health coverage due to a qualifying event may enroll for coverage during the calendar month of that qualifying event or the two following calendar months. Coverage will become effective the first day of the month following enrollment. Newly eligible employees may enroll in one of the PEIA PPB Plans or a managed care plan. They may make another plan selection during the next Open Enrollment period.

Special Rules for Newborn or Adopted Children

Newborn Child

When you have a child, you must:

- provide documentation;
- PEIA will accept the Certificate of Live Birth from the hospital as documentation to enroll the child initially, but you must provide the Birth Certificate as soon as you have it or PEIA will suspend the child's coverage until we receive it;
- 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 or to PEIA.

To enroll the child for health coverage you must:

- enroll your biological newborn child for health coverage during the calendar month of birth or the two following calendar months;
- coverage will be made effective retroactive to the date of birth;
- any premium increase associated with the addition of this child will also be retroactive to the month of birth; and
- if you do not enroll your newborn within this time frame, you cannot add the newborn child until the next Open Enrollment period.

To enroll the child for life insurance coverage you must:

- add a biological newborn child to your existing dependent life insurance policy during the calendar month of birth or the two calendar months following the date of birth;
- coverage will be made effective retroactive to the date of birth;
- any premium increase associated with the addition of this child will also be retroactive to the month of birth;
- if you add the child later, you will have to submit medical information and be approved to obtain dependent life insurance coverage for your child.

Adopted Child

When you adopt a child, you must:

- provide documentation;
- PEIA requires a copy of the adoption papers to enroll the child;
- in the case of a foreign adoption, PEIA requires adoption papers in English, and may require entry visa and/or statement from the U.S. consulate in the country of origin recognizing the adoption.

To enroll the child for health coverage you must:

- enroll an adopted child during the calendar month the child is placed in your home or the two following calendar months;
- coverage will be made effective retroactive to the date of placement;
- any premium increase associated with the addition of this child will also be retroactive to the date of placement;
- 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;
- if you do not enroll your child within this time frame, the adopted child cannot be added to your coverage until the next Open Enrollment period.

To enroll the child for life insurance coverage you must:

- add an adopted child to your existing dependent life insurance policy (Plans 1-4) during the calendar month of or the two calendar months following the date of placement in your home;
- coverage can be made effective retroactive to the date of placement;
- any premium increase associated with the addition of this child will also be retroactive to the date of placement;
- if you add the child later, or elect Plan 5, you will have to submit medical information and be approved to obtain dependent life insurance coverage for your adopted child.

Eligibility and Enrollment for Retired Employees

Who is Eligible?

Retired public employees are eligible for health and life benefits through PEIA, provided:

1. you meet the minimum eligibility requirements of the applicable State retirement system or a PEIA-approved retirement system; and
2. your last employer immediately prior to retirement is a participating employer in the PEIA Plan and under the State retirement system or a PEIA-approved retirement system*.

Members who participate in a non-State retirement system must, in the case of education employees (such as TIAA CREF, TDC 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. The retiring employee and all enrolled dependents must re-enroll to continue health benefits into retirement.

PEIA offers non-Medicare retirees coverage through PEIA PPB Plan A or B or an HMO. Non-Medicare retirees must continue coverage in the plan in which they were covered as active employees until the next Open Enrollment, when they can choose any plan for which they are eligible. Retiring employees enrolled in PEIA PPB Plans C or D must choose either PEIA PPB Plan A or B upon retirement, since Plans C and D are not offered to retirees. Medicare-eligible PPB Plan members who retire after the beginning of a plan year, and retired employees who become eligible for Medicare during the plan year are transferred to PEIA's Special Medicare Plan until the beginning of the next Medicare plan year. Members enrolled in an HMO when they become Medicare-eligible will be transferred to the Special Medicare Plan. Medicare's Plan Year runs from January through December; PEIA follows that plan year for Medicare Retirees. Open Enrollment for Medicare members is held during the month of October with benefits effective on January 1.

Under the Special Medicare plan, the member must enroll for traditional Medicare Parts A and B, and their secondary medical and prescription claims are paid by UMR and CVS Caremark, respectively. Medical benefits under the Special Medicare Plan are generally the same as those provided under PEIA'S Medicare Advantage plan. Members remain in the Special Medicare Plan until the beginning of the next Medicare Plan Year (January 1), when they are transferred to PEIA's Medicare Advantage Plan.

These members can request to be transferred immediately to the Humana/PEIA Plan 1. There are two main benefit differences between the PEIA Special Medicare Plan and the Humana/PEIA Plan 1:

1. The Special Medicare Plan does not offer the SilverSneakers® fitness benefit that includes a free fitness center membership. This is only available from Humana.
2. The cost of non-preferred brand name medications is different.
    a) Under the Humana/PEIA Plan 1, the cost-sharing for a 30-day supply of a non-preferred drug is 50% of the cost of the drug, and maintenance medications in this category are eligible for the maintenance medication discount.
    b) Under the Special Medicare plan, a 30-day supply of a non-preferred drug will cost you 75% of the cost of the drug, and maintenance medications in this category are NOT eligible for the maintenance medication discount.

* *Certain non-state agencies that participate in the PEIA health and life insurance plans for active employees have "opted out" of offering their employees PEIA's retiree insurance coverage, called the WV OPEB plan. If an employer opts out of the WV OPEB plan or is ineligible to participate in the WV OPEB plan due to retirement system participation, they are opting out of retiree eligibility for PEIA health and life coverage. Other post-employment benefits (OPEB) refers to the benefits, other than pensions, that a state or local government employee receives as part of his or her package of retirement benefits. Please be aware that, regardless of previous employment, previous or current coverage through PEIA and years of service, if an employee transfers to an opt-out agency immediately prior to retirement, the employee will not be eligible for retirement health or life insurance benefits through PEIA.*

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. See page 34 for more information on extending employer paid insurance upon retirement.

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 in the PEIA Plan and under the State retirement system and as long as you meet the minimum retirement qualifications as determined by CPRB. Coverage will be effective on the first day of the month following enrollment.

Return to Active Employment

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, you have PEIA benefits as an active employee, which makes your new effective date of coverage in the PEIA plan after July 1, 2001, and therefore you are ineligible for the sick/annual leave benefit. The only exception to this rule is provided for those who participated in the plan prior to July 1, 2001, and who become re-employed with an employer participating in the plan within two years following separation from employment (retirement). In this case, the employee would be permitted to apply any sick and/or annual leave earned after re-employment, toward health premiums at retirement.

Employees hired on and after July 1, 2010, will not receive any plan subsidy of their premiums at retirement. These employees may continue coverage in the plan at retirement but must pay the unsubsidized premium for the coverage of their choice. Two exceptions will be made to this rule:

1. Active employees hired before July 1, 2010, who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2010) hire date.
2. Retired employees who had an original hire date prior to July 1, 2010, may return to active employment and retain their pre-July 1, 2010, original hire date for purposes of determining their eligibility for premium subsidy.

Deferred Retirement

If you separate from employment before your retirement from a participating employer under the State retirement plan, you may not enroll in PEIA as a retiree if you have other earned income just prior to retirement. If you are self-employed or have earned income from any other source, you will not be permitted to enroll as a retiree. To be eligible to enroll in PEIA, your last employer immediately prior to retirement must have been a public entity that participates in the State retirement system or a PEIA-approved retirement system, and in the PEIA Plan.

Separated Pre-retirement Employees with 20 Years' Service

Employees with 20 or more years of service, who separate from public employment but who have not retired, may enroll in PEIA health benefits for up to two (2) years following separation. Employees in this category will be required to pay 105% of the total unsubsidized premium for the coverage they choose. Enrollees in this category are not eligible for PEIA's retiree premium assistance program or retiree premium subsidy until such time as they meet CPRB and PEIA's eligibility requirements as a full retiree. Employees in this category are not eligible to extend employer-paid insurance upon retirement using sick/annual leave or years of service credits.

Disability Retirement

A member who is granted disability retirement by a state retirement system or who receives Social Security disability benefits is eligible to continue coverage in the PEIA Plan as a retired employee, provided that the member meets the minimum years of service requirement of the applicable state retirement system. Members in this category continuously covered since before July 1, 2010, pay the same premiums as those with 25 or more years of service. Those hired on or after July 1, 2010, may continue coverage, but will pay the full, unsubsidized premium for that coverage. If you receive Social Security Disability benefits, please send a copy of your Disability Award letter to PEIA. Generally, those awarded

Social Security disability benefits will receive Medicare benefits after a two-year waiting period. When you receive your Medicare ID card, you must provide a copy of that card to PEIA immediately. Disability retirees may be eligible for a life insurance waiver of premium. See page 36 for details.

Non-State Agency Retirees

Employees who retire from non-state entities which employers joined the PEIA Plan after July 1, 2010, will be assigned a "hire date" in the PEIA systems that is the same as their effective date of coverage under the PEIA Plan. Upon retirement, these employees will be treated as those hired on or after July 1, 2010, and will be required to pay the full cost of their coverage.

Deputy Sheriffs

Deputy sheriffs have the right to retire prior to attaining age 55 and continue their health benefits by paying the premiums designated for them in the Shopper's Guide each year. At the time of retirement, these retirees must continue coverage in the plan in which they were covered as active employees until the next Open Enrollment, when they can choose any plan for which they are eligible. Retiring employees enrolled in PEIA PPB Plans C or D must choose either PEIA PPB Plan A or B upon retirement, since Plans C and D are not offered to retirees. For more information about Plans A or B, download the Summary Plan Description (Plans A, B & D) at www.wvpeia.com or call 1-888-680-7342.

Medicare

As a retired employee or a dependent of a retired employee, when you become an eligible beneficiary of Medicare, you must:

1. enroll in Medicare Part A and Medicare Part B; and
2. send a copy of your Medicare ID card to PEIA.

Your Medicare Beneficiary Identifier (MBI) number is required for coverage in PEIA's Medicare Advantage Plan or the Special Medicare Plan.

Most Medicare-eligible retired employees and Medicare-eligible dependents of retired employees have coverage through PEIA's Medicare Advantage plans.

- To be eligible for PEIA's Medicare Advantage plans, the member must enroll for Medicare Parts A and B.
- If you do not enroll in Medicare Parts A and B and pay the monthly premium, you will not be eligible for PEIA's Medicare Advantage plans, which is the only coverage offered to most retired, Medicare-eligible members.

The Medicare Advantage Plans provide different benefit options from which Medicare-eligible retirees can choose. Open Enrollment for Medicare retirees is held each October, with benefits effective on January 1. Medicare retirees' plan year runs from January through December. Benefits for non-Medicare dependents covered by PEIA will run on PEIA's plan year from July through June.

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

Medicare offers prescription drug coverage through a program called Medicare Part D. Please be aware that you should NOT purchase Medicare Part D coverage. You DO NOT need to enroll in a separate Medicare Part D plan, since PEIA will provide prescription drug coverage for retirees with Medicare. If you enroll in a separate Medicare Part D plan, you will be disenrolled from all medical and prescription benefits from PEIA. You will have only original Medicare Parts A, B and D with no secondary coverage.

Dependents

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

- your legal spouse;
- your biological children, adopted children, or stepchildren under age 26; or
- other children for whom you are the court-appointed guardian to age 18.

A child may not be enrolled for health coverage as both a policyholder (as a public employee in his or her own right) and as a dependent child.

From time to time PEIA may conduct eligibility audits to verify that policyholders and dependents in the plan qualify for coverage. If you are audited, you will have to produce documentation for the dependent in question. If you cannot prove that the dependent qualifies for coverage, coverage will be terminated retroactively to the date the dependent would otherwise have been terminated, and PEIA will pursue reimbursement of any medical or prescription drug claims paid during the time the dependent was ineligible.

How to Enroll

You may enroll for PEIA health and life benefits by completing enrollment forms available from your benefit coordinator or the PEIA website. On these forms, you will select the types of coverage you want and enroll the eligible dependents you wish to cover. When you have completed the forms, return them to your benefit coordinator (if initially retiring) or to PEIA (if already retired). Participation in PEIA benefit plans is not automatic upon retirement; you must complete the proper enrollment forms. Enrollment authorizes PEIA to deduct the premiums from your annuity for the coverages you select. 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.

At present, you cannot initially enroll for retirement benefits on PEIA's online enrollment website, but once you are retired, you may make changes in your information by going to www.wvpeia.com and clicking on "**Manage My Benefits**".

PEIA PPB Plan/PEIA's Medicare Advantage Plan

You may enroll for PEIA retiree benefits regardless of age, as long as you meet the eligibility requirements. Non-Medicare retirees have benefits through the PEIA PPB Plan A or B or the managed care plan of their choice. Most Medicare eligible retirees receive their benefits from PEIA's Medicare Advantage plan, although some are enrolled in PEIA's Special Medicare Plan.

Managed Care Plans

As a retired employee, you may enroll in a managed care plan if you are not 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. Generally, Medicare or an MAPD plan 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

You may continue your basic, optional and dependent life insurance at the time of retirement. If you wish to elect new or increased life insurance as a retired employee, you must enroll and submit medical information during the calendar month of retirement or the two following calendar months. Coverage will be effective upon approval of PEIA's life insurance carrier. You may not elect or increase life insurance after this period. If your life insurance lapses after retirement for any reason, for example, for non-payment of premiums, you will not be permitted to reinstate that coverage; you will need to seek life insurance from another source.

Enrolling Your Dependents

You may enroll dependents for health coverage when you enroll as a retiree, and if you do, their coverage begins the same day as yours. You may enroll dependents for health coverage outside your initial enrollment period only if you experience a qualifying event. To make a change as a result of a qualifying event, you must do so during the month of the event or the following two calendar months or you will have to wait until the next Open Enrollment. If you enroll them at a later date, their coverage will become effective the first day of the month following enrollment. In the absence of a qualifying event, you may only enroll dependents for health coverage during Open Enrollment; coverage will be effective on the first day of the following plan year. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent. See page 26 for details.

If you are adding a dependent to your existing dependent life insurance policy at a date later than the two calendar months following a qualifying event, coverage will not become effective until medical information has been submitted to and approved by PEIA's life insurance carrier. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent. See page 26 for details.

Dependents may be removed from coverage during Open Enrollment or at the time of a qualifying event. To make a change as a result of a qualifying event, you must do so during the month of the event or the following two calendar months or you will have to wait until the next Open Enrollment. Qualifying events which end eligibility (such as divorce) must be reported immediately. The policyholder must provide documentation supporting the qualifying event to remove dependents. Coverage of removed dependents will terminate at the end of the month in which the policyholder removes them from coverage. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce.

PEIA PPB Plan/Special Medicare Plan/PEIA's Medicare Advantage Plan

For the PPB Plan, the Special Medicare Plan or PEIA's Medicare Advantage Plan, you must enroll new dependents during the calendar month of, or the two calendar months following, the date of the qualifying event that makes them eligible (i.e., date of marriage, date of birth or adoption) even if you already have family coverage. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent. See page 26 for details. In the absence of a qualifying event, coverage may be added for the employee and/or eligible dependents, only during PEIA's annual Open Enrollment period.

Life Insurance

Add newly acquired dependents to your existing dependent life insurance policy (Plan 1) 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). Coverage greater than Plan 1 requires you to submit medical information and be approved to obtain dependent life insurance coverage. Dependent Plan 5 always requires completion of medical information to obtain approval.

Special Rules for Newborn or Adopted Children

Newborn Child

When you have a child, you must:

- provide documentation;
- PEIA will accept the Certificate of Live Birth from the hospital as documentation to enroll the child initially, but you must provide the Birth Certificate as soon as you have it or PEIA will suspend the child's coverage until we receive it;
- 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 or to PEIA.

To enroll the child for health coverage you must:

- enroll your biological newborn child for health coverage during the calendar month of birth or the two following calendar months;
- coverage will be made effective retroactive to the date of birth;
- any premium increase associated with the addition of this child will also be retroactive to the month of birth; and
- if you do not enroll your newborn within this time frame, you cannot add the newborn child until the next Open Enrollment period.

To enroll the child for life insurance coverage you must:

- add a biological newborn child to your existing dependent life insurance policy during the calendar month of or two calendar months following the date of birth;
- coverage will be made effective retroactive to the date of birth;
- any premium increase associated with the addition of this child will also be retroactive to the month of birth;
- if you add the child later, you will have to submit medical information and be approved to obtain dependent life insurance coverage for your child.

Adopted Child

When you adopt a child, you must:

- provide documentation;
- PEIA requires a copy of the adoption papers to enroll the child;
- In the case of a foreign adoption, PEIA requires adoption papers in English, and may require entry visa and/or statement from the U.S. consulate in the country of origin recognizing the adoption.

To enroll the child for health coverage you must:

- enroll an adopted child during the calendar month the child is placed in your home or the two following calendar months;
- coverage will be effective retroactive to the date of placement;
- any premium increase associated with the addition of this child will also be retroactive to the date of placement;
- 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;
- if you do not enroll your child within this timeline, the adopted child cannot be added to your coverage until the next Open Enrollment period.

To enroll the child for life insurance coverage you must:

- add an adopted child to your existing dependent life insurance policy (Plans 1-4) during the calendar month of or the two calendar months following the date of placement in your home;
- coverage can be made effective retroactive to the date of placement;
- any premium increase associated with the addition of this child will also be retroactive to the date of placement;
- If you add the child later, or elect Plan 5, you will have to submit medical information and be approved to obtain dependent life insurance coverage for your adopted child.

Eligibility and Enrollment for Surviving Dependents

Who is Eligible

The surviving spouse or dependent of an active or retired public employee who was insured as a spouse or dependent under the policyholder's coverage by PEIA at the time of the policyholder's death, may elect to continue health coverage as a policyholder in his or her own right under the health plan using a Surviving Dependent enrollment form available from PEIA.

If you are such a surviving spouse and you choose not to enroll immediately for coverage, you may elect PEIA health coverage during a future Open Enrollment Period if you have not remarried. The surviving spouse's eligibility for PEIA coverage terminates upon remarriage. The surviving spouse is required to report any remarriage immediately. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. remarriage of surviving spouse. If a divorce occurs after the remarriage, re-enrollment as a surviving dependent is not allowed.

Dependent Children

- surviving dependent children are eligible to continue health coverage, if they were enrolled in the health coverage at the time of the policyholder's death, subject to the same age restrictions as other dependent children in the PEIA plan;
- the deceased policyholder's biological or adopted children and/or stepchildren may continue coverage to age 26;
- other children for whom the deceased policyholder was the court-appointed guardian to may continue coverage to age 18;
- surviving dependent biological children, adopted children, or stepchildren may be covered under the plan to age 26, regardless of their residency, marital status, or the availability of other insurance coverage. The dependent child's marriage is a qualifying event to cancel PEIA coverage. A married surviving dependent child may not enroll his or her spouse for PEIA coverage.

From time to time PEIA may conduct eligibility audits to verify that policyholders and dependents in the plan qualify for coverage. If you are audited, you will have to produce documentation for the dependent in question. If you cannot prove that the dependent qualifies for coverage, coverage will be terminated retroactively to the date the dependent would otherwise have been terminated, and PEIA will pursue reimbursement of any medical or prescription drug claims paid during the time the dependent was ineligible.

How to Enroll

To continue health coverage without interruption, surviving dependents must complete enrollment forms in the calendar month death occurs or the two following calendar months. In this case, 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.

In the event of the death of the employee spouse who is the policyholder in the PEIA Plan, when the surviving dependent is also an active or retired public employee who is benefit-eligible in his or her own right, the surviving dependent has a choice to make. He or she must choose whether to enroll in the PEIA Plan as a surviving dependent of the policyholder, or as an active or retired employee.

If you enroll as a surviving dependent before July 1, 2015, premiums will be based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium with 25 or more years of service, but the surviving dependent is not eligible for life insurance.

If you enroll as a surviving dependent on or after July 1, 2015, premiums will be based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium and the years of service, but the surviving dependent is not eligible for life insurance.

If enrolled as an active or retired employee, premiums will be based on the appropriate active employee premium chart or, if retired, the surviving employee's own years of service, and he or she will be eligible for life insurance.

If you need help evaluating which would be better, please contact PEIA's customer service unit at 1-888-680-7342.

Special Eligibility Situations

If You and Your Spouse are Both Public Employees

Two public employees who are married to each other and 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 same 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.

To qualify for the Family with Employee Spouse premium, both employees MUST have basic life insurance. For active employees, the premium for Family with Employee Spouse coverage is based on the average of the two employees' salaries. The Family with Employee Spouse discount is also offered when the 'employee spouse' is a retired public employee; the premium for this coverage is based on the active employee's salary.

Generally, since both spouses, as policyholders, are eligible to make independent benefit elections, both spouses receive the Shopper's Guide, Summary Plan Description, and other relevant benefit information.

It the employee spouse on an active employee's plan is retired and Medicare-eligible, that employee spouse may want to consider becoming a "policyholder only" in PEIA's Medicare Advantage plan. Doing so could reduce your total premium and cost-sharing, depending on your situation.

In the event of the death of the employee spouse who is the policyholder in the PEIA Plan, when the surviving dependent is also an active or retired public employee who is benefit-eligible in his or her own right, the surviving dependent has a choice to make. He or she must choose whether to enroll in the PEIA plan as a surviving dependent of the policyholder, or as an active or retired employee.

If you enroll as a surviving dependent before July 1, 2015, premiums will be based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium with 25 or more years of service, but the surviving dependent is not eligible for life insurance.

If you enroll as a surviving dependent on or after July 1, 2015, premiums will be based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium and the years of service earned by the deceased policyholder, but the surviving dependent is not eligible for life insurance.

If enrolled as an active or retired employee, premiums will be based on the appropriate active employee premium chart or if retired, the surviving employee's own years of service, and he or she will be eligible for life insurance.

If you need help evaluating which would be better, please contact PEIA's customer service unit at 1-888-680-7342.

Transfer from One Participating Agency to Another

If you transfer from one participating agency to another in the middle of a plan year without a lapse in coverage, that transfer does not constitute a qualifying event to change coverage. 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 Plans A, B and C have an unlimited enrollment area, you will not be permitted to transfer out of them during the plan year, even if you move. PEIA PPB Plan D is available only to WV residents, so if you move outside the state you will be required to change plans.

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. In this case, a plan change may be permitted, if the transfer creates a qualifying change in family status under the Premium Conversion Plan. Other transfers may permit a change in coverage based on documented financial hardship.

Disabled Child

Your dependent child may continue to be covered after reaching age 26 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 26;
- the child must have been covered by PEIA upon reaching age 26; and
- the child must be incapable of self-sustaining employment and chiefly dependent on you for support and maintenance. To continue this coverage, the WV PEIA Disabled Dependent Disability Application must be obtained from PEIA, completed by a licensed physician, and returned to PEIA with all supporting medical records, between 2-3 months prior to the dependent's 26th birthday, to prevent a potential lapse in coverage.

Court-Ordered Dependent (COD)

If a PEIA policyholder and his or her spouse divorce, and the policyholder 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 noncustodial 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 or the dependent of an active employee becomes eligible for Medicare and has no other insurance, the PEIA PPB Plan remains the primary insurer, except if the policyholder or dependent attains Medicare eligibility due to End Stage Renal Disease (ESRD). As long as you are an active employee, you and your Medicare-eligible dependents are not required to sign up for Medicare Part B and pay the premium. When you prepare to retire, you and your Medicare-eligible dependents must enroll for Medicare Part B. If you do not enroll in Medicare Parts A and B, your coverage may be terminated.

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, which means that once Medicare has paid, PEIA will pay the balance up to 100 % of Medicare's allowed amount.

When you or your dependent become eligible for Medicare, you must send a copy of the Medicare card to PEIA.

Medicare-eligible Members Who Reside Outside the U.S.

Medicare-eligible retirees who reside outside the United States will have benefits through PEIA's Special Medicare Plan. Medicare claims will be processed by UMR, and PEIA will pay only the amount we would have paid if Medicare had processed your claim and made a payment. Prescription drug claims will be processed by CVS Caremark.

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 the 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 the 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

Qualifying Events

A qualifying event is a personal change in status which may allow you to change your benefit elections, whether you or your employer participate in an IRS Section 125 plan, or not. Qualifying events which end eligibility (such as divorce) must be reported immediately. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce.

All qualifying events require substantiating documentation, which must be provided in English, as detailed in the chart below:

Qualifying Event	Documentation Required
Divorce	Copy of the divorce decree showing that the divorce is final
Marriage (of policyholder or dependent)	Copy of valid marriage license or certificate – the dependent child's marriage is a qualifying event for the policyholder to remove the dependent child from coverage. The policyholder MAY remove the child but is not required to do so.
Birth of Child	Copy of child's birth certificate
Adoption	Copy of adoption papers
Adding coverage for a dependent child	Copy of child's birth certificate
Adding coverage for any other child who resides with policyholder	Copy of court-ordered guardianship papers
Open Enrollment under spouse's or dependent's employer's benefit plan	Copy of printed material showing Open Enrollment dates and the employer's name
Death of spouse or dependent	Copy of death certificate
Beginning of spouse's or dependent's employment	Letter from the spouse's employer stating the hire date, effective date of insurance, what coverage was added, and what dependents are covered
End of spouse's or dependent's employment	Letter from the employer stating the termination or retirement date, what coverage was lost, and dependents that were covered
Significant change in health coverage due to spouse's or dependent's employment	Letter from the insurance carrier indicating the change in insurance coverage, the effective date of that change and dependents covered
Unpaid leave of absence by employee, spouse or dependent	Letter from your or your spouse's or your dependent's personnel office stating the date the covered person went on unpaid leave or returned from unpaid leave
Change from full-time to part-time employment or vice versa for policyholder, spouse or dependent	Letter from the employer stating the previous hours worked and the new hours worked and the effective date of the change

All documents used in support of eligibility transactions: birth certificates, adoption papers, marriage certificates, divorce decrees, and citizenship documents (Visas, permits, residency documents, etc.), must be in English or have a certified English translation.

If you experience a qualifying event, you have the month of the event and the two following calendar months to act upon that qualifying event and change your coverage. If you do not act within that time frame, you cannot make the change until the next Open Enrollment. Qualifying events which end eligibility (such as divorce) must be reported immediately. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce.

Annual Open Enrollment

Each Spring PEIA holds an Open Enrollment period for active employees and non-Medicare retirees for health coverage. The period is typically the month of April. During Open Enrollment, current active employee and non-Medicare retiree participants may move between plans and make eligibility changes, such as adding or removing dependents or adding or dropping coverage. 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 any PEIA PPB Plan or any managed care plan, subject to the deadlines and rules in force for that enrollment period. 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 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.

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

Medical Identification Cards

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. New PEIA PPB Plan ID cards have been issued for all PPB members for Plan Year 2020 due to the transition to PEIA's new third-party administrator, UMR.

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. Members will receive one card for individual coverage, and two cards for family coverage in the policyholder's name. If you want additional cards, or if you need to replace a lost card, please contact UMR at 1-888-440-7342.

If you enroll in a managed care plan or if you are in PEIA's MAPD 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 or PEIA immediately of any changes in your participation status or in your family situation and make the appropriate change to keep your PEIA coverage up to date. Examples of such changes include retirement or disability retirement, a change of address, a change in your marital status, or a dependent child no longer qualifying for coverage.

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

You can update your enrollment records at any time by logging on to the PEIA website at www.wvpeia.com and clicking on the green "**Manage My Benefits**" button. If you do not have internet access, you may update your records using a form available from your benefit coordinator or by calling PEIA. Completed forms should be returned to your benefit coordinator.

When Coverage Ends

Coverage for a policyholder and/or dependent(s) will end at the end of the month in which the individual is no longer enrolled for or eligible for coverage. In most cases when your coverage 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" on page 30.

Voluntary Termination of Employment

PEIA coverage for an active policyholder and any covered dependents terminates at the end of the month in which the employee voluntarily ceases employment. For employees on delayed payroll, coverage will terminate at the end of the month in which their employment terminates, although they may continue to receive paychecks due to their delayed payroll status.

Involuntary Termination of Employment

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 employer must continue to pay the employer's share of the premium during these three months. The policyholder will be responsible for paying the employee's share of the premium during these three months.

Termination for Misconduct

If an employee is discharged for misconduct and chooses to contest the charge, he or she may extend coverage for up to 3 months while available administrative remedies are pursued. If the discharge is upheld, the former employee must reimburse the employer's share of the premium cost for the extended coverage to the former employer.

Voluntary Termination of Benefits

PEIA coverage for an active policyholder and any covered dependents terminates at the end of the month in which the employee voluntarily terminates the coverage; provided that the employee has experienced a qualifying event that allows such termination. Qualifying events which end eligibility (such as divorce) must be reported immediately. For purposes

of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce. In the absence of a qualifying event, coverage cannot be terminated until the next Open Enrollment period.

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, provided that the retired employee has experienced a qualifying event that allows such termination. In the absence of a qualifying event, coverage cannot be terminated until the next Open Enrollment period.

For retiring employees, coverage will terminate at the end of the month in which the employee ceases active employment, unless forms have been completed to continue coverage. 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 PEIA's Medicare Advantage plan or the Special Medicare 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 his/her 26th birthday;
- surviving spouse remarries;
- child for which policyholder is legal guardian reaches his/her 18th birthday;
- disabled dependent no longer meets disability guidelines; or
- policyholder voluntarily removes dependent from coverage.

The policyholder is required to report these events online at www.wvpeia.com using the "**Manage My Benefits**" button, or by completing the appropriate forms to remove ineligible dependents. Qualifying events which end eligibility (such as divorce) must be reported immediately. If a policyholder fails to remove ineligible dependents (divorced spouse, etc.) the Plan may pursue reimbursement of any claims paid for the ineligible dependent from the employee. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce.

The policyholder may voluntarily terminate coverage for dependents when there has been a qualifying event to allow such a change. To make a change as a result of a qualifying event, you must do so during the month of the event or the following two calendar months or you will have to wait until the next Open Enrollment. Qualifying events which end eligibility (such as divorce) must be reported immediately. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce. Go to www.wvpeia.com and use the "**Manage My Benefits**" button or complete the appropriate forms. If coverage is terminated, it cannot be reinstated until the next Open Enrollment period, unless there is a qualifying event.

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 30 days following the due date, all coverage may be suspended. If payment is not received within 45 days following the due date, health and life insurance coverage will be cancelled, and all medical and prescription drug claims incurred will be your personal responsibility. Canceled life insurance cannot be reinstated, even if past-due premiums are paid.

The cancellation is permanent, and you will need to seek life insurance from another provider. PEIA will also submit premiums over-due by 45 days to a collection agency.

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. PEIA requires a written 30-day notice of a Non-State Agency's intent to terminate its contract with PEIA.

Eligible retirees may continue participation in PEIA. The withdrawn agency is billed a non-participating agency premium for these retirees. Retirees not eligible to participate in PEIA must look to their former employer for retiree coverage.

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 UMR, and all COBRA eligibility is maintained by UMR. New enrollees in any PEIA-sponsored health plan will receive a detailed notice of their COBRA rights from UMR.

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 starting from the latest of:

(1) the date on which the qualifying event occurs;
(2) the date on which you lose (or would lose) coverage under the plan due to the qualifying event; or
(3) the date on which you are informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and procedures for doing so.

To enroll for COBRA benefits, contact UMR 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.

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 Securian Financial at 1-800-203-9515. The individual life insurance policy is issued by PEIA's life insurance carrier, Securian Financial. 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 Plans. 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 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 5th. If payment is not received by PEIA within 30 days following the due date, all coverage may be suspended. If payment is not received within 45 days following the due date, coverage will be cancelled, and all claims incurred will be your personal responsibility. PEIA will also submit premiums overdue by 45 days to a collection agency.

Tobacco-free Premium Discount

All health and optional life insurance premiums are based on the tobacco-use status of insureds. Tobacco-free insureds receive the preferred monthly premium rate. 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. From time to time, the tobacco-free waiting period may be adjusted, and members will be notified in writing.

If your doctor certifies on a form provided by the PEIA, that it is unreasonably difficult due to a medical condition for you to become tobacco-free or it is medically inadvisable for you to become tobacco free, PEIA will work with you

for an alternative way to qualify for the tobacco-free discount. Send all such doctors' certifications and requests for alternative ways to receive the discount to: **PEIA Discount Alternatives, 601 57th St., SE, Suite 2, Charleston, WV 25304-2345.**

For family health 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 "Tobacco Cessation" on page 65 for details.

Once a member has submitted a tobacco affidavit, PEIA will rely upon that affidavit from year to year, unless the member submits a replacement. It is not necessary for members to submit a tobacco affidavit each year, although PEIA may, periodically, require policyholders to update their tobacco status during Open Enrollment. Instructions for updating tobacco status, if required, will be provided in the Shopper's Guide.

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. Apply online at www.wvpeia.com; click on the green "**Manage My Benefits**" button at the top right of the page. Affidavits completed online are processed immediately, and the discount becomes effective on the first day of the following month. When using a paper affidavit, 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 to future premiums and WILL NOT be applied retroactively. No refunds will be granted based on tobacco status.

Newly hired insureds must have been tobacco-free for 6 months prior to their effective date of coverage to qualify for the discount and must complete the tobacco affidavit online or on paper to receive the discount.

Advance Directive/Living Will

PEIA no longer offers a discount for having an Advance Directive/Living Will, but encourages members to have an Advance Directive/Living Will and to discuss it with their family and health care providers.

Determining Monthly Premiums

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 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.

If you are a member of the West Virginia Legislature, a member of the West Virginia Board of Education, or an elected member of a county board of education, you must pay 100% of the premium for any coverage you elect.

Retired Employees

Premiums for retired employees are determined based on a number of factors, including hire date and retirement date. See more information below. Premiums for most retired employees are deducted from their annuity on a monthly basis. Some retired employees pay premiums directly to 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 5th.

Employees Hired on or After July 1, 2010

Employees hired on and after July 1, 2010, will not receive any plan subsidy of their health insurance premiums at retirement. These employees may continue coverage in the plan at retirement but must pay the unsubsidized premium for the coverage of their choice. Two exceptions are made to this rule:

- Active employees hired before July 1, 2010, who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2010) hire date.
- Retired employees who had an original hire date prior to July 1, 2010, may return to active employment and retain their pre-July 1, 2010, original hire date for purposes of determining their eligibility for premium subsidy.

Retirees from non-state entities which employers joined the PEIA Plan on or after July 1, 2010, will also receive no premium subsidy and must pay the full cost of their participation in the plan. Such non-state retirees will be assigned a "hire date" in the PEIA systems which is the same as the date they enroll in PEIA as an active employee.

Regardless of any other discussion of premium subsidy later in this section, employees hired on or after July 1, 2010, who don't meet one of the two exceptions above, will not receive any premium subsidy for years of service or any other factor.

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, but NOT their years of service. These retirees are not subject to the "years of service" policy. For premium purposes, employees who retired prior to July 1, 1997, fall into the "25 or more" years of service category on PEIA's premium charts. 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. 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 the premium will be covered by your accrued leave. The amount of sick and/or annual leave accrued by the retiring employee will be reported by the benefit coordinator at the agency from which the employee is retiring. Disability retiree premiums are assessed on twenty-five (25) years of service.

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.

Premiums charged to surviving dependents are determined by when the surviving dependent enrolls:

- For surviving dependents enrolled before July 1, 2010, premiums are based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium for "25 or more years of service."
- For surviving dependents enrolled on or after July 1, 2015, premiums are based on the Medicare or non-Medicare (depending on the survivor's age) retiree premium and the years of service earned by the deceased policyholder.

Premiums for surviving dependents are deducted from their annuity on a monthly basis or are paid directly to PEIA.

Extending Employer-Paid Insurance upon Retirement

You may be eligible to extend your employer-paid insurance upon retirement, but how you do that depends upon your employer. To take advantage of this benefit, you must move directly from active public employment into your respective retirement system. You must use your leave at the time of retirement. You may not save the leave for use later. If you choose to separate from employment and defer your retirement, you cannot defer your sick and/or annual leave or years of teaching service 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

If you are an employee of a PEIA-participating employer (State agency, county board of education, local agency, college or university) with coverage through PEIA and have accrued sick and/or annual leave when you retire, you may use that accrued leave to extend your employer-paid insurance coverage. You must be enrolled in a PEIA PPB plan or a PEIA-sponsored managed care plan or the group life insurance plan offered by PEIA prior to your retirement to qualify. This extended coverage must be for full months, and the leave must be used immediately at the time of retirement. 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.

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.

Calculating Your Benefit

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

Before July 1, 1988:

If you elected to participate in the plan before July 1, 1988, and have been continuously covered by PEIA since that time, then your extended employer-paid 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 elected to participate in the plan after July 1, 1988, and before July 1, 2001, or if you had a lapse in coverage during this period then your extended employer-paid 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 elected to participate in the plan 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

This benefit is not available to faculty hired on or after July 1, 2009.

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

This benefit is not available to faculty hired on or after July 1, 2009.

Retired Employee Assistance Programs

Retired employees whose total annual income is less than 250% of the federal poverty level (FPL) 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 called the Retired Employee Premium Assistance program. Applicants must be enrolled in the PEIA PPB Plan, the Special Medicare Plan or PEIA's Medicare Advantage 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 retired employees with health coverage each spring. Medicare-eligible retirees with 15 or more years of service who qualify for Premium Assistance may also qualify for Benefit Assistance. Benefit Assistance reduces the medical and prescription out-of-pocket maximums and most copayments. It is described in detail in the Evidence of Coverage provided by PEIA's Medicare Advantage Plan. For additional detail or for a copy of the application, call PEIA's customer service unit at 1-888-680-7342.

The amount of assistance for which you are eligible is based on years of active service and percentage of FPL. 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.

Following is a chart that shows the premium reductions provided under the Retired Employee Premium Assistance program.

Policyholder Only Monthly Premium Reduction				
This amount will be deducted from your monthly premium for Medicare or non-Medicare coverage. If the amount of the reduction is greater than the premium due, then the premium due will be $0.				
Years of Service	< 100% of FPL	100-150% of FPL	150-200% of FPL	200-250% of FPL
5-14	$51	$34	$19	$13
15-24	$65	$50	$31	$19
25+	$88	$74	$46	$24
Policyholder with Dependents Monthly Premium Reduction				
This amount will be deducted from your monthly premium for Medicare or non-Medicare coverage. If the amount of the reduction is greater than the premium due, then the premium due will be $0.				
Years of Service	<100% of FPL	100-150% of FPL	150-200% of FPL	200-250% of FPL
5-14	$76.50	$51.00	$28.50	$19.50
15-24	$97.50	$75.00	$46.50	$28.50
25+	$132.00	$111.00	$69.00	$36.00

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. 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 following example 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

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 include:

- 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
- 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/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.

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, use PEIA's online enrollment site, "**Manage My Benefits**" or get a Change-in-Status form from your benefit coordinator. ALL changes require additional documentation.

Health Care Benefits

Active employees may get health care benefits through PEIA from a managed care plan or from one of the PEIA PPB Plans. Non-Medicare retirees and surviving dependents may get health care benefits through PEIA from a managed care plan or from PEIA PPB Plan A or B, although Plan B is only available when all enrolled dependents are non-Medicare. Medicare-eligible members of the Special Medicare Plan also receive their benefits through PEIA. PEIA PPB Plans C and D are not offered to retirees.

Most Medicare-eligible retired employees and Medicare-eligible dependents of retired employees are covered by PEIA's Medicare Advantage plan, so the benefits described here do not apply to them.

If you choose to receive your benefits from a managed care plan, you must enroll with PEIA and choose a plan. Refer to the information provided by the managed care plan for details of your benefits.

If you choose the PEIA PPB Plan C, your benefits are described on the following pages. For more information about Plan A, B or D, download Summary Plan Description (Plans A, B & D) at www.wvpeia.com or call 1-888-680-7342.

PEIA PPB Plan C

The PEIA PPB Plan C pays for a wide range of health care services for employees and their dependents. These benefits include hospital services, medical services, surgery, durable medical equipment and supplies, and prescription drugs.

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

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

- Medical claims and benefits – UMR at 1-888-440-7342.
- Precertification, pre-authorizations, case management or prior approval for out-of-state care and maternity management—UMR at 1-888-440-7342.
- Prescription drug claims and benefits – CVS Caremark at 1-844-260-5894.
- Common Specialty Medication claims and benefits – CVS Caremark Specialty Medication Program at 1-844-260-5894.
- Specialty Injectable Drug claims and benefits – UMR at 1-888-440-7342

PEIA's Networks

The PEIA PPB Plan C provides care through several networks of providers. In West Virginia, any properly licensed 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, PEIA uses the UnitedHealthCare Plus PPO to provide care for members of PEIA PPB Plans A, B and C. The UnitedHealthCare Plus PPO contracts with some out-of-state providers to serve PEIA PPB Plans A, B and C participants only. To locate a network provider, call UMR at 1-888-440-7342.

PEIA also offers PPB Plans A, B and D. For more information about Plans A, B and D, download the Summary Plan Description (Plans A, B and D) at www.wvpeia.com or call 1-888-680-7342.

Care provided outside West Virginia, even by network providers, costs more. Outside West Virginia, even with the discount contracts we have with network providers, PEIA cannot control its costs as it can inside West Virginia. Therefore, your out-of-pocket costs will be higher if you use providers outside the state of West Virginia.

Not all providers in the UnitedHealthCare Plus PPO network may participate with PEIA. Kings Daughters Medical Center and Our Lady of Bellefonte hospitals in Kentucky remain out-of-network for PEIA, regardless of their network status with the PPO network. Also, PEIA does not use the PPO network in Washington County, Ohio, (including Marietta Memorial Hospital) or Boyd County, Kentucky. PEIA reserves the right to remove providers from the network, so not all providers listed in the network may be available to you.

Sanctioned Providers

Providers, both in and out of state, who are under sanction by Medicare, Medicaid or both are excluded from PEIA's network for the duration of their sanction. Additionally, providers may be excluded from PEIA's network based upon adverse audit findings. If you have questions about a specific network provider, please contact UMR at 1-888-440-7342.

Resident PPB Plan Participants

PEIA PPB Plan C 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:

- 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.

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

Non-Resident PPB Plan Participants

For PEIA PPB Plan C 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.

Non-Network Providers

For Plan C, care provided by non-network providers requires prior approval by UMR, or it will be paid at the out-of-network benefit level.

What You Pay with PEIA PPB Plan C

Deductible

During any plan year, if you or your eligible dependents incur expenses for covered medical services and prescription drugs, you must meet a deductible before the plan begins to pay. In Plan C, the deductible is a combined medical and prescription drug deductible, so amounts paid for covered medical services and prescription drugs accumulate toward the same deductible.

Deductibles are determined based on your tier of coverage (i.e., individual or family). All members of the family contribute to the family deductible, and the full amount of the family deductible must be met before the plan begins to pay. The family deductible can be met by just one person.

The deductibles for PEIA PPB Plan C are:

Employee Only	$1,350
Employee and Children	$2,700
Family	$2,700
Family with Employee Spouse	$2,700

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, 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.

Coinsurance for In-Network and Out-of-Network Benefits for PEIA PPB Plans

	If you live in WV, you will pay:	If you live in a bordering county of a surrounding state, you will pay:	If you live out-of-state (beyond bordering counties), you will pay:
Access care in WV or in a bordering county of a surrounding state using PPO providers	20% coinsurance	20% coinsurance	20% coinsurance
Access care outside WV (beyond bordering counties) using PPO providers with prior approval*	20% coinsurance	20% coinsurance	20% coinsurance
Access care outside WV (beyond bordering counties) using non-PPO providers with prior approval*	20% coinsurance + amounts that exceed PEIA's allowed amount	20% coinsurance + amounts that exceed PEIA's allowed amount	20% coinsurance + amounts that exceed PEIA's allowed amount
Access care outside WV (beyond bordering counties) using PPO providers without prior approval*	20% coinsurance + amounts that exceed PEIA's allowed amount	20% coinsurance + amounts that exceed PEIA's allowed amount	20% coinsurance + amounts that exceed PEIA's allowed amount
Access care outside WV using non-PPO providers without prior approval*	20% coinsurance + amounts that exceed PEIA's allowed amount	20% coinsurance + amounts that exceed PEIA's allowed amount	20% coinsurance + amounts that exceed PEIA's allowed amount

*Prior approval is generally only provided if services are not available in West Virginia.

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 deductible, 20% coinsurance, and non-covered services.

Out-of-network care is care provided by a provider who does not participate in PEIA's network, as well as care from in-network, out-of-state providers (beyond the bordering counties of surrounding states) that is not approved in advance. This includes providers who are UMR's participating providers that are physically located beyond the bordering counties of surrounding states. For care from in-network, out-of-state providers (beyond the bordering counties of surrounding states) that is not approved in advance, you will be responsible for paying 20% coinsurance based on UMR's contracted amount. Since this is considered out-of-network care, and there is no out-of-network out-of-pocket maximum, there is no limit to the amount you may be required to pay under these circumstances.

For non-contracted providers, PEIA will pay 80% of what it would have paid if the services had been provided in West Virginia. You will be responsible for the deductible, 20% coinsurance and for any amounts that exceed the WV PEIA fee allowances. Those balance billing amounts are considered non-covered services, so they do not count toward the deductible, and there is no out-of-network out-of-pocket maximum, so there is no limit to the amount you may be required to pay under these circumstances. Members are always responsible for paying 100% of non-covered services.

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 UMR 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

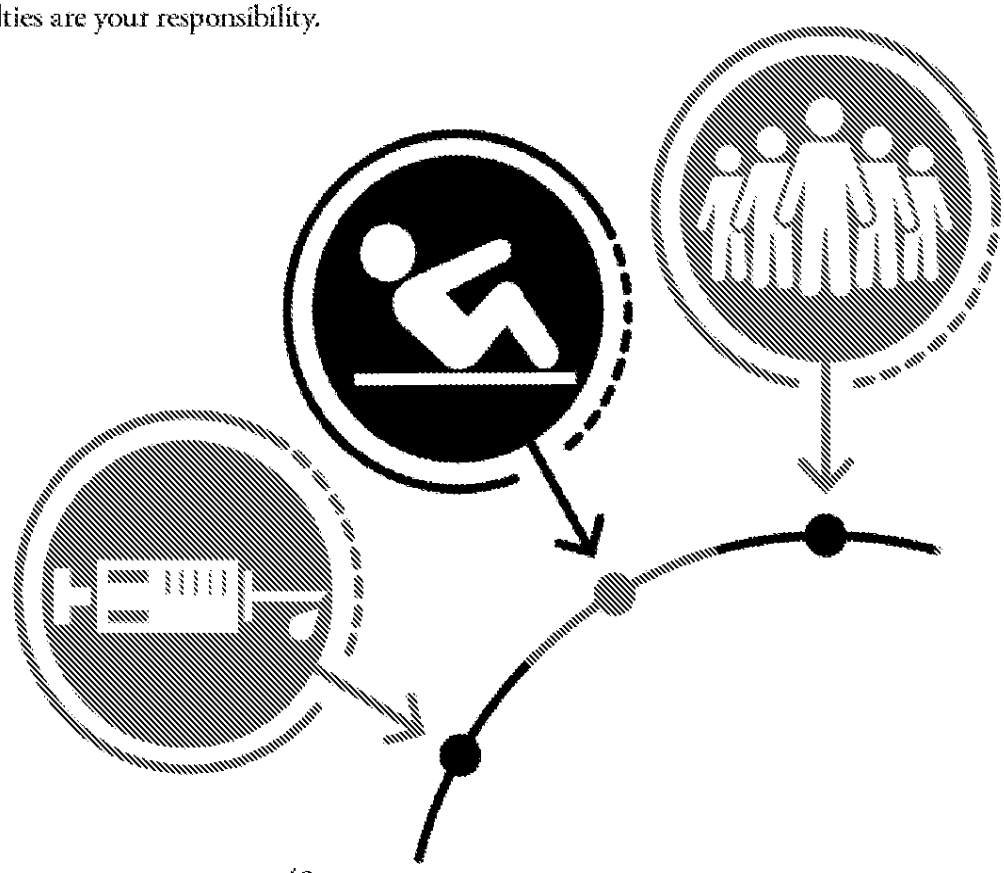
PEIA PPB Plan participants who reside outside West Virginia and beyond the bordering counties may access care using any network provider without prior approval, and the claims will be paid at 80% of the contracted payment rate. You will be responsible for any deductible, 20% coinsurance, and non-covered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

Care provided by non-network providers must have prior approval. Services of non-network providers will be paid at 80% of PEIA's maximum allowance and must be approved by UMR in advance. Precertification requirements apply for inpatient stays and certain outpatient procedures. Emergency services provided by non-network providers are paid at 80% of the Reasonable and Customary amount for professional claims and 80% of the charge amount for facility claims.

Out-of-network care is care provided by a provider who does not participate in PEIA's network, as well as care from in-network, out-of-state providers (beyond the bordering counties of West Virginia's surrounding states) that is not approved in advance. This includes providers who are UMR's participating providers that are physically located beyond the bordering counties of surrounding states. For care from in-network, out-of-state providers (beyond the bordering counties of West Virginia's surrounding states) that is not approved in advance, you will be responsible for paying 20% coinsurance based on the UMR's contracted amount. Since this is considered out-of-network care, and there is no out-of-network out-of-pocket maximum, there is no limit to the amount you may be required to pay under these circumstances.

For non-contracted providers, PEIA will pay 80% of what it would have paid if the services had been provided in-West Virginia. You will be responsible for the deductible, 20% coinsurance and for any amounts that exceed the WV PEIA fee allowances. Those balance billing amounts are considered non-covered services, so they do not count toward the deductible, and there is no out-of-network out-of-pocket maximum, so there is no limit to the amount you may be required to pay under these circumstances. Members are always responsible for paying 100% of non-covered services.

Please consult the preceding chart to determine your level of coinsurance based on where you reside, where you receive your services, and whether or not you obtain prior approval. Charges for non-covered services and applicable plan penalties, such as precertification penalties are your responsibility.



Covered in Full

The following services are covered in full in-network for all PEIA PPB Plans:

Type of Service	Frequency
Covered Preventive Services for Adults *AWV=Annual Wellness Visit	
Abdominal Aortic Aneurysm one-time screening for men aged 65-75 who have ever smoked	Once per lifetime
Alcohol Misuse screening and counseling	Included in AWV
Aspirin use for men and women of certain ages (requires a prescription; covered under prescription drug plan)	As Needed
Blood Pressure screening for all adults	Included in AWV
Cholesterol screening for men age 35 and older and women age 45 and older or others at higher risk	Included in AWV
Colorectal Cancer screening for adults over 50	See Colorectal Cancer Screening, page 52
Depression screening for adults	Included in AWV
Type 2 Diabetes screening for adults with high blood pressure	Included in AWV
Diet counseling for adults at higher risk for chronic disease	Included in AWV
Hepatitis B screening for people at high risk	As Needed
Hepatitis C screening for everyone born between 1945-1965 and people at high risk	As Specified
HIV screening for all adults at higher risk	Annually
Immunization vaccines for adults—doses, recommended ages, and recommended populations vary: Hepatitis A Hepatitis B Herpes Zoster Human Papillomavirus Influenza (Flu Shot) Measles, Mumps, Rubella Meningococcal Pneumococcal Tetanus, Diphtheria, Pertussis Varicella	As Recommended by the American Academy of Family Physicians
Lung cancer screening for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years	As Specified
Obesity screening and counseling for all adults	Included in AWV
Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk	Included in AWV
Tobacco Use screening for all adults and cessation interventions for tobacco users (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	See Tobacco Cessation, page 65
Syphilis screening for all adults at higher risk	Annually
Covered Preventive Services for Women, Including Pregnant Women	
Anemia screening on a routine basis for pregnant women	As Needed
Bacteriuria urinary tract or other infection screening for pregnant women	As Needed
BRCA counseling about genetic testing for women at higher risk	As Needed
Breast Cancer Mammography screenings every 1-2 years for women over 40	Every 1-2 years
Breast Cancer Chemoprevention counseling for women at higher risk	Once per lifetime
Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women	As Needed
Cervical Cancer screening for sexually active women	Annually
Chlamydia Infection screening for younger women and other women at higher risk	Annually

Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling (generic oral contraceptives require a prescription; covered under the prescription drug plan)	As Needed
Domestic and interpersonal violence screening and counseling for all women	Included in AWV
Folic Acid supplements for women who become pregnant (requires a prescription; covered under prescription drug plan)	As Needed
Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes	Once per pregnancy
Gonorrhea screening for all women at higher risk	Annually
Hepatitis B screening for pregnant women at their first prenatal visit	Once per pregnancy
Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women	Annually
Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older	Every 3 years
Osteoporosis screening for women over age 60 depending on risk factors	Annually after age 60
Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk	As Needed
Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	See Tobacco Cessation, page 65
Sexually Transmitted Infections (STI) counseling for sexually active women	Included in AWV
Syphilis screening for all pregnant women or other women at increased risk	Annually
Well-woman visits to obtain recommended preventive services	Annually
Covered Preventive Services for Children (*WCC=Well Child Care)	
Alcohol and Drug Use assessments for adolescents	Included in WCC
Autism screening for children at 18 and 24 months	Included in WCC
Behavioral assessments for children of all ages Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Blood Pressure screening for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Cervical Dysplasia screening for sexually active females	Annually
Congenital Hypothyroidism screening for newborns	Once, for newborn
Depression screening for adolescents	Included in WCC
Developmental screening for children under 3, and surveillance throughout childhood	Included in WCC
Dyslipidemia screening for children at higher risk of lipid disorders Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	As specified
Fluoride Chemoprevention supplements for children without fluoride in their water source (requires a prescription; covered under the prescription drug plan)	As Needed
Gonorrhea preventive medication for the eyes of all newborns	Once, for newborn
Hearing screening for all newborns	Included in WCC
Height, Weight and Body Mass Index measurements for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Hematocrit or Hemoglobin screening for children	Once per lifetime
Hemoglobinopathies or sickle cell screening for newborns	Once, for newborn
HIV screening for adolescents at higher risk	Annually

Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis — Haemophilus Influenzae type B — Hepatitis A Hepatitis B — Human Papillomavirus — Inactivated Poliovirus Influenza (Flu Shot) — Measles, Mumps, Rubella — Meningococcal Pneumococcal — Rotavirus — Varicella	As Recommended by the American Academy of Pediatrics
Iron supplements for children ages 6 to 12 months at risk for anemia (requires a prescription; covered under the prescription drug plan)	As Needed
Lead screening for children at risk of exposure	As Needed
Medical History for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Obesity screening and counseling	Included in WCC
Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years	Included in WCC
Phenylketonuria (PKU) screening for this genetic disorder in newborns	Once, for newborn
Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk	Included in WCC
Tuberculin testing for children at higher risk of tuberculosis Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	As specified
Vision screening for all children	Included in WCC

Deductible and Coinsurance

Services not listed in the preceding chart are covered at 80% after the deductible is met. For out-of-state (beyond the bordering counties) or non-network care which is not approved in advance by UMR, you pay the deductible, 20% coinsurance, and the difference between what your provider chargers and what PEIA PPB Plan C pays. You pay the deductible, coinsurance, and any charges for services not covered by the plan directly to your health care provider.

Out-of-Pocket Maximum

The out-of-pocket maximum is the most you pay in deductible and coinsurance in a plan year. This is a combined medical and prescription out-of-pocket maximum. All in-network coinsurance and copayments count toward this out-of-pocket maximum. Once the out-of-pocket maximum is satisfied, in-network services are covered at 100% for the remainder of the plan year.

Amounts you pay for precertification penalties, for amounts billed in excess of what PEIA pays to non-network providers, and for services that are not covered under the plan do not apply toward your annual out-of-pocket maximum. Your out-of-pocket maximum amount depends on your tier of coverage (employee only or family), where you receive your services, whether your provider is in the PEIA PPO network, and whether you have prior approval for out-of-network care.

There is no out-of-pocket maximum for out-of-network benefits in Plan C. The out-of-network benefit remains at 80%, regardless of the amount paid in coinsurance and copayments by the member.

PEIA PPB Plan C Out-of-Pocket Maximums	In-Network	Out-of-Network
Employee Only	$2,500	None
Employee and Child(ren)	$5,000	None
Family	$5,000	None
Family with Employee Spouse	$5,000	None

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 catastrophic cases involving serious long-term illness or injury resulting in loss or impaired function requiring medically necessary therapeutic intervention, 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. All services listed below must be medically necessary; otherwise, they are not covered.

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)
Pain Management and Rehabilitative Outpatient Services	20 visits (total amount allowed for all therapies combined)
Inpatient Rehabilitation	150 Days
Skilled Nursing Facility	100 Days

Lifetime Maximum

The PEIA PPB Plan C has no lifetime maximum.

PEIA PPB Plan Fee Schedules and Rates

The PEIA PPB Plan C 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.

Many outpatient hospital services are also paid on a prospective basis. PEIA has adopted a modified version of Medicare's Outpatient Prospective Payment System (OPPS). OPPS reimbursement is based on Ambulatory Payment Classification (APC) groups. APCs include groups of services that are similar clinically, and require similar resources. These rates are adjusted annually.

Pre-Service Decisions

The PEIA PPB Plan C requires that certain services and/or items be reviewed in advance to determine whether they are medically necessary and being provided in the most appropriate setting by a network provider, if possible. PEIA has three different types of pre-service determinations: prior approval, precertification/notification and preauthorization which are described on the next few pages.

Important things to remember about pre-service decisions:

- Requests for pre-service decisions should be submitted to UMR, as early as possible, in advance of the service/item.
- Services or items may be approved or denied in whole or in part.
- One or more of the pre-service determinations may be required depending on the type of service or item.
- Check with UMR to see if your provider is in-network.

For example, a hospital admission, the procedure to be performed and/or each physician's services may require pre-service determinations, particularly if any of these is an out-of-state network provider, a non-network provider or the service is covered only under limited circumstances.

Each type of pre-service requirement is described below. If you have questions, please call UMR.

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

If you are in PEIA PPB Plan C and 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 the higher benefit (usually 80% of the contracted payment rate); you will be responsible for any deductible and 20% coinsurance.

For services for all members provided by non-network providers without prior approval, the plan will pay 80% of PEIA's maximum allowance. You will be responsible for any deductible and 20% coinsurance, as well as any amount which exceeds PEIA's maximum allowance. Amounts exceeding PEIA's maximum allowance are considered non-covered services. They do not count toward the deductible or out-of-pocket maximum.

Precertification/Notification Requirements

Precertification of certain services (Mandatory)

The PEIA PPB Plan C 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 documented medical condition.

Precertification is required for the following:

1. All admissions to out-of-state hospitals/facilities
2. All admissions to rehabilitation or skilled nursing facilities
3. Ambulance Service for Non-Emergency transport, including air ambulance
4. Any potentially experimental/investigational procedure, medical device, or treatment
5. Autism Spectrum Disorder services
6. Chelation Therapy
7. Continuous glucose monitors
8. Durable medical equipment purchases and/or rentals of $500 per month rental or $1500 per purchase or more
9. Elective (non-emergent) facility to facility air ambulance transportation

10. Electroconvulsive shock therapy (ECT) and Trans magnetic stimulation (TMS)
11. Heart Perfusion Imaging
12. Home health care and/or IV therapy in the home
13. Hyperbaric Oxygen Therapy (HBOT)
14. Limited Molecular Diagnostic/Genetic Testing used to diagnose or treat disease. Examples include:

    Hereditary Non-Polyposis Colorectal Cancer (HNPCC) testing, BRCA gene testing, Oncotype DX breast cancer assay, Familial Adenomatous Polyposis (FAP) testing, Catecholaminergic Polymorphic Ventricular Tachycardia (FPVT) testing
15. Inpatient Mental Health and substance abuse treatment
16. Outpatient CTA (CT angiography)
17. Outpatient Dialysis Services
18. Outpatient IMRT (intensity modulated radiation therapy)
19. Outpatient MRI scan of the breast or spine (includes cervical, thoracic, and lumbar)
20. Outpatient PET Scans
21. Oxygen rental and supplies, with the exception of oxygen concentrators
22. Partial/day mental health or substance abuse treatment programs
23. Sleep studies, services and equipment. See section on "sleep management services" on page 61
24. Specialty drugs provided in a physician's office, by a pharmacy or mail order
25. SPECT (single photon emission computed tomography) of brain or lung
26. Stereotactic Radiation Surgery and Stereotactic Radiation Therapy
27. Surgeries
    a. artificial disc surgery
    b. bariatric surgery
    c. cochlear implants
    d. discectomy with spinal fusion surgery
    e. Potentially cosmetic surgeries including but not limited to abdominoplasty, blepharoplasty, breast reduction, breast reconstruction, panniculectomy, penile implants/vascular procedures, otoplasty, rhinoplasty, scar revision, testicular prosthesis, and surgery for varicose veins
    f. Endoscopic treatment of GERD
    g. hysterectomy
    h. implantable devices including, but not limited to: implantable pumps, spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators
    i. knee arthroscopy
    j. laminectomy, including laminectomy with spinal fusion surgery
    k. spinal fusion surgery
    l. total joint replacement
    m. transplants
    n. uvulopalatopharyngoplasty
    o. Vertebroplasty, Kyphoplasty, and Sacroplasty
28. Transplants and transplant evaluations (including but not limited to: kidney, liver, heart, lung and pancreas, small bowel, and bone marrow replacement or stem cell transfer after high dose chemotherapy)

Notification

Notification to UMR 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. Notification to UMR 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 pre-certify or notify UMR of an admission within the timeframes specified in the following chart 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 coinsurance, deductible, and amounts that exceed PEIA's maximum allowance.

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

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

Timely Precertification Requirements	
Type of Admission	Advance Notice Required
Scheduled:	
Planned inpatient admission	3 business days in advance
Inpatient or outpatient elective surgery or procedure	3 business days in advance
Maternity (notify UMR during your first trimester)	
Term pregnancy	Within 48 hours of admission
Caesarean section (planned)	3 business days in advance
Caesarean section (emergency)	Within 48 hours of admission
Other Admissions	
Urgent/Emergency service or procedure	Within 48 hours of admission
Extended stay	Additional days may be recommended based on medical necessity

Preauthorization (Voluntary)

Preauthorization is a voluntary process which allows you to contact UMR in advance of a procedure to verify that the service is a covered benefit and medically necessary so that you can make an informed decision about the procedure. To obtain preauthorization, ask your provider to send your request to:

UMR, P.O. Box 30541, Salt Lake City, UT 84130-0541

Your provider should include your name, address, telephone number, your ID number, and all information about the procedure that's recommended. UMR may contact your physician for more information. Remember, if your request for preauthorization is denied, you will be responsible for paying for the service or procedure if you choose to have it.

Medical Case Management

If you are experiencing a serious or long-term illness or injury, UMR's 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 UMR can:

- arrange home care to prevent hospitalization;
- arrange services in the home to facilitate early hospital discharge;
- coordinate care and benefits for transplant services;
- 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.

For catastrophic cases involving serious long-term illness or injury resulting in loss or impaired function requiring medically necessary therapeutic intervention, the UMR case manager may, based on medical documentation, recommend additional treatment for certain therapy services. For details of these benefits, see "What Is Covered" later in this section beginning on page 51.

Transition of Care Program (New Participants Only)

If you are new to the PEIA PPB Plan and have been receiving medical treatment from an out-of-state provider, you may be concerned that your care will be interrupted in your move to this Plan. To assist participants receiving treatment for serious medical conditions from out-of-state 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 UMR 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, UMR 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 and submit the completed form to UMR 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 UMR. You must apply for TOC within three months of your effective date of coverage.

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 Plans.

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 C 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;
- providing treatment within the scope or limitation of the license or certification;
- not under sanction by Medicare, Medicaid or both. Services of providers under sanction will be denied for the duration of the sanction; and
- not excluded by PEIA due to adverse audit findings.

Types of Services Covered

PEIA PPB Plan C covers a wide range of health care services. Some major categories are listed below. The description of each service includes the level of coinsurance 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 costs if not prior approved by UMR. If you have questions about coverage of services, call UMR at 1-888-440-7342. Special arrangements that have been made for participants who live more than one county beyond the borders of West Virginia are explained on page 42 under "Non-resident PPB Plan Participants".

In this section, services marked with "X" require precertification in some or all circumstances.

● **Allergy Services.** Including testing and related treatment; covered at 80% after deductible is met.

✖ **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% of the PEIA allowance after in-network deductible. The PEIA allowance for air ambulance transportation is the current Medicare rural rate. The benefit limit for air ambulance services is $25,000. Non-medically necessary, non-emergency ground transportation is not covered. Non-emergency air ambulance transportation requires precertification and is generally not covered.

✖ **Ambulatory Surgery.** Covered at 80% after deductible is met. See "Outpatient Surgery" on page 56.

- **Annual Routine Physical and Screening Exam.** The PEIA PPB Plans cover a routine physical and screening examination once every year for insureds age 16 and over. Exams may be provided more often if the patient's medical history indicates a need, but these additional visits are subject to the deductible and 20% coinsurance. The routine physical and screening examination includes history and physical (screening and counseling for alcohol and/or substance abuse, blood pressure, depression, diabetes, domestic violence, nutrition, obesity, physical activity, STD prevention and other health risk factors as appropriate and provided for by the Patient Protection and Affordable Care Act; review of medications; blood work including general health panel and lipid panel, and immunizations as recommended by the American Academy of Family Physicians). Any additional services, including lab work, diagnostic testing and procedures, that are provided to you during this visit will be subject to your deductible and coinsurance, if there is a diagnosis to support them. For more information, see page 43 for a complete list of services covered under the Annual Routine Physical and Screening. See page 103 for information you can take to your physician.

✖ **Autism Spectrum Disorder.** Applied behavior analysis (ABA) services, to the extent mandated by W. Va. Code §5-16-7(a)(8), when provided in-network are covered at 80% after the in-network deductible is met.

✖ **Bariatric Surgery.** This benefit is subject to 20% coinsurance. Must meet plan guidelines.

- **Cardiac or Pulmonary Rehabilitation.** Benefits are limited to 3 sessions per week for 12 weeks or 36 sessions per year. Covered at 80% after deductible is met.

✖ **Chelation Therapy.** Benefits for these services are limited. If covered, therapy is paid at 80% after the deductible has been met.

- **Childhood Immunizations.** Immunizations, as recommended by the American Academy of Pediatrics, for children through age 16 are covered at 100% of allowed charges, including the office visit. This benefit is not subject to deductible or coinsurance. See also Immunizations.

✖ **Chiropractic Services.** Services of a chiropractor for acute treatment of neuromuscular-skeletal conditions are included in the Pain Management and Rehabilitative Services Benefit (see page 56) and are covered at 80% after the deductible is met. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. Visits 21+ require approval from UMR. See Pain Management and Rehabilitative 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 deductible is met. 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.

✖ **Colorectal Cancer Screenings.** Routine screening to detect colorectal cancer is covered at 100% in-network with no deductible or coinsurance required. This benefit is covered as follows:

- Fecal-occult blood test – 1 in 12 months/age 50 and over
- Flexible sigmoidoscopy – 1 in 5 years/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 5 years/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 neoplastic 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 when required as the result of accidental injury or disease, or when performed to correct birth defects. Covered at 80% 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 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. The Least Expensive Professionally Acceptable Alternative Treatment (LEPAAT) for accident-related dental services will be covered. For example, the dentist may recommend a crown, but the Plan will only provide reimbursement for a large filling. Contact UMR 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 UMR within the initial six months.

- **Dental Services (impacted teeth).** Medically-necessary extraction of impacted wisdom teeth is covered at 80% in-network after the deductible is met. Extractions for 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 the 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.** Services of a diabetes education program that meets the standards of the American Diabetes Association are covered at 80% after the deductible is met. Coverage is limited to six (6) visits per patient, per lifetime: three visits with the dietician and three visits with a registered nurse. Contact UMR for specific benefit limitations.

- **Dietician Services.** Services of a licensed, registered dietician are covered at 80% after the deductible is met. Coverage is limited to two visits per year when prescribed by a physician for adult members with the following conditions: hypertension, hyperlipidemia, heart disease, kidney disease, and metabolic syndrome. Diabetic patients see Diabetes Education above. Benefit may be extended to children who meet criteria.

- ✖ **Durable Medical Equipment (DME) and Prosthetics.** Coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices, and for the rental (at the plan's discretion) of standard DME, when prescribed by a physician. Prosthetics and DME purchases of $1,500 or more, or rentals of $500 or more for more than 3 months must be pre-certified by UMR.

- **Emergency Services (including supplies; for the first six visits in a Plan Year).** Services received in an emergency room are subject to 20% coinsurance after the annual deductible is met.

- **Emergency Room Treatment (for the first six visits in a Plan Year).** Services received in an emergency room are subject to 20% coinsurance after the annual deductible has been met. Members who visit the emergency room for non-emergency services an excessive number of times may be placed on case management or otherwise have payment for their ER services restricted or terminated by the PEIA Plan.

- **Emergency Room Treatment over six visits in a Plan Year (including ambulance transport , supplies, testing, consultation, and all associated costs).** Emergency Room treatment should be used only when there is an actual "Emergency Medical Condition" as defined by applicable State law: "Emergency Medical Condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected (by a prudent layperson) to result in serious jeopardy to the individual's health or with

respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of a bodily part or organ." If you have such a condition, PEIA urges you to go immediately to a hospital emergency room.

Because use of the emergency room for non-emergency care is inappropriate and very expensive for the member and the PEIA Plans, after the sixth emergency room visit by a policyholder and their dependent(s) in a Plan Year, any emergency room visits will be assumed to be non-emergency care and will not be covered (including associated costs). However, the member may appeal these claims and if, upon appeal, the claim is shown by the member to be for an actual emergency medical condition, the claim will be adjusted and paid the same as an emergency room claim for the first six visits per policyholder per plan year. (See "Appealing a Claim" in this Summary Plan Description).

✖ **Home Health Services.** Intermittent health services of a home health agency when prescribed by a physician are covered at 80% after the 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 twelve (12) visits are necessary, precertification is required.

✖ **Hospice Care.** When ordered by a physician; covered at 80% after the deductible is met.

✖ **Hyperbaric Oxygen Therapy.** Covered at 80% after the deductible is met.

● **Immunizations.** 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, 4-6 years, a booster at age 11-12, and a single dose at age 16-18.
- Tetanus-Diphtheria (Td): At 11-18 years with booster every 10 years.
- Measles-Mumps-Rubella (MMR): At 12-15 months and 4-18 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.
- Hepatitis A: Begin at 6 months, with second dose at least 6 months apart.
- Pneumococcal disease (Prevnar™): At 2 months, 4 months, 6 months, and 12-15 months. If missed, talk to your health care provider.
- Influenza: At 6 months and then annually.
- Varicella: At 12-15 months and 4-6 years. Adults, if not previously immunized, 2 doses per lifetime
- Meningococcal: At 2-10 years for certain children as recommended by the American Academy of Pediatrics, a booster at age 11-12, and a single dose at age 16-19.
- Human Papillomavirus (HPV): At 11-26 years.
- Rotavirus: At 2 months, 4 months, and 6 months depending on vaccine used.
- Zoster: ages 60 and over

For children through age 16, the plan covers immunizations and the associated office visit with no deductible or coinsurance required. Also see "Well Child Care" on page 57.

For adults and children over age 16, the plan covers immunizations provided and administered in a physician's office as recommended by the American Academy of Family Physicians at 100% in-network. The associated office visit is covered at 80% after the deductible is met, unless it is administered at the time of an "Annual Routine Physical

and Screening Examination." Other immunizations covered at 80% after the deductible is met. If administered at a pharmacy, the pharmacy can submit an electronic bill to the Medical TPA and be reimbursed directly.

✖ **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 deductible is met.

✖ **Inpatient Medical Rehabilitation Services.** When ordered by a physician, coverage is subject to the 20% coinsurance after the deductible is met and is limited to 150 days per plan year.

✖ **Intensive Modulated Radiation Therapy (IMRT).** Covered at 80% after the deductible is met.

● **Mammogram.** A routine mammogram every 1-2 years for women over 40 to detect breast abnormalities is covered at 100% in-network with no coinsurance or deductible required. 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.** Therapeutic services by a provider licensed to perform massage therapy for treatment of neuromuscular-skeletal conditions are covered under the Outpatient Therapy Benefit when ordered by a physician. Covered at 80% after the deductible is met. Combined coverage for all outpatient therapies is limited to a maximum of 20 visits per person per plan year. Coverage may be extended beyond the 20-visit limit for members in case management due to a catastrophic illness or injury, if approved in advance by UMR. Maintenance services are not covered. See Outpatient Therapy Services for more information.

✖ **Mastectomy and Follow-up.** 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, which will be covered at 80% after the deductible is met:

- 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 lymphedemas.

● **Maternity Services.** See "Maternity Benefits" on page 59 for details.

✖ **Mental Health Services.**

- Inpatient programs and outpatient 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. Cases requiring more than 20 visits 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 deductible is met.
- 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 deductible is met.

● **MRA.** Magnetic Resonance Angiography services when performed on an outpatient basis are covered at 80% after the deductible is met.

✖ **MRI.** Magnetic Resonance Imaging services when performed on an outpatient basis, are covered at 80% after the deductible is met. MRI of the knee and spine, including cervical, thoracic and lumbar require precertification.

✖ **Neuromuscular stimulators and bone growth stimulators, when criteria are met, are covered at 80% after the deductible is met.**

● **Oral Surgery.** Coverage is limited and pre-authorization is recommended. Services are limited to extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction covered at 80% after the deductible is met. Dental implants are not covered.

✖ **Organ Transplants.** See "Organ Transplant Benefits" on page 60 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 deductible is met.

✖ **Outpatient Surgery.** Covered at 80% after the deductible is met when performed in a hospital or alternative facility.

✖ **Outpatient Therapies.** Coverage for the following outpatient therapies is combined into one benefit and is paid at 80% after the deductible is met. The benefit is limited to a maximum of 20 visits per person per plan year for all the therapies combined. Coverage may be extended beyond the 20-visit limit for members in case management due to a catastrophic illness or injury, if approved in advance by UMR. Maintenance services are not covered.

- **Massage Therapy.** When ordered by a physician, therapeutic massage therapy services by a provider licensed to perform massage therapy are covered at 80% after the 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 deductible is met.
- **Vision Therapy.** This benefit is included in the Outpatient Therapies benefit and is covered, up to age 18, at 80% after the deductible is met.

✖ **Pain Management and Rehabilitative Services.** Coverage for the following outpatient therapies is combined into one. The benefit is limited to a maximum of 20 visits per person per plan year for all therapies combined. Coverage may extend beyond the 20-visit limit for members in case management if approved in advance by UMR. Initial 20 visits are covered at 80% after the deductible is met. Visits 21+, if approved in advance by UMR are covered at 80% after the deductible is met.

- **Chiropractic Treatment.** Services of a chiropractor for treatment of neuromuscular-skeletal conditions are covered with the cost-sharing described above. Office visits and x-rays are covered at 80% after the deductible is met.
- **Occupational Therapy.** This benefit is covered with the cost-sharing described above.
- **Osteopathic Manipulations.** Services of an osteopathic physician to eliminate or alleviate somatic dysfunction and related disorders are covered at 80% after the 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 deductible is met.

● **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 covered at 80% after the deductible is met, unless it is the Annual Routine Physical and Screening Exam, which is covered at 100%. When billed with a medical diagnosis (instead of a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.

● **Physician's Office Visits (treatment for illness, injury, or medical condition).** These visits are subject to the deductible and 20% coinsurance.

- **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 to a primary care or specialty care physician services are covered at 80% after the deductible is met.
- **Prostate Cancer Screening.** For men age 50 and over. The screening is covered in full if conducted as a part of the Routine Physical and Screening Exam. The PSA blood test associated with this screening, when ordered by a physician, is covered at 100% with no deductible or coinsurance in-network.
- **Second Surgical Opinions.** Office visits for second surgical opinions are covered at 80% after the deductible is met. Second surgical opinions are paid at 100% if required by UMR.
- ✖ **Specialty Medications.** Coverage is provided for treatments utilizing specialty drugs through a program managed by CVS Caremark. Specialty medications covered under the medical benefit plan are covered at 80% after the deductible is met. Specialty medications covered under the prescription drug program are covered with a $100 copay if on the WV Preferred Drug List and a $150 copay if not on the WV Preferred Drug List, after the prescription drug deductible is met.
- ✖ **SPECT.** Single Photon Emission Computed Tomography is covered at 80% after the deductible is met. SPECT of brain or lung requires precertification.
- ✖ **Skilled Nursing Facility Services.** Confinement in a skilled nursing facility including semi-private room, related services and supplies is covered at 80% after the deductible is met. Confinement must be prescribed by a physician in lieu of hospitalization. Coverage is limited to 100 days per plan year.
- ✖ **Sleep Management Services.** All sleep testing, equipment and supplies for resident PPB Plan members are covered through a network of West Virginia providers and require precertification through CareCentrix, if determined to be otherwise covered. Non-resident PPB Plan members should call UMR for precertification of sleep management services. Covered at 80% after the deductible is met. See further details under Sleep Management Services later in this section.
- **Smoking Cessation.** See "Tobacco Cessation" on page 65 for details.
- **Telehealth.** Services of a telehealth physician provided through PEIA's telehealth vendor, iSelectMD, are covered at 100% the deductible has been met.
- **Travel Benefits.** Members are eligible for some reimbursement for travel benefits (mileage and tolls). See Travel Benefits on page 62.
- **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 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.

  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, 30 months, 3 years and 4 years.
  - Late childhood: Annually from ages 5 through 12.
  - Adolescence: Annually from ages 13 through 16.

  Adolescents over the age of 16 receive the Annual Routine Physical and Screening Exam benefit described on page 57.

Disease Management Program

The Disease Management Program identifies those individuals who have certain chronic diseases and would benefit from this program. Specially trained nurses work telephonically with members to help them improve their chronic diseases and maintain quality of life. UMR identifies individuals with one or more of the seven targeted chronic conditions:

1. Asthma,
2. coronary artery disease,
3. congestive heart failure,
4. chronic obstructive pulmonary disease,
5. diabetes,
6. hypertension, and
7. depression as a comorbidity linked to another chronic condition we manage.

Identified members are invited to participate in the appropriate Disease Management program, and then work with specially trained nurses through phone calls and printed materials to learn more about their condition and how to manage it.

In addition to the telephonic services, UMR Disease Management also provides HealtheNotes. These targeted mailings are sent to members' homes and to their health care providers. They identify chronic condition gaps in care and include information on ways to prevent long-term issues and avoid health care costs.

HealtheNotes provide useful, personalized information based on an individual member's health care utilization, including information on provider visits, prescriptions, and health screenings. HealtheNotes is an educational tool in the Disease Management Program for managing a member's chronic condition(s).

Hemophilia Disease Management Program

To provide quality care at a reasonable cost, PEIA has partnered with the Charleston Area Medical Center (CAMC) and West Virginia University Hospitals (WVUH) to provide a Hemophilia Care Program to PEIA PPB Plan members. Members who participate in the program will be eligible for the following benefits:

- An annual evaluation by specialists in the Hemophilia Disease Management Program which will be paid at 80% after deductible. (This evaluation is not intended to replace, or interrupt care provided by your existing provider or specialists. This evaluation does not include routine or sick care visits with your doctor or ER).
- Hemophilia factor expenses incurred at CAMC or WVUH will be paid at 80% after deductible.
- Reimbursement for travel and lodging for an annual evaluation
    1. Child and 1 or 2 parents
    2. Adult and an accompanying adult
    3. Lodging will be at an approved hotel for a maximum of two (2) nights for one room only.
    4. Gas will be reimbursed at the federal rate for one vehicle only.
    5. Receipts for food will be paid at 80%, after deductible, for the child and parents or for the 2 adults.

Lodging and Travel Expenses:

Lodging expenses include:

1. a) Expenses incurred by the patient traveling between his or her home and the participating facility to receive services in connection with the Hemophilia Disease Management Program.
2. b) Expenses incurred by the patient's companion to enable the patient to receive services from the Hemophilia Disease Management Program.
3. For children under the age of 18, lodging will be covered for one (1) or two (2) parents.
4. For patients over the age of 18, lodging will be covered for one (1) companion.

Lodging will be covered at 80% of the charge, after deductible, at an approved hotel.

Travel expenses (gas & meals) include:

1. Expenses incurred while traveling with the patient between the patient's home and the medical facility to receive services in connection with the Hemophilia Disease Management program.
2. Gas receipts are required for reimbursement.
3. Reimbursement of meal expenses up to $30 per day per person. Receipts are required for the reimbursement of meals.

All claims must be submitted with the six-month timely filing period, including the submission of all travel expenses.

For more information about this program please contact: UMR at 1-888-440-7342.

Maternity Benefits

The PEIA PPB Plan C provides coverage for maternity-related professional and facility services, including prenatal care, midwife services and birthing centers. Maternity related services are covered for the employee and covered dependents.

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

You will need to contact UMR 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.

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of long-term hospital stays for both mothers and babies. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the member's risk level and educational needs. The program uses incentives in order to increase participation and encourage program completion.

UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they are pregnant. Members self-enroll in the pre-pregnancy coaching program by calling UMR's toll-free number. They are then contacted by nurse case managers who have extensive clinical backgrounds in obstetrics/gynecology. The nurses complete pre-pregnancy assessments to determine risk levels, if any, and provide members with education and materials based on their needs.

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. Other maternity services, including hospital charges and anesthesia services, are paid at 80% after the deductible is met.

High-Risk Birth Score Program

For infants identified at birth as being at risk for health problems, PEIA PPB Plan C 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. UMR 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 or online at www.wvpeia.com under "**Manage My Benefits**".

Nursery Charges

If the baby is enrolled for coverage under PEIA PPB Plan C, charges for the newborn nursery care will be paid in the baby's name. If the baby is not enrolled for coverage under the Plan, only charges for a normal, healthy newborn's nursery care will be covered if billed as part of the mother's maternity benefit, and all other claims will be denied. 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 UMR. You should contact UMR as soon as your doctor determines you or a member of your family covered by PEIA PPB Plan C may need a transplant. All transplants require precertification for determination of medical necessity. You should advise your physician that UMR 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 a network of providers for organ transplant services. This helps to control health care costs for both you and the plan. PEIA's primary OTN facilities are:

- University of Kentucky's UK HealthCare
- Cleveland Clinic
- WVU Hospital for bone marrow
- Charleston Area Medical Center (CAMC) for kidney

For services not available at these facilities, PEIA uses the Optum transplant network. UMR will work with patients and physicians to determine which 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.

Travel Allowance: Because network facilities may be located some distance from the patient's home, reimbursement benefits include up to $5,000 per transplant for patient travel, lodging and meals related to visits to the transplant facility or physician. 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 of meals and lodging; cost estimates are not acceptable. No alcoholic beverages will be reimbursed. Mileage will be reimbursed at the federal mileage rate for medical expenses.

NOTE: To seek reimbursement for transplant-related travel expenses, use the Medical Claim Form on www.wvpeia.com and submit the form to UMR, the third-party administrator. All claims must be submitted within the six-month timely filing period, including the submission of all lodging and travel expenses.

Medical Case Management: UMR offers support and assistance in evaluating treatment options and referrals. 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 UMR at 1-888-440-7342.

You should contact UMR as soon as you learn that you or a member of your family covered by PEIA PPB Plan C may need a transplant. All transplants must be pre-certified through UMR.

Out-of-Network Organ Transplant Benefits

For patients who choose to use a non-network facility for transplant services, you will be responsible for the annual deductible, 20% coinsurance and any amounts that exceed the PEIA maximum allowance. If treatment at a non-network facility is approved as medically necessary in advance by UMR, it will be treated as in-network care. No travel benefits will be provided for out-of-network transplants (except medically necessary ambulance transport).

Transplant-Related Prescription Drugs

PEIA PPB Plan C covers transplant-related immunosuppressant prescription drugs with no deductible, but standard copayments, if they are filled at a network pharmacy. Transplant-related immunosuppressants are a specialty medication and must be purchased through the CVS Specialty Pharmacy. PEIA will allow a one-time initial fill of the medication at a retail pharmacy.

Medical case management of transplant patients includes notification to the prescription drug administrator to qualify the patient for coverage of transplant-related immunosuppressant drugs under the Preventive Drug List.

Sleep Management Services

The PEIA PPB Plans cover services for the diagnosis and treatment of sleep apnea and other sleep-related conditions that can affect your health. To ensure compliance and to administer prescribed sleep services at the highest quality, UMR, the third-party administrator for PEIA, has contracted with CareCentrix to provide sleep diagnostic and therapy management services for PPB Plan members. A precertification process has been established to qualify services as medically necessary and appropriate. PEIA requires that the ordering physician request approval from CareCentrix prior to a member receiving sleep services that include sleep testing, sleep therapy or sleep therapy supplies and services out of state.

Using evidence-based guidelines, CareCentrix will review your request for a sleep study and make recommendations for those studies that can be performed in the member's home. If the member is appropriate for a diagnostic home sleep study, the member will be directed to a CareCentrix-contracted home sleep testing provider.

In addition to managing sleep testing services, CareCentrix also manages PAP therapy services by providing prior approval for PAP therapy and supply requests. CareCentrix directs the member to a CareCentrix-contracted DME

provider. In addition, CareCentrix provides comprehensive support for members' prescribed PAP therapy to provide assistance with adherence to therapy through the iComply program.

To obtain prior authorization for sleep services, you may call CareCentrix at 1-888-49-SLEEP (75337), or you may fax your request to 1-888-571-8816 using the Prior Authorization Fax Form found at http://help.carecentrix.com/ProviderResources/PEIA_Health_Fax_Request_form.pdf. Non-resident PPB Plan members must call UMR for precertification of sleep management services.

Specialty Drug Program

PEIA's Specialty Drug Program has two components:

1. Specialty Injectable Drugs are administered by injection or infusion, and are managed by UMR through the medical benefit.
2. Common Specialty Medications are self-administered, and are managed by CVS Specialty Pharmacy

Specialty Injectable Drugs are prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring. The PEIA PPB Plans cover specialty injectable drugs through a program managed by UMR. The program provides comprehensive direction to policyholders and their dependents for treatments utilizing specialty drugs. If your physician prescribes a specialty drug, that physician, you, or the pharmacist must call UMR at 1-888-440-7342. The Specialty Injectable Drug list is located at https://fhs.umr.com/print/UM1428.pdf. To obtain a paper copy, call 1-888-680-7342. UMR will review the drug for medical necessity If denied, UMR will contact your physician for additional information which may allow approval of the requested medication.

Common Specialty Medications are self-administered specialty injectable drugs through the CVS Specialty Pharmacy. Through the CVS Specialty Pharmacy, you will be assigned a dedicated CareTeam with specialists in your condition. These specialists will check in to see what you need and how they can help moving forward. They'll also make arrangements for injection training, as needed. If your physician prescribes a common specialty drug, they can call 1-800-237-2767, fax 1-800-323-2445, or e-prescribe the specialty drug to the CVS Specialty Pharmacy. CVS Specialty will then work with your doctor to obtain prior authorization for the specialty medication. Once approved, you can have your specialty medications delivered directly to you.

Many specialty medications have manufacturer programs which will financially assist patients in the purchase of the medication. PEIA requires that if a financial assistance program is available, you must participate in the program. Only your actual out-of-pocket payments will count toward your drug deductible and annual out-of-pocket maximum; not amounts discounted off the price by the manufacturer or seller of the specialty medication.

Travel Benefits

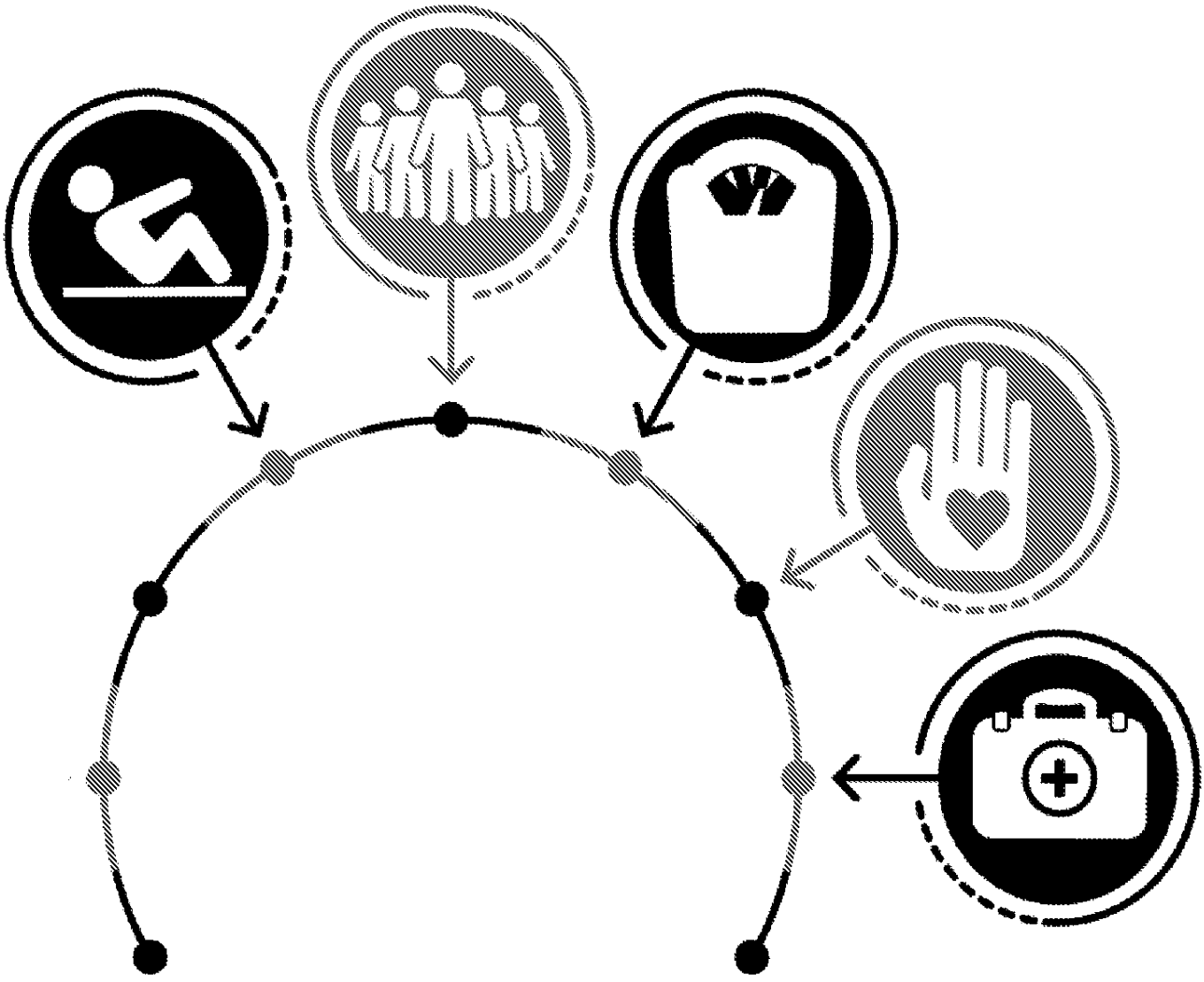
If a covered PEIA participant travels more than 60 miles, one-way, from their home, to receive care in West Virginia, the PPB Plan will reimburse the policyholder some of the travel expenses related to their medical care.

Limitations and requirements:

- Only mileage and tolls are covered.
- Mileage is reimbursed at federal rates for one vehicle in effect for the time period.
- You must provide receipts for tolls.
- Travel must be on the same day as the medical procedure.
- Other travel related expenses are not covered.

- Benefit is only for care and services received at providers in West Virginia. Travel to providers outside of West Virginia is not covered except as specified in the Summary Plan Description.
- Maximum reimbursement shall not exceed $250 per benefit year.

NOTE: To seek reimbursement for travel expenses, use the Medical Travel Expense Reimbursement Request Form on www.wvpeia.com, and submit the form to PEIA, 601 57th St., SE, Suite 2, Charleston, WV 25304-2345. All claims must be submitted within the six-month timely filing period, including the submission of all travel expenses.



Healthy Tomorrows

The Healthy Tomorrows Initiative

As a part of its financial plan for Plan Year 2020, the PEIA Finance Board voted to suspend the Healthy Tomorrows bloodwork and reporting requirements. If you submitted a Healthy Tomorrows form for Plan Year 2020, thank you for your efforts. PEIA will destroy any forms that have already been submitted. New wellness programs, initiatives, and training will be rolled out during Plan Year 2020, including several pilot programs for chronic disease management. For the latest news and updates, please make sure your email is current on Manage My Benefits, connect with PEIA on Facebook, visit our website, or talk to your Workplace Wellness Coordinator..

NOTE: PEIA still covers an annual physical for members at no cost (state and network rules apply). Take the Adult Annual Physical and Screening Examination Form on page 103 to your doctor. This form explains what is covered in full, and how the physician's office needs to bill to have the visit reimbursed correctly.

Face-to-Face (F2F) Diabetes Program

PEIA's F2F Diabetes Program is a statewide, two-year program for PPB Plan members (subject to the availability of providers) open to active employees and non-Medicare retirees who have diabetes.

Under the program, members and/or their dependents with diabetes or gestational diabetes agree to make regular visits to a participating provider of their choosing for counseling and health education services. The provider works with each member over the course of the two-year program to ensure he/she gets the best diabetes care possible by monitoring:

1. recommended testing and treatment of diabetes;
2. the member's currently prescribed medicines and knowledge about how to take them; and
3. physical activity and nutrition plan to assist the member in achieving optimal health.

New members enrolling in the F2F Diabetes program will have 12 months from the date of enrollment to get their HbA1c at a value of 8 or below (or provide a physician's statement of why they cannot). Members benefit from participating in the F2F Diabetes program by improving their health and quality of life, and by saving money, since copayments are waived for generic and brand-preferred diabetes related prescription drugs, and/or supplies. Copayments are waived only at retail pharmacies, not mail order. Copayments are not waived on brand non-preferred prescription drugs. PEIA benefits from the member's better management of their disease through fewer health care costs from the disease or its complications.

Members participating in the F2F Diabetes program must be tobacco free and must be eligible for the tobacco-free premium discount, which means they must have been tobacco free for a minimum of six months prior to enrollment in the program. F2F is a twice-in-a-lifetime benefit (with the exception of gestational diabetes). Members who either failed to comply or dropped out of the program may re-enroll after a 12-month waiting period, which begins on the date PEIA disenrolls you from the program. Prior bariatric surgery will make the member ineligible to participate in F2F.

For more information or an application, check the PEIA website, www.wvpeia.com, or the F2F Care Management Program website, www.peiaf2f.com, or call PEIA Customer Service at 1-888-680-7342.

Weight Management Program

PEIA offers a facility-based weight management program for PEIA PPB members who meet the program qualifications and are willing to make the necessary commitment to the program. Members will be subject to monthly program compliance checks and must meet certain goals to continue in the program. To participate in the PEIA Weight Management Program, PPB Plan Members must have a Body Mass Index of 30 or greater; or a waist circumference of 35 inches or greater (for women) or 40 inches or greater (for men). The program includes comprehensive services from registered and licensed dietitians, degreed exercise physiologists and personal trainers at approved fitness centers. The current list of

participating facilities is on PEIA's website at www.wvpeia.com. This is a twice per lifetime benefit with a maximum of 24 months. The program requires a copayment of $20 per month. Members who previously participated in the PEIA Weight Management Program for fewer than 18 months may be eligible for a second attempt. Members who have exhausted the lifetime benefit, have undergone bariatric or lap band surgery within the last 10 years, or are under age 18, are not eligible for this benefit.

To enroll, you must complete the online application, which includes some medical information. For more information, or to enroll in the program, call 1-866-688-7493 or go to www.wvpeia.com.

Tobacco Cessation

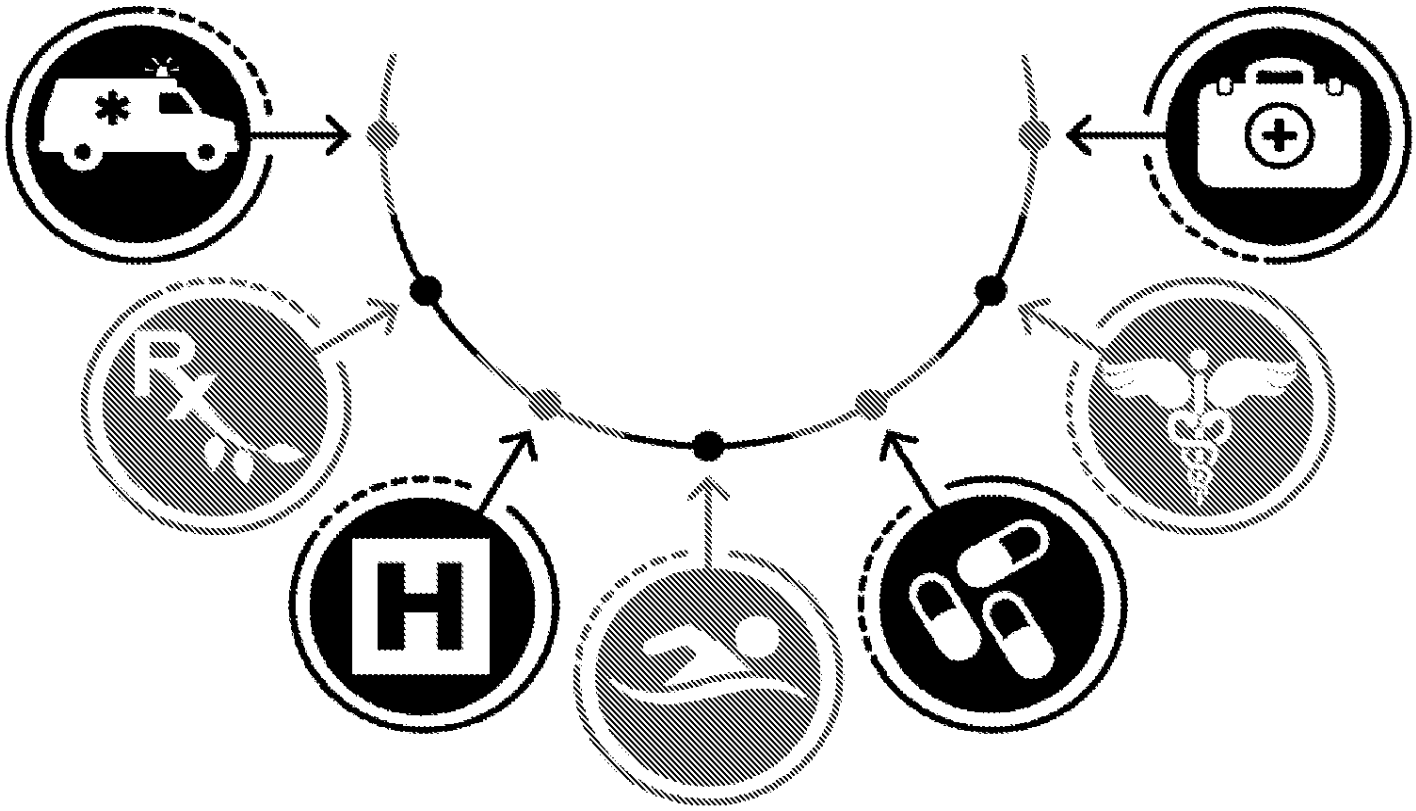
PEIA PPB Plan C provides benefits for participants who wish to quit smoking or using smokeless tobacco products. Only those members who have been paying the Standard (tobacco-user) premium are eligible for the Tobacco Cessation benefit. If you signed an affidavit claiming to be tobacco-free, you will be declined the Tobacco Cessation benefit.

To access the benefits, simply visit your primary care provider. PEIA will cover an initial and follow-up visit to your physician or nurse practitioner. PEIA covers both prescription and non-prescription tobacco cessation medications if they are dispensed with a prescription. PEIA will cover two 12-week cycles of drug therapy, even if more than one type of therapy is used. If extended therapy is required, the provider must submit a written appeal to the Director of PEIA with proof of medical necessity.

You can use the benefit (office visits and prescriptions) twice per year (rolling 12-month period). For pregnant participants, PEIA will provide 100% coverage for the tobacco cessation benefit during any pregnancy.

Payment Level

PEIA will cover an initial and follow-up visit to your physician or nurse practitioner at no cost to the member. Tobacco-cessation products are available at no cost to the member; both the deductible and the copayment are waived when prescribed by a physician and purchased at a network pharmacy.



What Is Not Covered

Some services are not covered by the PEIA PPB Plans regardless of medical necessity. Some specific exclusions are listed below. If you have questions, please contact UMR at 1-888-440-7342. The following services are not covered:

1. Acupuncture
2. Aqua therapy
3. Autopsy and other services performed after death, including transportation of the body or repatriation of remains
4. Biofeedback
5. Chemical dependency treatments when a patient leaves the hospital or facility against medical advice
6. Cologuard
7. Coma stimulation
8. Cosmetic or reconstructive surgery when not required as the result of accidental injury or disease, or not performed to correct birth defects. Services resulting from or related to these excluded services also are not covered
9. 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, including applied behavior analysis (ABA), except to the extent ABA is mandated to be covered for treatment of autism spectrum disorder by W.Va. Code §5-16-7(a)(8)
10. Dental implants, whether medically indicated or not
11. Dental services including dental implants, routine dental care, x-rays, treatment of cysts or abscesses associated with the teeth, dentures, bridges, or any other dentistry and dental procedures
12. Daily living skills training
13. Duplicate testing, interpretation or handling fees
14. Education, training and/or cognitive services, unless specifically listed as covered services
15. Elective abortions
16. Electronically controlled thermal therapy
17. Emergency evacuation from a foreign country, even if medically necessary
18. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts
19. Expenses incurred as a result of the commission of a felony, while incarcerated or while under the control of the court system
20. Experimental, investigational or unproven services, unless pre-approved by UMR
21. Fertility drugs and services
22. Foot care. Routine foot care including:
    - Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or 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
23. Genetic testing for screening purposes is generally not covered, unless specifically mandated by the Patient Protection and Affordable Care Act. See Precertification item 13 on page 47 for exceptions
24. Glucose monitoring devices or test strips, except Accu-Chek Aviva Plus, Accu-Chek Nano and Accu-Chek Guide models covered under the prescription drug benefit
25. Homeopathic medicine
26. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery
27. Hypnosis
28. Incidental surgery performed during medically necessary surgery

29. 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, including the workup for infertility treatment
30. Maintenance outpatient therapy services, including, but not limited to:
    - Chiropractic
    - Massage Therapy
    - Occupational Therapy
    - Osteopathic Manipulations
    - Outpatient Physical Therapy
    - Outpatient Speech Therapy
    - Vision Therapy
31. Marriage counseling
32. Medical equipment, appliances or supplies of the following types:
    - Augmentative communication devices
    - Bariatric beds and chairs
    - Bathroom scales
    - Educational equipment
    - Environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters
    - 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 (including Hoyer lifts); recliners; contour chairs; adjustable beds; or tilt stands
    - Support devices which are widely available over the counter such as prophylactic wrist, ankle and knee supports
    - Exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines
    - Hearing aids of any type
    - Hygienic equipment such as bed baths, commodes, and toilet seats
    - Motorized scooters
    - Nutritional supplements, over-the-counter (OTC) formula (with the exception of certain amino acid-based formulas for the treatment of severe protein allergic conditions or absorption disorders, through the age of 20, as specifically provided for under W.Va. Code § 5-16-7, or infant formula administered through a feeding tube), food liquidizers or food processors
    - Omnipod, V-go, Finesse and other disposable insulin delivery systems
    - Orthopedic shoes, unless attached to a brace
    - Professional medical equipment such as blood pressure kits or stethoscopes
    - Replacement of lost or stolen items
    - Supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags
    - Standing/tilt wheel chairs
    - Traction devices
    - Vibrators
    - Whirlpool pumps or equipment
    - Wigs or wig styling

33. Medical rehabilitation and any other services that are primarily educational or cognitive in nature
34. Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning
35. Optical services:
    - Routine eye examinations, refractions, eye glasses, contact lenses and fittings
    - Glasses and/or contact lenses following cataract surgery
    - Low-vision devices, including magnifiers, telescopic lenses and closed-circuit television systems
36. Oral appliances, including, but not limited to, those treating sleep apnea
37. Orientation therapy
38. Orthodontia services
39. Orthotripsy
40. Physical examinations and routine office visits except those covered under the Periodic Physicals benefit
41. 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
42. 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
43. 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
44. Provider charges for phone calls, prescription refills, or physician-to-patient phone consultations
45. Radial keratotomy, Lasik procedure and other surgery to correct vision. Surgery to prevent legal blindness or restore vision from legal blindness is covered, if not correctable by lenses or other more conservative means
46. Reversal of sterilization and associated services and expenses
47. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities
48. Screenings, except those specifically listed as covered benefits
49. Service/therapy animals and the associated services and expenses, including training
50. 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
51. Services rendered outside the scope of a provider's license
52. Surgical or pharmaceutical treatments associated with gender dysphoria or any physical, psychiatric, or psychological examinations, testing, treatments or services provided or performed in preparation for, or as a result of, sex transformation surgery
53. Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit
54. Sensory stimulation therapy
55. Take-home drugs provided at discharge from a hospital or any facility
56. 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
57. The difference between private and semi-private room charges
58. Therapy and related services for a patient showing no progress
59. Therapies rendered outside the United States that are not medically recognized within the United States

60. Transportation other than medically-necessary emergency ambulance services, or as approved under the Organ Transplant Network benefit or the Travel Benefit
61. War-related injuries or illnesses. Treatment in a State or Federal hospital for military or service-related injuries or disabilities
62. 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 the Weight Management Program offered by PEIA
63. Work-related injury or illness

How to File a Claim

Medical claims are processed by UMR and should be submitted to:

UMR, P.O. Box 30541, Salt Lake City, UT 84130-0541

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

To process a medical claim, UMR 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 which is primary, you need to submit an Explanation of Benefits (EOB) from the other insurance which shows the amount the primary insurance paid 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, 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 receive from PEIA. See "Subrogation and Reimbursement" on page 98 for details.

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 UMR 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 call 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 UMR or the prescription drug administrator.

PEIA is a Covered Entity under 45 CFR 160.103 and is required to be compliant with any and/or all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as other Privacy and Security laws, rules, and regulations enacted by the State of West Virginia and/or the United States, and not rule(s) of the European Union. The European Union's GDPR (General Data Protection Regulation) does not apply to PEIA or its operations.

UMR 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 plan you're enrolled in.

Notice of Appeal Rights

PEIA PPO Plan C

You have a right to appeal any decision that denies payment on your claim or your request for coverage of a health care service or treatment. You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact the Third-Party Administrator when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document; or
- Disagree with the denial or the amount not covered and you want to appeal.

Type of Error	Who to Call	Where to Write
Pre-Service Medical claim or case management denial	UMR Appeals 1-888-440-7342	UHC Appeals-UMR P.O. Box 400046 San Antonio, TX 78229 Fax: 888-615-6884 Attn: UMR Appeals
Post-Service Medical claim	UMR 1-888-440-7342	UMR P.O. Box 30541 Salt Lake City, UT 84130-0541
Out-of-state care denial or denial of precertification	UMR 1-888-440-7342	UMR P.O. Box 30541 Salt Lake City, UT 84130-0541
Prescription drug claim	CVS Caremark 1-844-260-5884	CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-2084
Common Specialty Medications claim	CVS Caremark 1-844-260-5884	CVS Caremark Specialty Appeals Department 800 Biermann Court Mount Prospect, IL 60056
Specialty Injectable Drugs	UMR 1-888-440-7342	UMR P.O. Box 30541 Salt Lake City, UT 84130-0541

If your medical claim or service has been denied, or if you disagree with the determination made by one of the Third-Party Administrators, the second step is to appeal in writing within 120 days of the denial to the Third-Party Administrator at the address listed above. Explain what you think the problem is, and why you disagree with the decision. Please have your physician provide any additional relevant clinical information to support your request. The Third-Party Administrator 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 the Third-Party Administrator. Facts, issues, comments, letters, Explanations of Benefits (EOBs), and all pertinent information about the case should be included and mailed to:

Director, Public Employees Insurance Agency, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345

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 sixty (60) days of the date of the letter. If the additional information is not received, the case will be closed.

External Review: If we have denied your request for the provision of or payment for a health care service or course of treatment, our decision may be reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. An external review may be initiated by us or requested by you. You may submit a request for external review within four (4) months after receipt of the notice of denial to the PEIA Clinical Unit, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345. For standard external review by your request, a decision will be made within forty-five (45) days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may request an expedited external review of our denial. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may request for an external review of our denial. External review is the final level of appeal, regardless of whether the external review was initiated by us or requested by you. External review is not available for items or treatments that are simply not covered by the Plan or for out-of-state benefit level appeals..

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, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345.

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 120 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.

Prescription Drug Benefits

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

1. The Retail Pharmacy Program gives you access to local participating pharmacies to get your prescription filled;
2. The CVS Caremark 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;
3. The CVS Caremark Specialty Medication Program provides access to 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.

What You Pay

Deductible

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

Combined Medical and Prescription Drug Deductibles	
Policyholder Only	$1,350
Policyholder & Child(ren)	$2,700
Family	$2,700
Family with Employee Spouse	$2,700

This means you will pay the amount listed in the chart above before the plan begins to pay for any drug other than those listed on the Preventive Drug List. The family deductible may be divided up among the family members or may be met by just one member of the family. Once the family deductible is met, the plan pays on all members of the family. After you meet your deductible, you will pay copayments or coinsurance based on the amount and type of drug you're taking. The following chart shows the copayments and coinsurance.

Copayments and Coinsurance

Once you meet your deductible, you pay a copayment or coinsurance to obtain drugs. Copayments and coinsurance 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 or coinsurance.

	Up to a 30-day supply	90-day supply*
Generic Drug	$10	$20
Brand-name drug on the WV Preferred Drug List	$25	$50
Brand-name drug not listed on the WV Preferred Drug List#	75% Coinsurance	75% Coinsurance
Common Specialty Medications on WV Preferred Drug List	$100	Not Available
Common Specialty Medications NOT on WV Preferred Drug List†	$150	Not Available

* For maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. You must purchase all medications on the Maintenance Drug List in 90-day supplies through a Retail Maintenance Network pharmacy or through Mail Service. Read on for details.

†Should your doctor prescribe, or you request the brand-name Specialty Medication when a generic drug is available, you must pay 75% coinsurance.

#Should your doctor prescribe, or you request the brand-name drug when a generic drug is available, you must pay 75% coinsurance.

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.

PEIA PPB Plan C Preventive Drug List

Prescription Drugs on the Preventive Drug List are not subject to the deductible, but will be covered with normal co-pays of $10, $25 and 75% coinsurance, depending on their generic, preferred or non-preferred status. Copayments paid for drugs on the Preventive Drug List do not count toward the deductible. All in-network copayments count toward the out-of-pocket maximum. For a copy of the Preventive Drug List, visit www.wvpeia.com and click on Forms & Downloads > Prescription Drug Information > High Performance Preventive Drug List (Plan C Only).

West Virginia Preferred Drug List (WVPDL)

In addition to the Preventive Drug List, PEIA PPB Plan C also uses the traditional formulary we call the West Virginia Preferred Drug List (WVPDL). The WVPDL is a list of carefully selected medications that can assist in maintaining quality care while providing opportunities for cost savings to the member and the 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 copayment structure works:

- **Highest Cost:** You will pay a 75% coinsurance for brand-name drugs that are not listed on the WVPDL.
- **Middle Cost:** You will pay a mid-level copayment for brand-name drugs that are listed on the WVPDL.
- **Lowest Cost:** You will pay the lowest copayment for 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, a CVS Caremark 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 CVS Caremark 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, please call CVS Caremark Customer Care at 1-844-260-3894.

Non-Preferred Drugs

Non-preferred (tier 3) drugs are brand name drugs that do not appear on the WVPDL. Non-preferred drugs require 75% coinsurance after the prescription drug deductible.

If your doctor prescribes a non-preferred brand name drug, and you have tried and failed on the generic and preferred brand name alternatives offered by CVS Caremark, your provider may file an appeal to lower your out-of-pocket cost. To file the appeal, your provider must submit medical justification, in writing, to:

CVS Caremark
Attn: Exceptions Dept
1300 E. Campbell Rd.
Richardson, TX 75081

Or fax to: 1-888-487-9257

Your tier appeal, if approved by CVS Caremark, will lower your out-of-pocket cost from 75% of the cost of the drug to the $25 preferred drug monthly copay. The decision by CVS Caremark is final. There is no further level of appeal for a tier exception.

Prescription Out-of-Pocket Maximum

PEIA PPB Plan C has a combined out-of-pocket maximum on medical services and prescription drugs of $2,500 for an individual and $5,000 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 includes the medical/prescription drug deductible and all coinsurance paid for medical services, as well as copayments and coinsurance for prescription drugs.

Getting Your Prescriptions Filled

Using a Retail Network Pharmacy

CVS Caremark has a nationwide network of pharmacies. To get a prescription filled, simply present your medical/prescription drug ID card at a participating CVS Caremark network pharmacy. You can purchase acute medications at any CVS Caremark network pharmacy. Maintenance medications must be purchased from a Retail Maintenance Network pharmacy or using the CVS Caremark Mail Service Pharmacy Program (see below for details). You may refill your prescription when 75% of the medication is used up or 80% of a controlled substance is used up.

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 a CVS Caremark network 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. All applicable management, such as prior authorization, step therapy, and quantity limits still apply. You may submit the receipt with a completed claim form to CVS Caremark 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, and your deductible (if applicable). This reimbursement is usually less than you paid for the prescription.

If you need claim forms, call CVS Caremark Customer Care at 1-844-260-5894 or visit their website at www.caremark.com.

To find the participating pharmacies nearest you, call CVS Caremark Customer Care at 1-844-260-5894 and use the voice-activated Pharmacy Locator System. If you have Internet access, you can find a pharmacy online at www.caremark.com.

Using the Retail Maintenance Network

If you take a drug on a long-term basis, you MUST purchase a 90-day supply of that drug if it is on maintenance list (see the Maintenance Drug List later in this section) from a Retail Maintenance Network pharmacy or through CVS mail service. Check with your local pharmacist to verify participation.

Maintenance Medication Cost-Sharing		
	PEIA PPB Plan C	
	Up to 30-day supply†	90-day supply*
Generic medication	$10	$20
Brand-name medication listed on the WV Preferred Drug List	$25	$50
Brand-name medication not listed on the WV Preferred Drug List#	75% Coinsurance	75% Coinsurance

*For maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. You must purchase all medications on the Maintenance Drug List in 90-day supplies 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 75% coinsurance.

† For initial start on a new drug, patient may receive up to 2 30-day fills to be sure the drug is tolerated. After these two initial fills, the drug must be purchased in a 90-day supply to be covered.

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 CVS Caremark. 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 and your deductible (if applicable). This reimbursement is usually less than you paid for the prescription. All applicable management, such as prior authorization, step therapy, and quantity limits still apply.

If you purchase a Maintenance Medication at a non-network pharmacy, you will not be reimbursed for your purchase. Maintenance Medications must be purchased from Retail Maintenance Network pharmacies or using the CVS Caremark Mail Service Pharmacy Program.

If you need claims forms call CVS Caremark Customer Care at 1-844-260-5894 or visit their website at www.caremark.com.

Using the CVS Caremark Mail Service Pharmacy Program

CVS Caremark 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 must order a 90-day supply of a medication on the maintenance list, as prescribed by your doctor, and pay the member cost share indicated above. You may refill your prescription when 75% of the medication is used up. CVS Caremark's 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 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 in 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 e-prescribe or to fax your order to 1-800-378-0323. 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.
    a) Refills online: Log on or register at CVS Caremark's website at www.caremark.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.
    b) Refills by phone: Call 1-844-260-5894 and use the automated refill system. Have your member ID number, refill slip with the prescription number, and your credit card ready.
    c) 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, American Express, electronic check, or PayPal. 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.

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. All prior authorization requests must be reviewed annually.

The medications listed below require prior authorization:

1. acitretin (Soriatane®)
2. adapalene (Differin®)
3. amphetamines (Adderall XR®, Vyvanse®)
4. anabolic steroids (Anadrol, Oxandrin)
5. armodafinil (Nuvigil®)
6. atomoxetine (Strattera®)
7. becaplermin (Regranex®)
8. buprenorphine (Subutex®)
9. buprenorphine/naloxone (Suboxone®, Bunavail™, Zubsolv®)
10. Butrans Patch
11. Calcitonin gene-related peptide (CGRP) receptor antagonists (Aimovig™, Ajovy™, Emgality™)
12. ciclopirox topical solution (Ciclodan®, Penlac®)
13. chenodiol (Chenodal™)

14. cinacalcet (Sensipar®)
15. Compounded Medications
16. cyclosporine ophthalmic emulsion (Restasis®)
17. dextromethorphan hydrobromide/quinidine sulfate (Nuedexta®)
18. diclofenac sodium gel (Solaraze®, Voltaren®)
19. diclofenac sodium topical solution (Pennsaid®)
20. edoxaban tosylate (Savaysa™)
21. enfuvirtide (Fuzeon®) *
22. Sacubitril/Valsarten (Entresto)
23. fentanyl oral and topical (Abstral®, Actiq®, Duragesic®, Fentora®, Lazanda®, and Subsys™)
24. fluocinonide 0.1% (Vanos®)
25. Hydrocodone Extended Release (Zohydro ER)
26. linezolid (Zyvox®)
27. lidocaine patch (Lidoderm®)
28. lifitegrast (Xiidra®)
29. metformin ext-rel (Fortamet/Glumetza)
30. modafinil (Provigil®)
31. naltrexone extended-release injectable suspension (Vivitrol®)
32. naproxen sodium extended release (Naprelan®)
33. omeprazole sodium bicarbonate (Zegerid)
34. Oral Acne medications (Absorica, Clavaris)
35. PCSK-9 Inhibitors (Praluent®, Repatha®)
36. select medical devices (e.g. Avenova®, Beau Rx, Eletone®, Epiceram®, Gelclair®, HPR Plus™, PromiseB®)
37. select medical devices – artificial saliva (e.g. NeutraSal®, SalivaMAX®)
38. sodium oxybate (Xyrem®)
39. Specialty medications*
40. stimulants (Concerta®, Focalin XR®, methylphenidate)
41. tazarotene (Tazorac®, Fabior®)
42. testosterone products (oral, topical, injectable products)
43. tiopronin (Thiola®)
44. tolvaptan (Samsca®)
45. Topical Antifungals (Jublia, Kerydin)
46. tretinoin cream (e.g. Retin-A) for individuals 35 years of age or older
47. vacation supplies of medication for foreign travel (allow 7 days for processing)
48. vitamin D analogs, topical (Calcipotriene, Calcitrene, Dovonex®, Enstilar®, Sorilux®, Taclonex®, Vectical®)
49. vorapaxar (Zontivity®)

*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 in writing. 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.

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:

1. Angiotensin II Receptor Antagonists (Benicar, Benicar HCT, Tekturna, Tekturna HCT, Edarbi, Edarbyclor)
2. Anti-depressants (Pristiq®, Aplenzin®, Khedezla®, Fetzima™, Irenka)
3. Antifungal, topical (Ecoza™, Ertaczo®, Exelderm®, Loprox®, Lotrisone®, Luzu™, Mentax®, Naftin®, Oxistat®, Vusion®, Xolegel®)
4. Benign Prostatic Hypertrophy (Cardura/XL®, Rapaflo®)
5. Bisphosphonates (Fosamax Plus D™, Binosto®)
6. Cholesterol-lowering medications (Altoprev®, Crestor®, Vytorin®, Livalo™, Liptruzet™)
7. crisaborole (Eucrisa®)
8. Dermatologicals (doxepin cr, Prudoxin®, Zonalon®)
9. Insulins (Apidra, Humalog, Humalog Mix, Humulin 70/30, Humulin N, Humulin R, Novolin R Relion, Novolin N Relion, Novolin 70/30 Relion)
10. Febuxostat (Uloric®)
11. Fenofibrates (Triglide®, Fenoglide®)
12. Lyrica®, Gralise®, Horizant®
13. Migraines (Sumavel Dosepro™, Alsuma, Treximet®, Onzetra Xsail, Zembrace)
14. Nasal Steroids (Beconase AQ®, Veramyst®, Omnaris®, Dymista®, Qnasl®, Zetonna®)
15. Non-Steroidal Anti-inflammatory Drugs (brand-name NSAID e.g., Cambia®, Duexis, fenoprofen 200mg, Fenortho 200 mg, Flector®, Pennsaid®, Nalfon, Tivorbex, Vivlodex, Zipsor, Zorvolex)
16. Ophthalmic prostaglandins (Lumigan®, Travatan/Z®, Zioptan®)
17. Opioid pain medications
18. Overactive Bladder: (Oxytrol, Toviaz®, Vesicare®, Enablex®, Gelnique®, Myrbetriq®)
19. Proton Pump Inhibitors (e.g., Dexilant®, Prilosec/Protonix/Zegerid Powder packets, compounding kits for PPI suspension formulations)
20. Sedative Hypnotics (Belsomra, Rozerem™, Edluar™, Zolpimist™, Silenor®)
21. Selective Serotonin Reuptake Inhibitors (e.g., Pexeva, Viibyrd®, Trintellix)
22. Tetracyclines (e.g., Adoxa®, Doryx®, Oracea®, Solodyn®, Oraxyl®, Vibramycin®)
23. Topical Acne products, kits and cleansers (e.g., Acanya, Aczone, Akne-Mycin, Azelex, Clindagel, Fabior, Panoxyl, Riax, Tretin-X)
24. Topical immunomodulators (Elidel®, Protopic®)

This list is subject to change during the plan year, if circumstances arise which require adjustment. Changes will be communicated to members in writing. 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 (QL)

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. 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. Acetaminophen and Aspirin containing pain reliever medications are limited to quantities not to exceed 4 grams of acetaminophen or aspirin per day.
2. Amphetamines, methylphenidate and stimulant products to treat ADHD or narcolepsy are subject to limits on quantity within FDA approved doses.
3. Antipsychotic Drugs (Abilify® 30 units, Abilify Discmelt® 60 units, Fanapt™ 60 units, Geodon® 60 units, Invega® varies, Risperdal® 60 units, Saphris® 60 units, Seroquel/XR® varies, Zyprexa® 30 units, and Zyprexa Zydis® 30 units, Latuda® 30 units)
4. Antiemetics:
   - Aloxi® is limited to 2 vials per 21 days.
   - Anzemet® is limited to 6 tablets per 21 days.
   - Anzemet 100/5 & 12.5/0.625 injection is limited to 15ml per 180 days.
   - Akynzeo is limited to 2 capsules per 21 days.
   - Cesamet® is limited to 18 capsules per 30 days.
   - Emend® 40 mg is limited to 3 capsules per 6 months.
   - Emend® 80 mg is limited to 4 capsules per 21 days.
   - Emend® 150 mg vial is limited to 2 vials per 21 days.
   - Emend® 125 mg is limited to 2 capsules per 21 days.
   - Emend® Tri-fold Pack is limited to 2 packages per 21 days.
   - Kytril® is limited to 12 tablets per 21 days.
   - Kytril® 0.1mg/ml is limited to 2ml per 21 days.
   - Kytril® 1mg/ml is limited to 2ml per 21 days.
   - Kytril® 4mg/4ml (1mg/ml) injection is limited to 2ml per 21 days.
   - Marinol is limited to 60 capsules per 25 days.
   - Netupitant-Palonosetron is limited to 2 capsules per 21 days.
   - Sancuso® is limited to 2 patches per 21 days.
   - Varubi is limited to 4 tablets per 21 days.
   - Zofran® 24 mg is limited to 2 tablets per 21 days.
   - Zofran® 4mg and 8mg are limited to 18 tablets per 21 days.
   - Zofran® ODT 4mg and 8mg are limited to 18 tablets per 21 days.
   - Zofran® Solution is limited to 200ml per 21 days.
   - Zofran® 2mg/ml injection is limited to 20ml per 21 days.
   - Zofran® 40mg/20mg (2mg/ml) is limited to 20ml per 21 days.
   - Zuplenz® is limited to 18 films per 21 days.

5. Abstral®, Actiq®, Fentora®, Onsolis, Subsys® Coverage is limited to 120 units per 30 days; Lazanda®: Coverage is limited to 30 bottles per 30 days.
6. Benzodiazepines (excluding insomnia) (alprazolam, Ativan®, chlordiazepoxide, clonazepam, diazepam, Klonopin®, lorazepam, Niravam®, oxazepam, Tranxene®, Valium®, Xanax®, Xanax® XR).
7. Buprenorphine/naltrexone containing products (Bunavail™, Suboxone®, Subutex®, and Zubsolv®) is limited to 24mg in initial 60-day period then 16mg.
8. Cholesterol Lowering Medications. (Advicor® varies, Caduet® 30 units, Vytorin® 30 units, Altoprev® 30 units, Crestor® 30 units, Lescol® varies, Lipitor® 30 units, lovastatin varies, Mevacor® 30 units, Pravachol® 30 units, pravastatin sodium 30 units, Simcor® 30 units, simvastatin 30 units, Zocor® 30 units and Livalo® 30 units)
9. Diabetic test strips (Accu-Chek brand) 204/month
10. Enbrel®: Coverage is limited to 4 syringes or 8 vials per 28 days.
11. Estrogen patches: Alora®, Estraderm®, Minivelle®, Vivelle/Dot® limit is 8 patches/28 days. Climara/Pro and Menostar® limit is 4 patches per 28 days.
12. Gabepentin (Neurontin). Coverage is limited to 3,600mg per day.
13. Humira®: Coverage is limited to 2 syringes/pens per 28 days.
14. Lidocaine/Lidocaine topical products is limited to one tube/pack every 25 days.
15. Migraine medications. Coverage is limited to quantities listed below:

Generic name	Brand name	Quantity Level Limit for 30-day Period
Almotriptan tablets 6.25 mg	Axert®	12 tablets
Almotriptan tablets 12.5 mg	Axert®	12 tablets
Diclofenac potassium, 50 mg powder packet	Cambia	9 packets
Dihydroergotamine nasal spray vials, 4mg/mL vial	Migranal®	1 kit=8-unit dose sprayers
Eletriptan 20mg, 40mg	Relpax®	12 tablets
Frovatriptan tablets 2.5mg	Frova®	18 tablets
Naratriptan tablets 1mg, 2.5mg	Amerge®	12 tablets
Rizatriptan tablets 5mg, 10mg	Maxalt®	18 tablets
Rizatriptan tablets 5mg, 10mg, orally disintegrating tablets	Maxalt-MLT®	18 tablets
Sumatriptan injection pre-filled auto-injectors, 6mg/0.5ml	Alsuma®	6 kits (12 syringes)
Sumatriptan auto-injectors 3mg/0.5ml	Zembrace Symtouch	24 injectors (12ml)
Sumatriptan injection syringes, 6mg/0.5ml	Imitrex® Statdose System	6 kits=12 injections
Sumatriptan injection vials, 4mg/0.5 ml	Generics	18 vials
Sumatriptan injection vials, 6mg/0.5 ml	Imitrex®, generics	12 vials
Sumatriptan nasal spray 20 mg	Imitrex®, generics	2 boxes=12-unit dose spray devices
Sumatriptan nasal spray 5mg	Imitrex®, generics	4 boxes= 24-unit dose spray devices
Sumatriptan nasal spray 11mg	Onzetra Xsail	1kit=8 pouches
Sumatriptan needle-free injection vial 4mg/0.5ml	Sumavel™ DosePro™	3boxes=18 needle-free devices
Sumatriptan tablets 25mg, 50mg, 100mg	Imitrex®, generics	12 tablets

Sumatriptan (85mg) naproxen sodium (500mg) tablets	Treximet™	9 tablets
Sumatriptan (10mg) and naproxen sodium (60mg) tablets	Treximet™	9 tablets
Zolmitriptan nasal spray 5mg	Zomig®	2 boxes=12-unit dose spray devices
Zolmitriptan tablets 2.5 mg, 5mg, orally disintegrating	Zomig-ZMT®	12 tablets
Zolmitriptan tablets 2.5 mg, 5mg	Zomig®	12 tablets

16. Multiple Sclerosis: Avonex® 4 units per 30 days, Betaseron®/Extavia 14 or 15 units per 30 days, Copaxone® 1 kit per 30 days, Rebif® 1 pkg/12 syringes per 30 days.
17. Nuvigil®: Coverage limit varies.
18. Opioid pain medications have a quantity limit (QL) for all medications in the opioid class. Additional quantities require Prior Authorization. Long-acting Opioids and immediate-acting Opioids – quantities vary based on strength of medications. Medications in this class include, hydrocodone products, Avinza, Nucynta, Nucynta ER, Xartemis XR, Kadian, Embeda, morphine products, Oxycontin, Hysingla ER, Zohydro ER, Opana, Opana ER, methadone, codeine products, hydromorphone products, oxycodone products, Meperidine products, Exalgo, Vicoprofen, Talwin NX, Tramadol and Tramadol-containing products, Soma and Soma-containing products. Initial prescription is limited to a 7-day supply only.
19. Other Antidepressants (Budeprion SR® 60 units, Budeprion XL ® 30 units, Bupropion HCL SR® 60 units, Forfivo® XL 30 units, Wellbutrin SR® 60 units, and Wellbutrin XL® 30 units, Aplenzin® 30 units).
20. Provigil®: Coverage limit varies.
21. Respiratory/Asthma inhalers, nasal steroid inhalers, and COPD inhalers are limited to quantity in accordance with FDA-approved dosing.
22. Sedative Hypnotics (Ambien®, Ambien CR™, Doral®, estazolam, flurazepam, Intermezzo®, Lunesta™, Restoril®, Rozerem™, Sonata®, Edluar™, Silenor®, temazepam, triazolam). Coverage is limited to 15 units per 30 days. Zolpimist™, coverage is limited to 1 bottle.
23. Selective Serotonin Reuptake Inhibitors (Celexa® 30 units, citalopram HBR 30 units, fluoxetine HCL varies, fluvoxamine maleate varies, Lexapro® 30 units, Luvox CR® varies, paroxetine HCL® varies, Paxil® varies, Paxil CR® 60 units, Pexeva® varies, Prozac Weekly® 5 units, Sarafem® 30 units, Selfemra™ varies, sertraline HCL® varies, Viibyrd® 30 units, and Zoloft® varies).
24. Serotonin and Norepinephrine Reuptake Inhibitors (Cymbalta® varies, Effexor® varies, Effexor XR® varies, Pristiq® 30 units, Savella® varies, venlafaxine ER® varies, Viibryd® 1 pack).
25. Sprix: Coverage is limited to 5 days of therapy per prescription.
26. Tamiflu® and Relenza®: Coverage is limited to one course of treatment every 90 days. Additional quantities require prior authorization from RDT.
27. Topical steroids (120gm or ml/month)
28. Toradol: Coverage is limited to 20 tablets per prescription.

Maintenance Medications

All Maintenance Medications must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through CVS Caremark mail service. You must receive a 90-day supply of the medications and classes listed below. Maintenance medications dispensed in quantities less than 90 days are not covered by the plan. If you are starting on a new maintenance medication, you may receive up to two 30-day fills to be sure you tolerate the medication

and that your dosage is correct. After the second 30-day fill, the maintenance medication will be covered only in a 90-day supply, and only when filled at a Retail Maintenance Network pharmacy or using the CVS Caremark Mail Service Pharmacy Program.

1. Allergies
2. Alzheimer's Disease
3. Antipsychotics
4. Blood Modifiers/Thinners
5. Cancer (non-specialty)
6. Contraceptives/Hormone Replacement
7. Depression
8. Diabetes
9. Accu-Chek test strips/lancets
10. Digestive Enzymes
11. Diuretics
12. Enlarged Prostate
13. Gastrointestinal agents
14. Glaucoma
15. Gout
16. High Blood Pressure & Heart Disease
17. High Cholesterol
18. Immune Disorders (non-specialty)
19. Inflammatory Bowel Disease (non-specialty)
20. Irritable Bowel Disease
21. Kidney Disease
22. Osteoporosis
23. Overactive Bladder
24. Parkinson's Disease
25. Respiratory Agents
26. Rheumatoid Arthritis
27. Seizure Disorders
28. Thyroid
29. Ulcer/GERD

Specialty Drug Program

PEIA's Specialty Drug Program has two components:

1. **Specialty Injectable Drugs** are administered by injection or infusion, and are managed by UMR through the medical benefit.
2. **Common Specialty Medications** are self-administered, and are managed by CVS Specialty Pharmacy

Specialty Injectable Drugs are prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring. The PEIA PPB Plans cover specialty injectable drugs through a program managed by UMR. The program provides comprehensive direction to policyholders and their dependents for treatments utilizing specialty drugs. If your physician prescribes a specialty drug, that physician, you, or the pharmacist must call UMR at 1-888-440-7342. The Specialty Injectable Drug list is located at https://fls.uhc.com/print/UM1428.pdf. To obtain a paper copy, call 1-888-680-7342. UMR will review the drug for medical necessity If denied, UMR will contact your physician for additional information which may allow approval of the requested medication.

Common Specialty Medications are self-administered specialty injectable drugs through the CVS Specialty Pharmacy. Through the CVS Specialty Pharmacy, you will be assigned a dedicated CareTeam with specialists in your condition. These specialists will check in to see what you need and how they can help moving forward. They'll also make arrangements for injection training, as needed. If your physician prescribes a common specialty drug, they can call 1-800-237-2767, fax 1-800-323-2445, or e-prescribe the specialty drug to the CVS Specialty Pharmacy. CVS Specialty will then work with your doctor to obtain prior authorization for the specialty medication. Once approved, you can have your specialty medications delivered directly to you.

Many specialty medications have manufacturer programs which will financially assist patients in the purchase of the medication. PEIA requires that if a financial assistance program is available, you must participate in the program. Only your actual out-of-pocket payments will count toward your drug deductible and annual out-of-pocket maximum; not amounts discounted off the price by the manufacturer or seller of the specialty medication.

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

After you have met your prescription drug deductible, the copayment on these medications will generally be $100 for any Common Specialty Medications on the WV Preferred Drug List and $150 for any Common Specialty Medications not on the WV Preferred Drug List; however, certain specialty medications are subject to variable copayments, depending on the availability of programs. Only your actual out-of-pocket payments will count toward your drug deductible and annual out-of-pocket maximum, not amounts discounted off the price by the manufacturer or seller of the specialty medications. Contact CVS Caremark to verify copayments. These drugs are not available in 90-day supplies. If you are prescribed one of these common specialty medications, call CVS Caremark at 1-844-260-5894.



Common Specialty Medications

Drug Name	Category
Acthar® HP [QLL]	Multiple Sclerosis
Actimmune	Anti-Neoplastic
Adcirca® [QLL]	Pulmonary Hypertension
Afinitor [QLL]	Anti-Neoplastic
Ampyra [QLL]	Multiple Sclerosis
Aranesp®	Anemia
Avonex [QLL]	Multiple Sclerosis
Betaseron® [QLL]	Multiple Sclerosis
Boniva®	Osteoporosis
Cerezyme® [QLL]	Gaucher Disease
Copaxone® [QLL]	Multiple Sclerosis
Eligard	Anti-Neoplastic
Enbrel® [QLL]	Inflammatory Conditions
Epclusa* [QLL]	Hepatitis C
Epogen®	Anemia
Forteo® [QLL]	Osteoporosis
Genotropin	Growth Hormone
Gilenya® [QLL]	Multiple Sclerosis
Gleevec® [QLL]	Anti-Neoplastic
Harvoni* [QLL]	Hepatitis C
Humatrope®	Growth Hormone
Humira® [QLL]	Inflammatory Conditions
Incivek	Hepatitis
Inlyta® [QLL]	Cancer
Intron A®	Interferons
Jakafi® [QLL]	Cancer
Kalydeco® [QLL]	Respiratory conditions
Kineret® [QLL]	Inflammatory Conditions
Kuvan	Enzyme deficiencies
Letairis® [QLL]	Pulmonary Arterial Hypertension
Leukine	Hematopoietic
Lupron Depot®	Endometriosis, Anti-Neoplastic, Precocious Puberty
Lupron Depot®-Ped	Precocious Puberty
Lupron®	Anti-Neoplastic
Neulasta® [QLL]	Neutropenia
Neupogen®	Neutropenia
Nexavar [QLL]	Anti-Neoplastic, Immunosuppressant

Drug Name	Category
Norditropin®	Growth Hormone
Nutropin®	Growth Hormone
Octreotide Acetate	Endocrine disorders
Pegasys®	Hepatitis C
Peg-Intron® [QLL]	Hepatitis C
Procrit®	Anemia
Pulmozyme® [QLL]	Cystic Fibrosis
Rebif® [QLL]	Multiple Sclerosis
Revatio® [QLL]	Pulmonary Arterial Hypertension
Revlimid® [QLL]	Anti-Neoplastic, Immunosuppressant
Riba pak	Hepatitis
Ribavirin®	Hepatitis C
Sandostatin LAR [QLL]	Endocrine disorders
Simponi® [QLL]	Rheumatoid Arthritis
Sprycel [QLL]	Anti-Neoplastic
Sutent® [QLL]	Anti-Neoplastic
Tarceva® [QLL]	Anti-Neoplastic
Tasigna [QLL]	Anti-Neoplastic
Temodar®	Anti-Neoplastic
Tev-Tropin®	Growth Hormone
Thalomid® [QLL]	Anti-Neoplastic
Thyrogen® Kit	Diagnostic
Tobi® [QLL]	Cystic Fibrosis
Tracleer® [QLL]	Pulmonary Arterial Hypertension
Tykerb [QLL]	Anti-Neoplastic
Tyvaso® [QLL]	Pulmonary Arterial Hypertension
Victrelis [QLL]	Hepatitis
Votrient [QLL]	Anti-Neoplastic
Xalkori® [QLL]	Cancer
Xeloda® [QLL]	Anti-Neoplastic
Xenazine® [QLL]	CNS Disorders
Zarxio	Neutropenia
Zoladex®	Anti-Neoplastic
Zolinza [QLL]	Anti-Neoplastic
Zytiga® [QLL]	Anti-Neoplastic

All Common Specialty Medications require Precertification from CVS Caremark. [QLL] This drug is subject to Quantity Level Limits (QLL). This list is not all-inclusive and is subject to change throughout the Plan Year.

*Coverage of this drug is limited to a once-in-a lifetime course of treatment.

Diabetes Management

PEIA covers diabetes management items under its Maintenance Medication benefit, which means that needles, syringes, lancets and test strips must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through CVS mail service. For patients just starting use of needles, syringes, lancets or test strips, PEIA will permit two 30-day fills of the new prescription at a network pharmacy, but after that, all items must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through CVS mail service.

Blood Glucose Monitors: Covered diabetic insureds can receive a free Accu-Chek Aviva Plus, Accu-Chek Nano, or Accu-Chek Guide blood glucose monitor with a current prescription. All major chain pharmacies and some doctor's offices have vouchers for the Accu-Chek meters. Take your prescription to them or call the CVS Caremark Diabetic Meter Program at 1-800-588-4456 to request a meter.

Glucose Test Strips: The plan covers only Accu-Chek Aviva Plus test strips, Accu-Chek Nano test strips, and Accu-Chek Guide test strips at the preferred copayment of $50 per 90-day supply. Other brands require a 100% copayment.

Needles/Syringes and Lancets: The plan covers only BD needles and syringes. You can obtain a supply of disposable needles/syringes and lancets for the copayments listed below.

Diabetes Management Copayments		
	PEIA PPO Plan C	
	Up to 30-day supply	90-day supply*
Accu-Chek test strips, as noted above	Not Covered	$50
BD needles/syringes	Not Covered	$20
Lancets	Not Covered	$20

*You must purchase all Diabetes Management items in 90-day supplies through a Retail Maintenance Network pharmacy or through Mail Service.

Tobacco Cessation Program

PEIA has a tobacco cessation program that includes coverage for both prescription and over-the-counter (OTC) tobacco cessation products. For a full description of the benefits, please see "Tobacco Cessation" on page 65. The drugs are covered under your prescription drug program.

What is Covered?

PEIA will cover prescription and over-the counter (OTC) tobacco cessation products if they are dispensed with a prescription. Toll-free numbers are provided by the manufacturers of most of these products for phone coaching and support.

Coverage is limited to two twelve-week cycles per rolling twelve-month period. Tobacco-cessation products are available at no cost to the member; both the deductible and the copayment are waived when prescribed by a physician and purchased at a network pharmacy.

Who is Eligible for Tobacco Cessation?

Only those members who have been paying the Standard (tobacco-user) premium are eligible for this benefit. If you have signed an affidavit claiming to be tobacco-free, and then you attempt to use the tobacco cessation benefit, you will be declined services. 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. Abortifacient (i.e., Mifeprex)
2. Anorexiants (any drug used for the purpose of weight loss)
3. Anti-wrinkle agents (e.g. Renova®)
4. Arestin
5. Bleaching agents (e.g., Eldopaque®, Eldoquin Forte®, Melanex®, Nuquin®, Solaquin®)
6. Bulk ingredients (i.e. bulk chemicals, bulk powders, bulk compounding ingredients, hormone replacement bulk ingredients, high cost bases, compound kits, etc.)
7. Charges for the administration or injection of any drug
8. Compounds containing one or more ingredients which are commercially available in alternate medications, are an over-the counter (OTC) product or lack clinical evidence in compounded dosage forms. This list is subject to change throughout the Plan Year.
9. Contraceptive devices and implants
10. Diagnostic agents
11. Drugs dispensed by a hospital, clinic or physician's office
12. Drugs excluded from the formulary by the PBM. You can find a list of these medications at https://peia.wv.gov/prescription_drug_lists/Documents/Formulary_Exclusions.pdf
13. 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.
14. Drugs requiring prior authorization when prescribed for uses and quantities not approved by the FDA
15. Drugs requiring a prescription by State law, but not by federal law (State controlled) are not covered
16. Erectile dysfunction medications
17. Fertility drugs
18. Fioricet® with Codeine (butalbital/acetaminophen caffeine with codeine)
19. Fiorinal® with Codeine (butalbital/aspirin caffeine with codeine)
20. Hair growth stimulants
21. Homeopathic medications
22. Hypoactive Sexual Desire Disorder (HSDD) Agents
23. Immunizations, biological sera, blood or blood products, Hyalgan®, Synvisc®, Remicade®, Synagis®, Xolair®, Amevive®, Raptiva®, Vivitrol®, (these are covered under the medical plan)
24. Latisse™
25. Medical or therapeutic foods (with the exception of certain "medical foods," through the age of 20, as specifically provided for under W.Va. Code § 5-16-7)
26. 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
27. Medications 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.
28. Newly released prescription medications that have been on the market less than 12 months
29. Non-legend drugs
30. Nutritional Supplements (that require a prescription, i.e., Metanx, Limbrel, Deplen)
31. Omnipod V-go®, Finesse® or other disposable insulin delivery systems
32. Pentazocine/Acetaminophen (Talacen®)
33. 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.
34. Replacement medications for lost, damaged or stolen drugs
35. Requests for less than a 90-day supply of maintenance medications, or requests for more than a 30-day supply of short-term medications.

36. Respiratory Therapy Supplies: Nebulizers
37. Respiratory Therapy Supplies: Peak Flow Meters
38. Stadol® Nasal Spray (butorphanol)
39. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those listed above.
40. Unit dose medications
41. Vacation supplies, unless leaving the country. If you are leaving the country, and want PEIA to cover a vacation supply, you must submit documentation (copy of an airline ticket, travel agency itinerary, etc.) to substantiate your international travel arrangements. Please allow seven (7) days for processing.

Other Important Features of Your Prescription Drug Program

Your prescription drug program is designed to provide the care and services 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.

CVS Caremark 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 CVS Caremark's 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. CVS Caremark's 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 CVS Caremark 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 CVS Caremark mails. Your retail pharmacy may also provide you with drug information. By visiting www.caremark.com, you also can access other health-related information. Click on Health Resources 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.caremark.com. Any written health information cannot replace the expertise and advice of health care practitioners who have direct contact with a patient. All CVS Caremark 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, CVS Caremark may provide information to you on one or more of CVS Caremark's 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 a CVS Caremark pharmacist or nurse. CVS Caremark 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 CVS Caremark to have the secondary claim processed:
   - a completed CVS Caremark claim form;
   - the receipt from the pharmacy; and
   - 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 30 days from receipt of your claim form.

If you need claim forms, call CVS Caremark's Member services at 1-844-260-5894 or visit their website at www.caremark.com.

2. Medicare Part B: 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. UMR 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:
   a) Immunosuppressants
   b) Oral Chemotherapeutic medications
   c) Drugs for nausea associated with chemo meds
   d) Diabetic testing supplies
   e) Limited Inhalation therapies

How to File a Claim

Filing a Prescription Drug Claim

Prescription drug claims are processed by CVS Caremark and should be submitted to:

CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-2084

To process a prescription drug claim, CVS Caremark requires a prescription receipt/label which includes:

• Pharmacy Name/Address	• Quantity
• Date Filled	• Days' Supply
• Drug Name, Strength and NDC	• Price
• Rx Number	• Patient's Name

Claims received missing any of the above information may be returned or payment may be denied or delayed.

Cash register receipts and canceled checks are not acceptable proof of your claim.

If you have other insurance which is primary, you need to submit an Explanation of Benefits (EOB) from the other insurance which shows the amount the primary insurance paid 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 services to file a prescription claim. If PEIA is your secondary insurer, 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.

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 receive from PEIA. See "Subrogation and Reimbursement" on page 98 for details.

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 must use your I.D. card at a participating pharmacy to receive prescription benefits.

Claims Incurred Outside of the U.S.A.

If you or a covered dependent incur prescription drug expenses while outside the United States, you will 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 CVS Caremark.

CVS Caremark will determine, through a local banking institution, the currency exchange rate and you will be reimbursed according to the terms of PEIA PPB Plans A, B & D.

Appealing a Drug 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 CVS Caremark 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 CVS Caremark 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 (for Physician's offices or pharmacists ONLY)	RDT 1-800-847-3859	Rational Drug Therapy Program WVU School of Pharmacy P.O. Box 9511 HSCN Morgantown, WV 26506
Prescription drug claim payment error or denial	CVS Caremark 1-844-260-5894	CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-2084
Appealing a Specialty Drug Claim	CVS Caremark Call: 1-844-260-5894 Fax: 1-855-230-5548	CVS Caremark Specialty Appeals Department 800 Biermann Court Mount Prospect, IL 60056

CVS Caremark or RDT will respond in writing to you and/or 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 CVS Caremark or RDT.

Mail third step appeals to:

Director, Public Employees Insurance Agency, 601 57th St. SE, Charleston, WV 25304-2345.

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, considering 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 CVS Caremark at 1-844-260-5894.

External Review: If we have denied your request for the provision of or payment for a health care service or course of treatment, our decision may be reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. An external review may be initiated by us or requested by you. You may submit a request for external review within 4 months after receipt of the notice of denial to the PEIA Clinical Unit, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345. For standard external review by your request, a decision will be made within 45 days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may request an expedited external review of our denial. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may request an external review of our denial. External review is the final level of appeal, regardless of whether the external review was initiated by us or requested by you. External review is not available for drugs, services or items which are simply not covered by the Plan. External review is also not available for out-of-state benefit level appeals or for a change in drug cost-sharing tier.

How to Reach CVS Caremark

On the Internet: Reach CVS Caremark at www.caremark.com. Visit CVS Caremark's 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 CVS Caremark via the Internet, you can learn more about your program by calling CVS Caremark Customer Care at 1-844-260-5894, 24 hours a day, 7 days a week.

Special Services: CVS Caremark continually strives to meet the special needs of PEIA's insureds: You may call a registered pharmacist at any time for consultations at 1-844-260-5894.

PEIA's hearing-impaired insureds may use CVS Caremark's TDD number at 1-800-863-5488.

Visually impaired insureds may request that their mail service prescriptions include labels in Braille by calling 1-844-260-5894.

Controlling Costs

Prohibition of Balance Billing

All PEIA health plans are 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 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 UMR for details.

Preferred Provider Organizations

For services provided outside the State of West Virginia, UMR utilizes several networks. 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 UMR uses, see "PEIA's Networks" on page 39.

After you receive medical attention, your claim will be routed to UMR. 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). UMR will send you an Explanation of Benefits (EOB).

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:

1. charges for services not received; and
2. overcharges or overpayments resulting from clerical error or miscalculation.
3. Any claim for a condition not present on admission, such as a hospital acquired infection or fall.

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 UMR or CVS Caremark 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

Healthcare Fraud and Abuse

By law, PEIA must report suspected fraud to the WV Insurance Commission. In addition, PEIA works with the US Attorney's office in the investigation of potential fraud and/or abuse.

Examples of Provider Fraud:

- waiving member copays;
- balance billing members for services;
- billing for services not provided;
- billing for a non-covered service as a covered service (e.g. billing a "tummy tuck" (non-covered) as a hernia repair (covered);
- billing that appears to be a deliberate claim for duplicate payments for the same services;
- misrepresenting dates, services or identities of members or providers;
- intentional incorrect reporting of diagnoses or procedures to maximize payment (up-coding);
- billing for separate parts of a procedure rather than the whole (unbundling);

- accepting or giving kickbacks for member referrals;
- prescribing additional and unnecessary treatments (over-utilization).

Examples of Member Fraud:

- providing false information when applying for PEIA coverage;
- forging or selling prescription drugs;
- "loaning" or using another's insurance card.

How to Report Healthcare Fraud and Abuse

If you suspect healthcare fraud, please call the PEIA toll-free number (1-888-680-7342) and ask to speak with a member of the Special Investigations Team or complete the Health Care Fraud and Abuse Form on PEIA's website. You will be asked to provide as much information as possible. PEIA will investigate your concern(s) and, if appropriate, refer the information to the appropriate legal authorities.

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.

UMR, 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, 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:
    a) the policy covers a specified disease, accident only, disability, or other limited benefits;
    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.

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 an active employee's dependent who has coverage as a retired employee from his or her former employer and is also covered by Medicare, benefits are determined in this order:

    1) the plan which covers the individual as a dependent of an active employee will pay first;
    2) Medicare will pay next;
    3) the plan which covers the person as a retired employee will pay last.

D. 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.

E. 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.

F. 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 "D" Above will apply;

G. 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 "D" above will apply;

H. for a dependent child who has coverage under either or both parents' plans and also has coverage as a dependent under a spouse's plan, the Plan which has covered the dependent the longest will be primary;

I. in the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under the parent's plans, the order of benefits shall be determined by applying the birthday rule to the dependent child's parent and the dependent's spouse;

J. 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;

K. 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 the person's dependent) will be primary;
2) the benefits under the continuation coverage will be secondary;

L. 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.

"Carve-out" 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 C pays 80% in-network with no limit when services are pre-certified.
- **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, if the services are covered by PEIA.

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

For most retirees and their Medicare-eligible dependents covered by PEIA and Medicare, regardless of age (see exception below), PEIA's Medicare Advantage plan is the primary insurer.

When you become an eligible beneficiary of Medicare, you must enroll in Medicare Parts A and B and send a copy of your Medicare card to PEIA. 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 requires payment of a monthly premium. You MUST NOT enroll in a separate Medicare Part D plan, since PEIA will provide prescription drug coverage for retirees with Medicare.

If you do not enroll in Medicare Parts A & B, your coverage may be terminated.

If you or your dependents have other coverage in addition to PEIA and Medicare, contact UMR 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 UMR or PEIA to determine who the primary insurer will be.

Whenever you or your covered dependents become eligible for Medicare, you should send a copy of your Medicare card to PEIA.

Members enrolled in an HMO when they become Medicare-eligible will be transferred to the Special Medicare Plan.

Special Medicare Plan

PEIA created the Special Medicare plan to accommodate the needs of two specific groups of Medicare-eligible members:

1. Members who are unable to access medical care through the PEIA's Medicare Advantage Plan due to provider limitations are permitted, on a case-by-case basis, to move into PEIA's Special Medicare Plan.
2. Employees who retire after the beginning of a plan year, and retired employees who become eligible for Medicare during the Plan year. Retired members who are enrolled in an HMO when they become Medicare-eligible will be transferred to PEIA's Special Medicare Plan. These members in the Special Medicare Plan will be moved to PEIA's Medicare Advantage Plan at the beginning of the next plan year (the following January).

Most members are enrolled in the Special Medicare Plan for less than a year. Those who become eligible for Medicare in the middle of a plan year, move into the Special Medicare Plan, and are transferred to the PEIA Medicare Advantage Plan at the beginning of the next Medicare plan year.

Under the Special Medicare plan, the member purchases traditional Medicare Parts A and B, and their secondary medical and prescription claims are paid by UMR and CVS Caremark, respectively. Medical and Prescription Drug benefits under the Special Medicare Plan are generally the same as those provided under the PEIA's Medicare Advantage plan.

The Medicare retiree's plan year is from January 1 to December 31 of each year. Below are the benefits for Plan Year 2019:

Service Description	Medicare Retiree Benefit Plan Year 2019 January – December 2019
Annual Deductible	$150
Primary Care Office Visit	$20
Specialty Office Visit	$40
Emergency Room	$50
Hospital Inpatient care	$100 per admission
Outpatient and Office Surgery	$100
Other services (testing, etc.)	$0
Medical Out-of-Pocket Maximum	$1,200
Prescription Drug Deductible	$75
Generic Drugs Copayment	$5
Preferred Drug Copayment	$15
Non-preferred Drug Copayment	50% coinsurance
Specialty Drug Copayment	$100 preferred/$150 non-preferred
Prescription Drug Out-of-Pocket Maximum	$1,750

The benefits described in the "What is Covered" section beginning on page 51 will be provided to members of the Special Medicare plan with the cost-sharing detailed in the chart above.

There are two main differences between the Special Medicare Plan and the Humana Medicare Advantage and Prescription Drug (MAPD) plan.

1. The non-preferred drug costs - in the Special Medicare Plan, the non-preferred drug cost-sharing is 75% coinsurance; in the MAPD plan, the non-preferred drug coinsurance is 50%.
2. The MAPD plan offers a free gym membership through a program called SilverSneakers. SilverSneakers is not available in the Special Medicare Plan.

Those who become eligible for the Special Medicare plan during a plan year have the right to request immediate enrollment in the Humana plan. Call PEIA for details.

If you have questions about the benefits of the Special Medicare plan, please contact PEIA's customer service unit at 1-888-680-7342.

Medicare for Active Employees

For PEIA PPB Plan active employees and their dependents that 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 and your Medicare-eligible dependents do not need to sign up for Medicare Part B and pay the premium. When you prepare to retire, you and any Medicare-eligible dependents must enroll for Medicare Part B. If you do not enroll in Medicare Parts A & B, your coverage may be terminated.

You DO NOT need to enroll in Medicare Part D as an active employee or upon retirement.

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, you must 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.

Benefit Assistance Program

Medicare-eligible retired employees with 15 or more years of service whose annual household income falls below 250% of the federal poverty level, and who are members of the PEIA PPB Plan can qualify for benefit assistance. 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. The details of the Benefit Assistance Program are described in the Evidence of Coverage produced by Coventry. Since Benefit Assistance is not available to non-Medicare retirees, there is no further discussion of it here. If you are interested in the details of the program, you can find more information online at www.wvpeia.com. If you qualify, contact PEIA for an application, or you can print a copy at www.wvpeia.com.

Medicare Part D

Medicare offers prescription drug coverage through Medicare Part D. Please be aware that you DO NOT have to purchase Medicare Part D coverage.

PEIA's Medicare Advantage Plan: Humana provides prescription drug coverage for retirees in the Medicare Advantage Plan through a Medicare Part D plan.

Special Medicare Plan: PEIA continues to provide creditable prescription drug coverage to our members in the Special Medicare Plan, and Medicare Part D will be of little or no use to you. If you enroll in a Medicare Part D plan, PEIA will reject your prescription at the pharmacy, and require the pharmacy to bill the Medicare Prescription Drug Plan first.

For those "dual eligible" that have both Medicare and Medicaid, you will be automatically enrolled in a Medicare Part D plan. Using the Medicare Part D plan will be to your benefit, since it is a better benefit to the "dual eligible" member.

Medicare Part D Creditable Coverage Notice

The coverage you have now through West Virginia PEIA is considered by Medicare to be creditable coverage, or coverage as good as or better than that offered under Medicare's standard Part D benefit. if you are eligible for Medicare and decide to opt out of this plan's coverage, you should consider joining another plan as soon as possible to avoid having to pay a late enrollment penalty. If you choose to leave this plan and do not join another plan within 63 days of the termination date of this coverage, you will be charged a late enrollment penalty of at least 1% per month you went without coverage as good as or better than that offered under Medicare Part D.

When can you change to a different plan?

Generally, Medicare-eligible members can change plans during the yearly enrollment period (called the "annual coordinated election period"). Generally, this is the only time of year to choose a different Medicare plan. Certain individuals, such as those with Medicaid, those who get "Extra Help" paying for their drugs, or those who move out of the geographic service area, can make changes at other times.

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:

1. 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;
2. 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
3. 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:

1. the PEIA's withholding payment of further benefits; and
2. an obligation by the PEIA insured to pay costs, attorney's 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 PEIA or with one of the managed care plans associated with PEIA.

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.

HIPAA Notice of Privacy Practices

Effective date of this notice: September 23, 2013

If you have questions about this notice, please contact the person listed under "Who to Contact" 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, pharmacies, 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 that is created, received, used, or maintained by PEIA or its Business Associates that relates to the past, present, or future physical or mental health, healthcare, or payment for the healthcare of an individual.

Who Must Abide by This Notice

- PEIA
- All employees, staff, students, volunteers, contractors, and other personnel who work for and/or 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 the purpose(s) of treatment, and as necessary for payment and healthcare operations activities as described below.

Our Legal Duties

- We are required by law to maintain the privacy and security 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 respond to your requests or concerns within a timely manner.
- 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.

This notice describes how we may use your personal, protected health information, or disclose it to others, for a number of different 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 and use the results to discuss with your health issues. 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 administrators 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 that 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. These third-parties are called "Business Associates" and are held to the same standards as PEIA with regard to ensuring the privacy, security, integrity, and confidentiality of your personal information. If, in the course of healthcare operations, your confidential information is transmitted electronically, PEIA requires that information to be sent in a secure and encrypted format that renders it unreadable and unusable to unauthorized users.
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. We will only disclose the minimum amount of health information necessary to fulfill the legal requirement.

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. We will only disclose the minimum amount of health information necessary to fulfill the investigation request.

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.

11. 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.

12. Research. We may disclose your health information in an appropriately de-identified format in connection with approved medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.

13. 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.

14. 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.

15. PEIA will not release, disclose, exchange, and/or sell your health information for use in marketing or for-profit ventures by third parties.

Your Rights

1. Authorization. We may not 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. We will only disclose the minimum amount of health information necessary to fulfill the authorization request. 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 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 and certain specific exclusions do apply. 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 will accept electronic request for releases of information in the form of e-mails or other electronic means. If you choose, you may receive your records in an electronic format but PEIA has the right to make sure that electronic information is delivered in a safe, secure, and confidential format. We may charge a fee for the cost of copying, mailing and/or e-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 including the change. The new notice will include an effective date. We will make the new notice available 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 have any questions about the privacy and security of your records, 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, 601 57th St. SE, Charleston, WV 25304-2345, 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.Help@wv.gov.

June 1, 2004

Revised: August 2, 2013

Effective date: September 23, 2013

Tear this page out and take it to your doctor!

PEIA Adult Annual Routine Physical and Screening Examination Form

Primary Care Visit

You are entitled under the Patient Protection and Affordable Care Act (PPACA) to an annual primary care visit that is covered at 100% with no deductible, copayment or coinsurance once per plan year. * We recommend your Annual Routine Physical and Screening examination be provided by your CCP or primary care physician. This visit includes the following:

☐ History & Physical to include:
- ⊕ Screening and counseling for
  - Alcohol and/or substance abuse
  - Blood pressure
  - Depression
  - Diabetes
  - Domestic violence
  - Nutrition
  - Obesity
  - Physical activity
  - STD prevention
  - Other health risk factors as appropriate and provided for by PACA
- ⊕ Review of medications

☐ Blood Work to include:
- ⊕ General Health Panel
- ⊕ Lipid Panel

☐ Immunizations as recommended by the American Academy of Family Physicians

Any additional services, including lab work, diagnostic testing and procedures with the appropriate diagnosis, that are provided to you during this visit will be subject to your deductible, coinsurance and copayments. This may result in additional out-of-pocket costs!

To the Provider:

☐ Bill one of the following codes for this visit:
- ⊕ 99381-99397 for the annual adult preventative care visit

☐ The most commonly used diagnosis code for this visit is:
- ⊕ Z00.00

☐ If you are CLIA certified, you may process labs in your office. You can bill the following for the lab work:

Panel Code	Component Code	Code Description
80061		Lipid Panel
80050	-	General Health Panel -- includes the following component:
-	80053	Comprehensive Metabolic Panel -- includes the following component code:
-	84443	Thyroid Stimulating Hormone (TSH) plus ONE of the following CBC or combination of CBC component codes for the same patient on the same date of service:
-	85025	Blood Count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
-	85027 + 85004	Blood Count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) AND Blood count; automated differential WBC count
-	85027 + 85007	Blood count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) AND Blood count; blood smear, microscopic examination with manual differential WBC count
-	85027 + 85009	Blood count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) AND Blood count; manual differential WBC count, buffy coat

☐ If you are not CLIA certified, labs must be performed and billed by a CLIA certified provider.

☐ Bill appropriate immunization codes.

*More details are available in the PEIA Summary Plan Description What Is Covered section.

Public Employees Insurance Agency

601 57th Street, SE / Suite 2
Charleston, WV 25304-2345

JOIN PEIA!

PEIA	Answers to questions about the PEIA PPB Plans	888-680-7342 (toll-free)	www.wvpeia.com
UMR	Answers to questions about eligibility, benefits and network.	888-440-7342 (toll-free)	www.UMR.com
The Health Plan of West Virginia, Inc. HMOs & POS	Answers to questions about The Health Plan of West Virginia, Inc.'s Benefits	800-624-6961 (toll-free) or 888-847-7902	www.healthplan.org
Securian Financial	Answers to questions about life insurance or to file a life insurance claim	800-283-9515 (toll-free)	www.securian.com
Mountaineer Flexible Benefits	Dental, vision, disability insurance, flexible spending accounts, etc.	844-559-8248 (toll-free)	www.myfbmc.com