SUMMARY PLAN DESCRIPTION

PLAN YEAR 2013 BENEFITS

July 1, 2012 - June 30, 2013

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

Under a 1996 Federal law, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is self-funded by the employer, rather than provided through a health insurance policy. The Public Employees Insurance Agency (PEIA) has elected to exempt the PEIA PPB Plans from item number five (5) of the following requirements:

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

The PEIA PPB Plan complies with all of the other listed Federal requirements. The exemption from the Federal requirement will be in effect for the plan year beginning July 1, 2012, and ending June 30, 2013. The election may be renewed for subsequent plan years. The only practical effect to PEIA members of this election is that benefits relating to mental health treatment will be substantially the same as last year.

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

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

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 64 for details.

Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families. Please note that there are currently no Federal funds available for this program.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

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Introduction

Welcome to your PEIA Summary Plan Description. This booklet describes the benefits provided for PEIA insureds for Plan Year 2013 (July 1, 2012 - June 30, 2013). It includes important information for all public employees who have ANY coverage through PEIA.

Managed Care Members

For those who are enrolled in managed care plans, this booklet provides all of the eligibility and enrollment information regarding your benefits. If you need or want to change your benefits, please refer to the information in the beginning of this booklet for details of your rights, responsibilities, and the time frames for making eligibility changes. Information in this booklet regarding managed care plan 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, C 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 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 the PEIA PPB Plans. 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 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, 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. 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. You will find the benefits of the four plans detailed in two sections of this book. PEIA PPB Plans A, B & D are explained together. PEIA PPB Plan C has its own section, since the benefits are very different from Plans A & B.

Medicare-primary Members

For most Medicare-eligible retired employees and Medicare-eligible dependents of retired employees, PEIA contracts 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 the 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 Minnesota Life at **1-866-397-3498.**

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

Precertification, Pre-authorizations, Prior Approvals for Out-of-State Care and Utilization Management - ActiveHealth at 1-304-353-7820 or 1-888-440-7342 (toll-free).

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

Common Specialty Medications – HealthSmart at 1-888-440-7342 (toll-free)

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

PEIA - Answers to questions about eligibility and third-level claim appeals 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 – Humana at 1-800-783-4599

Minnesota Life – Answers to questions about life insurance or to file a life insurance claim. Call Minnesota Life at 1-800-203-9515

Mountaineer Flexible Benefits - Dental, vision, and disability insurance and flexible spending accounts. Fringe Benefits Management Company at 1-800-342-8017 (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 Pathways to Wellness – health screenings and related services at participating worksites, visit www.peiapathways.com

PEIA Weight Management Program – for information or to enroll in the program, call 1-866-688-7493

The Health Plan HMO at 1-800-624-6961 (toll-free), 1-740-695-3585 or on the web at www.healthplan.org

Terms & Definitions

ActiveHealth: PEIA's utilization management and case management vendor.

Aetna Signature Administrators℠ (ASA) PPO: PEIA's out-of-state Preferred Provider Network.

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, 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 Plan. For more information, read the "Recovery of Incorrect Payments" section.

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

Claims Administrator: HealthSmart.

Common Specialty Medications: Specialty medications are high-cost injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of the patient's drug therapy. Under the PEIA PPB Plans, all specialty medications require precertification from HealthSmart.

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

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

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

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

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

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

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

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

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

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

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

Exclusions: Services, treatments, supplies, conditions, or circumstances that are not covered under the PEIA PPB 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 meets the definition of Phase 1, 2, 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

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

Handicap: A medical or physical impairment which substantially limits one or more of a person's major life activities. The term "major life activities" includes functions such as care for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working. "Substantially limits" means interferes with or affects over a substantial period of time. Minor, temporary ailments or injuries shall not be considered physical or mental impairments which substantially limit a person's major life activities. "Physical or mental impairment" includes such diseases and conditions as orthopedic, visual, speech and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; autism; multiple sclerosis and diabetes. The term "handicap" does not include excessive use or abuse of alcohol, tobacco or drugs.

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. No permission or authorization from the IRS is necessary to establish an HSA. When the member sets up an HSA, he or she will need to work with a trustee. A qualified HSA trustee can be a bank, an insurance company, or anyone already approved by the IRS to be a trustee of individual retirement arrangements (IRAs) or Archer MSAs. The HSA works in conjunction with a High Deductible Health Plan. For more information, and a full description of PEIA's HDHP, see the section entitled PEIA PPB Plan C.

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.

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

HMO (Health Maintenance Organization): A managed care organization that provides a wide range of comprehensive health care services for a fixed periodic payment. PEIA contracts with HMOs to provide health coverage for policyholders and their dependents 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.

Improve Your Score: PEIA's premium discount program based upon participation in a PEIA Pathways to Wellness worksite health screening or a comparable screening as discussed in the section entitled "Improve Your Score."

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.

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.

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

Medical Home: A West Virginia provider who is a general practice doctor, family practice doctor, internist, pediatrician, geriatrician, or OB/GYN who has enrolled with HealthSmart as a medical home provider, and who is listed in PEIA's Medical Home directory.

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

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

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

Notification: The required process for reporting an inpatient stay to ActiveHealth. 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 the PEIA PPB Plans.

PEIA Pathways to Wellness Program: PEIA's worksite wellness program providing health screens and lifestyle change programs.

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

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

PEIA 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 in the section of this document 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 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 providers in the Aetna Signature Administrators Preferred Provider Organization. For services provided outside of the State, contact HealthSmart to find an out-of-state network provider.

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

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

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

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

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

Pre-existing Condition: 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.

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 ActiveHealth 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, divorce, or death of a spouse
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 requirement – marriage of a dependent or no longer satisfying the definition of 'qualifying child' or 'qualifying relative.'

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

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 100.

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 HealthSmart and prescription claims are paid by Express Scripts. The medical benefits are identical to those provided to members of the Humana MAPD plan.

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

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

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

HealthSmart: The third party administrator that handles medical claim processing and customer service for the PEIA PPB Plans.

What PEIA Offers

Health Coverage

PEIA offers the PEIA PPB Plans A, B, and C to all active employees, and PEIA PPB Plan D to active employees who are West Virginia residents.

Plan A is the standard plan available to all eligible enrollees, including active employees and non-Medicare retirees.

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

Plan C is an IRS-qualified High Deductible Health Plan. The benefits of Plan C are detailed in the PEIA PPB Plan C Medical & Prescription Benefits section of this book.

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.

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

The PEIA PPB Plans use a coordination of benefits provision that determines how they will pay if you have other health insurance available to you. See page 99 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 are 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 some 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 and vision coverage on a post-tax basis. Enrollment materials are mailed to all eligible retired employees during the enrollment period. If you have questions about these benefits, contact Fringe Benefits Management Company at **1-800-342-8017**.

Open Enrollment for Mountaineer Flexible Benefits is held each Spring. 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 **1-800-342-801**

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 $2,500 for tax-free reimbursement of eligible medical expenses.
Dependent Care Flexible Spending Account	Deposit up to $5,000 for tax-free reimbursement of eligible expenses.
*Legal Plan	Coverage for legal matters.

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

Eligibility and Enrollment for Active Employees

Who Is Eligible?

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

- a full-time employee (working regularly at least 20 hours per week);
- an elected official who works full-time in the elected position;
- a member of the West Virginia Legislature (must pay 100% of the premium);
- 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.

Temporary and part-time employees are not eligible for coverage, except as noted above.

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

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

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, including your most recent Federal tax return showing that you've claimed the dependent(s) on your taxes. 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 completing enrollment forms at your place of employment or by contacting PEIA, in the case of retirees or surviving dependents. 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.

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

New Employees

You may enroll for health coverage, basic life insurance, dependent life insurance, and up to $500,000 of optional life insurance coverage during the calendar month 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 28 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.

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.

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-July1, 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.

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:

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.

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 following qualifying events:.

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

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.

Transfer

If you transfer from one participating State agency to another in the middle of a plan year without a lapse in coverage, that transfer does not give you the right to change health plans. You can only change plans if the transfer moves you out of the enrollment area of a plan so that accessing care is unreasonable. Since the PEIA PPB 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. Transfer from a State agency to a non-State agency may permit a change in coverage based on financial hardship.

Life Insurance

Existing employees may add or increase the amount of life insurance at any time by 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 28 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 28 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 28 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. 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.

Medicare for Active Employees

For PEIA PPB Plan active employees or dependents of active employees who are age 65 or older and eligible for Medicare, as long as you are an active employee, PEIA will be your primary insurer, except in a few rare cases. As long as you are an active employee, 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.

Dependents

If you enroll your dependents for health coverage due to a qualifying event, their coverage begins the first day of the month following enrollment. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent see page 28 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. You may add new dependents to your existing dependent life insurance policy during the month of or the two calendar months following the date of their qualifying event, and no medical information will be required. Coverage will become effective the first day of the month following enrollment. Otherwise, you will have to submit medical information and be approved by the life insurance carrier to obtain dependent life insurance coverage.

To add dependents, you must use PEIA's online enrollment site, "Manage My Benefits," or complete enrollment forms to add them to your coverage. Coverage will become effective the first day of the month following enrollment. Coverage is not automatic, even if you have an existing family plan. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent see page 28 for details.

Dependents may be removed from coverage during open enrollment or at the time of a qualifying event. 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.

Special Rules for Newborn or Adopted Children

Newborn Child

When you have a child you must:

- enroll your biological newborn child during the calendar month of birth or the two following calendar months.
  - coverage will be made effective retroactive to the date of birth,
  - 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.
- 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.

Adopted Child

When you adopt a child 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, and
  - 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.
- 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

Life Insurance

Newborn Child

If you add a biological newborn child to your existing dependent life insurance policy during the calendar month of or the two calendar months following the date of birth, 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. 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.

Adopted Child

If you add an adopted child to your existing dependent life insurance policy during the calendar month of or the two calendar months following the date of placement in your home, coverage can be made effective retroactive to the date of placement, and 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, you will have to submit medical information and be approved to obtain dependent life insurance coverage for your adopted child. PEIA requires a copy of the adoption papers to enroll the child.

Eligibility and Enrollment for Retired Employees

Who Is Eligible?

If you are a retired public employee, you 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 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. Non-Medicare retiring employees enrolled in PEIA PPB Plans B, C or D will be transferred to PEIA PPB Plan A upon retirement.

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 for the remainder of that plan year. Members enrolled in an HMO when they become Medicare-eligible may be transferred to the Special Medicare Plan or may choose to remain with the HMO.

Under the Special Medicare plan, the member purchases traditional Medicare Parts A and B, and their secondary medical and prescription claims are paid by HealthSmart and Express Scripts, Inc., respectively. Medical and Prescription Drug 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 following July 1, when they are transferred to PEIA's Medicare Advantage Plan.

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 24 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 reemployed 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-July1, 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 (private sector) employment just prior to retirement. 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 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.

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 pay the same premiums as those with 25 or more years of service. 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 26 for details.

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 B, C or D will be transferred automatically to PEIA PPB Plan A upon retirement, since Plans B, 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 Health Insurance Claim (HIC) 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 plan.

- To be eligible for PEIA's Medicare Advantage plan, the member must enroll for Medicare Parts A and B.
- If you do not enroll in Medicare Parts A & B and pay the monthly premium, you will not be eligible for PEIA's Medicare Advantage plan, which is the only coverage offered to most retired, Medicare-eligible members.

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 through a Medicare Part D Plan administered by Express Scripts, Inc. 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 or adopted children, stepchildren or other children for whom you are the court-appointed guardian under **age 26.**
- 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, including your most recent Federal tax return showing that you've claimed the dependent(s) on your taxes. 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. 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 the 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 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 yet eligible for Medicare. If you or any enrolled dependents have Medicare as your primary health coverage (or will at any time during the plan year) you may not join an HMO. If either you or your enrolled dependents become Medicare-primary while enrolled in a managed care plan, you must notify PEIA so that we can discuss your options for coverage. 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.

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. 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 28 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 28 for details.

Dependents may be removed from coverage during open enrollment or at the time of a qualifying event. 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.

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

Special Rules for Newborn or Adopted Children

Newborn Child

You must enroll your biological newborn child during the calendar month of birth or the two following calendar months; coverage will be made effective retroactive to the date of birth, and any premium increase associated with the addition of this child will also be retroactive to the month of birth. If you do not enroll your newborn within this time frame, you cannot add the newborn child until the next open enrollment period. 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 pend 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.

Adopted Child

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, and 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. PEIA requires a copy of the adoption papers to enroll the child.

Life Insurance

Newborn Child

If you add a biological newborn child to your existing dependent life insurance policy during the calendar month of or the two calendar months following the date of birth, coverage will be made effective retroactive to the date of birth, and 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. 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 pend the child's coverage until we receive it.

Adopted Child

If you add an adopted child to your existing dependent life insurance policy during the calendar month of or the two calendar months following the date of placement in your home, coverage can be made effective retroactive to the date of placement, and 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, you will have to submit medical information and be approved to obtain dependent life insurance coverage for your adopted child. PEIA requires a copy of the adoption papers to enroll the child.

Eligibility and Enrollment for Surviving Dependents

Who Is Eligible

If you are a surviving dependent of an active or retired public employee, and you were insured as a dependent under the policyholder's coverage by PEIA (in the PEIA PPB Plan, the Special Medicare Plan, PEIA's Medicare Advantage plan, or in a managed care plan) at the time of the policyholder's death, you may elect to continue health coverage as a policyholder in your own right under your health plan. 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 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.

Dependents

If you elect PEIA health coverage, you may also enroll the following dependents, if they were enrolled in the plan at the time of the policyholder's death:

- your biological or adopted children, stepchildren or other children for whom you are the court-appointed guardian under **age 26.**

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, including your most recent Federal tax return showing that you've claimed the dependent(s) on your taxes. 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 that 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 whether to enroll as a surviving dependent of the policyholder, or as an active or retired employee.

- If enrolled as a surviving dependent, premiums will be based on 25 or more 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 the surviving retired employee's 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 PPB Plan;
4. as "Employee Only" and "Employee and Child(ren)" in the same managed care plan. All children must be enrolled under the same policyholder; or
5. 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. The Family with Employee Spouse premium discount will not be granted unless both employees are basic life insurance policyholders in the plan. 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. The retired public employee must carry the basic life insurance.

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.

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

When an employee transfers from one participating State agency to another, PEIA will collect updated salary information, and the premium at the new agency will be based on the salary at the new agency, whether it is a salary increase or a decrease. In this case, a plan change may be permitted, if the transfer creates a qualifying change in family status under the Premium Conversion Plan. Transfer from a State agency to a non-State agency may permit a change in coverage based on 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, contact PEIA for an application. You will be asked to provide documentation when the child reaches age 26 and periodically thereafter.

Court-Ordered Dependent (COD)

If a PEIA-insured employee and his or her spouse divorce, the employee must remove the ex-spouse from coverage, even if the court orders the employee to provide medical coverage for the ex-spouse. Ex-spouses are NOT eligible dependents in the PEIA plan. To provide the coverage for an ex-spouse as ordered by the court, the employee must look to COBRA coverage or for other privately available coverage.

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

Medicare and Active Employees

If an active employee 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 & 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.

When you or your dependent become eligible for Medicare, please 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. Medical claims will be processed by HealthSmart, 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 Express Scripts.

Leaves of Absence

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

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

Medical Leave (Non-Workers' Compensation)

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

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

Medical Leave (Workers' Compensation)

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

Personal Leave

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

Family Leave

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

Military Leave

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

An employee who is on an approved military leave of absence without pay, due to an active call of duty from the President, is entitled to continue health and life benefit coverage for as long as premium payments are made. The employee is responsible for paying 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

Annual Open Enrollment

Each Spring PEIA holds an open enrollment period for health coverage. The period is typically the month of April. During Open Enrollment, current 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 the 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 managed care plan. A physician's withdrawal from a managed care plan does not qualify a member to change plans in the middle of a plan year.

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.

Your PEIA PPB Plan ID card verifies that you have medical and prescription drug coverage through PEIA. On the back we've listed important phone numbers you may need. One card will be issued for individual coverage, and two cards will be issued for family coverage. The policyholder's name and identification number will be printed on all cards. If you want additional cards for children not residing with you, or if you need to replace a lost card, please contact HealthSmart at **1-888-440-7342.**

If you enroll in a managed care plan or if you are in PEIA's Medicare Advantage 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 should 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 Change in Status form or a Change of Address form (depending on what information you need to update). The forms are available from your benefit coordinator or by calling PEIA. Completed forms should be returned to your benefit coordinator.

When Coverage Ends

In most cases when your employment ends you have the option to extend health coverage under the federal COBRA law, or convert your life insurance benefits into a private policy. All of these options are at your expense and require you to act within a specified time. Please see the section on "Options After Termination of Coverage" on page 21.

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. 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 ;
- dependent child aged 19-26 becomes eligible for his/her own employer-sponsored health coverage;
- surviving spouse remarries;
- 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. If a policyholder fails to remove ineligible dependents (divorced spouse, married children, etc.) the Plan may pursue reimbursement of any claims paid for the ineligible dependent from the employee.

The policyholder may voluntarily terminate coverage for dependents when there has been a qualifying event to allow such a change. To do this, 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 the policyholder has 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, coverage will be cancelled, and all claims incurred will be your personal responsibility. 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 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 may only allow re-enrollment 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 appeal for and the PEIA director may, at his or her discretion, grant a waiver of the 60-day requirement.

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.

Eligible retirees may continue participation in PEIA. The withdrawn agency is billed a subsidy premium for these retirees.

Retirees not eligible to participate in PEIA must look to their former employer for retiree coverage.

Certificate of Creditable Coverage

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

Options After Termination of Coverage

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

Continuing Health Coverage under COBRA

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

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

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

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

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

To enroll for COBRA benefits, contact HealthSmart 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 Minnesota Life at **1-800-203-9515.** The individual life insurance policy is issued by PEIA's life insurance carrier, Minnesota Life. Once you have completed the application form, mail it to the address printed on the application form. Premiums for individual policies are generally higher than rates for a group plan.

Paying For Benefits

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

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

PEIA offers several premium discounts as detailed below

Who Gets The Premium Discounts			
	Active Employees in PEIA PPB Plans A, B, C or D	Active Employees or Retirees in The Health Plan HMO	Retired Employees in PEIA PPB Plan A, the Special Medicare Plan or the Medicare Advantage and Prescription Drug (MAPD) Plan
Advance Directive/Living Will	Yes	Yes	Yes
Improve Your Score	Yes	No	No
Tobacco-free	Yes	Yes	Yes

Tobacco-free 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. 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. From time to time, the tobacco-free waiting period may be adjusted and members will be notified in writing. 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 47 for details.

Once a member has submitted a tobacco affidavit, either at initial enrollment or during a previous Open Enrollment, 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.

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. 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 to receive the discount.

Advance Directives/Living Will Discount

PEIA offers the Advance Directive/Living Will discount. This discount is $4 per month off of the health insurance premium for health policyholders who have completed a living will or an advance directive for healthcare.

The policyholder must have completed one of the following advance directive forms to claim the discount:

1. WV Living Will Form
2. WV Medical Power of Attorney form
3. WV Combined Living Will and Medical Power of Attorney form
4. Five Wishes form. Call **(888) 5WISHES (594-7437).**

The first three items on this list are available free of charge from the WV Center for End of Life Care at www.wvendoflife.org or by calling **1-877-209-8086.** The WV Combined Living Will and Medical Power of Attorney form has been printed in the Shopper's Guide for a number of years. Policyholders who live outside West Virginia must complete the advance directive document that is legal in his/her state of residence to claim the discount.

Existing employees may change their Advance Directive/Living Will affidavit online. Go to www.wvpeia.com and click on the green "Manage My Benefits" button at the top right of the page. Employees who do not have internet access may call PEIA's Customer Service unit to request a copy of the affidavit. In most cases, the change in premium will occur on the first of the month following receipt of the affidavit.

New employees may mark their Advance Directive/Living Will Affidavit on the Health Benefit enrollment form or may set their status online during the initial enrollment process on the Manage My Benefits site. Go to www.wvpeia.com to get started.

Please remember, PEIA does not want a copy of the advance directive or living will document,. Please DO NOT mail or fax the document to the agency.

Improve Your Score Discount

Improve Your Score Discount. PEIA offers a unique opportunity to understand your health risk factors and improve your health status by offering a $10 per month discount off the standard health premium to active policyholders in all PEIA PPB Plans who participate in the Improve Your Score program. Retired policyholders are not charged the $10 premium increase, and are not eligible for the $10 Improve Your Score premium discount. The Improve Your Score program is a two-step process designed to make you and your doctor aware of individual health risks, including cholesterol, glucose or blood sugar, blood pressure and waist circumference, and then to act on your modifiable risk factors to attempt to improve them. Details of the program are found on pages 47 and 81.

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, your tobacco-use status, whether you've completed an Advance Directive/Living Will affidavit and your participation in the Improve Your Score program..

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

Retired Employees

Premiums for retired employees are determined based on a number of factors, including 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 the PEIA each month, and for them, premiums are due by the fifth of the month following the month for which the premium was invoiced. Example: May premium is due June 5.

For Direct Pay non-Medicare Retired Employees:

If payment is not received by June 5, a late notice will be sent to the policyholder. 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 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 may only allow re-enrollment during the open enrollment period, and only if the policyholder enrolls as a new enrollee and agrees to pay premiums by direct draft from a bank account. In no event will an appeal and re-instatement due to termination for failure to pay occur more than once in a 12-month period.

At PEIA's discretion, a policyholder who has been terminated for failure to pay may revoke the right to ever re-enroll with PEIA. In this case, the policyholder will be required to reimburse PEIA for the claim costs incurred by plan after last premium payment as a final settlement of the debt. The policyholder will be required to sign an agreement accepting the settlement arrangement and permanently revoking the right to re-enroll in 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.

For Direct Pay Medicare Eligible Retirees

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.

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, their Advance Directive/Living Will affidavit 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. Generally, retired employees' contributions pay for about 30% of the cost of their claims. The remaining 70% of the cost is paid by employers. Eligible retired employees may use sick and/or annual leave to extend employer-paid health coverage.

Employees Who Retire On or After July 1, 1997

Employees who retire on or after July 1, 1997, pay premiums for their health coverage based on the plan they choose, their eligibility for Medicare, their tobacco-use status, their Advance Directive/Living Will affidavit status and their credited years of service as reported by the Consolidated Public Retirement Board (CPRB), or for those in the Teachers Defined Contribution Plan or a non-State retirement plan, the years of service reported by the employing agency or the non-State plan. These premiums may be adjusted annually for medical inflation. Employees with 25 or more years of service will be charged the same premium as those who retired before July 1, 1997. Those with fewer than 25 years of service will pay higher premiums. If you are using accrued sick and/or annual leave or years of service to extend your employer-paid insurance, all or a portion of 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, their Advance Directive/Living Will affidavit status, and their tobacco-use status. These premiums may be adjusted annually for medical inflation. Surviving dependents are considered to have 25 or more years of service, and will be charged the same premium as those who retired before July 1, 1997. Premiums for surviving dependents are deducted from their annuity on a monthly basis or are paid directly to PEIA.

Direct Pay

Some surviving dependents pay premiums directly to the PEIA each month. Their premiums are due by the fifth of the month following the month for which the premium was invoiced. Example: May premium is due June 5.

For non-Medicare surviving dependents, if payment is not received by June 5, a late notice will be sent to the policyholder. 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 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 may only allow re-enrollment during the open enrollment period, and only if the policyholder enrolls as a new enrollee and agrees to pay premiums by direct draft from a bank account. In no event will an appeal and re-instatement due to termination for failure to pay occur more than once in a 12-month period.

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.

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.

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. If you choose to defer your retirement, you cannot defer your sick and annual leave for use later. Elected public officials are not eligible for this benefit. This benefit terminates when the policyholder dies; it cannot be used by surviving dependents, who may continue coverage by paying the monthly premium.

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

Using Accrued Sick and Annual Leave to Extend Coverage

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

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

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

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

Before July 1, 1988:

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

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

Between July 1, 1988 and June 30, 2001:

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

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

On or after July 1, 2001:

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

Extending Coverage for Higher Education Faculty

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

- 3 1/3 years of teaching service = 1 year of single coverage
- 5 years of teaching service = 1 year of family coverage

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.

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	$77	$51	$29	$20
15-24	$98	$75	$47	$29
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. In most cases, your employer will contribute up to the same amount toward your coverage as if you were enrolled in the PEIA PPB Plan. If the managed care plan's premium is higher than this amount, you will be responsible for the difference. Local government agencies will determine their contribution for managed care plans. To find the amount of your premium contribution, check the Shopper's Guide for the current plan year, or contact your benefit coordinator.

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

Premium Conversion

Paying Premiums With Pre-Tax Dollars

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

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

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

With premium conversion, your premiums are deducted from your salary before federal, state and Social Security taxes are calculated. This reduces the amount of your income subject to tax. You must agree to pay the premiums through this plan for a full plan year, unless you have a change in family status that allows you to change your benefits. The 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 as detailed in the following chart:

Status Change Event	Documentation Required
Divorce	Provide a copy of the divorce decree showing that the divorce is final.
Marriage	Copy of valid marriage license or certificate
Birth of Child	Copy of child's birth certificate
Adoption	Copy of adoption papers
Adding coverage for a stepchild who resides with the policyholder	Copy of child's birth certificate
Open Enrollment under spouse's employer's benefit plan	A copy of printed material showing open enrollment dates and the employer's name.
Death of spouse or dependent	A copy of the death certificate.
Beginning of spouse's employment	A 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 employment	A letter from the spouse's 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 employment	A letter from the spouse's insurance carrier indicating the change in insurance coverage, the effective date of that change and dependents covered.
Unpaid leave of absence by employee or spouse	A letter from your or your spouse's personnel office stating the date that you or your spouse went on unpaid leave or returned from unpaid leave.
Change from full-time to part-time employment or vice versa for employee or spouse	A letter from your or your spouse's employer stating the previous hours worked and the new hours worked and the effective date of the change.

Health Care Benefits

Active employees and non-Medicare-eligible retirees and surviving dependents may get health care benefits through PEIA from a managed care plan or from the PEIA PPB Plan. Medicare-eligible members of the Special Medicare Plan also receive their benefits through PEIA.

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 or B, your benefits are described on the following pages. This section describes only the benefits offered under the PEIA PPB Plans A, B & D. PEIA PPB Plan C benefits are described later in this book. PEIA PPB Plans B and C are not offered to retirees.

The PEIA PPB Plans A, B & D

The PEIA PPB Plans A, B & 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 & D are identical. The difference is in the deductibles 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 - HealthSmart at **1-888-440-7342**
- Precertification, case management, and pre-authorizations, and prior approvals for out-of-state care – ActiveHealth at **1-888-440-7342.**
- Prescription drug claims and benefits - Express Scripts at **1-877-256-4680**
- Common Specialty Medication claims and benefits – HealthSmart at **1-888-440-7342**

PEIA's Networks

PEIA PPB Plans A & B

The PEIA PPB Plans provide 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 Aetna® Signature Administrators℠ PPO to provide care for members of PEIA PPB Plans A, B and C. In addition, HealthSmart contracts with some out-of-state providers to serve PEIA PPB Plans A, B and C participants only. To locate a network provider, call HealthSmart at **1-888-440-7342 or 304-353-7820.** For PEIA PPB Plans A, B and C, care provided by non-network providers requires prior approval, or it will be paid at the lower out-of-network benefit level (typically 60% of PEIA's maximum allowance with the additional out-of-network deductible). Not all providers in these networks may participate with PEIA. Kings Daughters Medical Center and Our Lady of Bellefonte hospitals in Kentucky and UPMC Health System remain out-of-network for PEIA, regardless of their network status with the ASA PPO network. Also, PEIA does not use the ASA PPO network in Washington County Ohio, or in Boyd County, Kentucky. PEIA reserves the right to remove providers from the networks, so not all providers in all networks 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 ActiveHealth when it appears that out-of-state care may be necessary. ActiveHealth 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 ActiveHealth **IS NOT COVERED.**

Providers 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 HealthSmart 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 requires 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. Care from network providers does not require prior approval, and that care will be covered at the in-network benefit level (typically 80%). Precertification of inpatient stays and certain outpatient procedures is still required. See page 35 for details.

What You Pay With The PEIA PPB 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 outside of the network.

The family deductible is divided up among the family members. No one member of the family will pay more than the individual deductible (see Employee Only in the chart below). 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 participants of the family may contribute to the family deductible with no one person meeting the individual deductible; once the family deductible is met, the plan pays on all members of the family.

The deductibles are listed on the following chart according to income level and coverage tier. Deductibles for Family with Employee Spouse coverage are based on the average of the two employees' salaries. This provision does not apply to local government agencies or retired employees.

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

*One family member may have to meet the 'employee only' deductible, which is $1,000. 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 plan year, new plan year or both plan years. For example, if you go into the hospital on June 28 and are released on July 6, the hospital bill is paid based on the date of admission, so it would fall under the old plan year's deductible. Physician charges are paid based on the date of service, so if you have surgery on July 2, the surgeon's bill will be processed based on the new plan year, and the deductible for the new plan year will apply to the surgeon's bill.

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

	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 the Reasonable and Customary amount.	20% coinsurance + amounts that exceed the Reasonable and Customary amount.	20% coinsurance + amounts that exceed the Reasonable and Customary amount.
Access care outside WV (beyond bordering counties) using PPO providers without prior approval*	40% coinsurance + $500 copayment for unapproved out-of-state care	40% coinsurance + $500 copayment for unapproved out-of-state care	20% coinsurance + $500 copayment for unapproved out-of-state care
Access care outside WV using non-PPO providers without prior approval*	40% coinsurance + $500 copayment for unapproved out-of-state care + amounts that exceed the PEIA fee schedule.	40% coinsurance + $500 copayment for unapproved out-of-state care + amounts that exceed the PEIA fee schedule.	40% coinsurance + $500 copayment for unapproved out-of-state care + amounts that exceed the PEIA fee schedule.

*** 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 ActiveHealth 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 Aetna Signature Administrators PPO network with a few exclusions. See page 29 for details.

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 80% of the contracted payment rate, and you will be responsible for any copayments, deductible, 20% coinsurance, and non-covered services.

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 80% of the contracted payment rate, and you will be responsible for any copayments, deductible, 20% coinsurance, and non-covered services.

For services of non-network providers without prior approval, the plan will pay 60% of PEIA's maximum allowance; you will be responsible for any deductible, a $500 copayment for unapproved out-of-state care, 40% coinsurance and any amount which exceeds PEIA's maximum allowance. For non-network providers, PEIA will pay what it would have paid if the services had been provided in-State. You will be responsible for any balance billing, and those balance billing amounts are considered non-covered services, so they do not count toward the deductible or out-of-pocket maximum.

PPB Plan participants traveling out-of-state have coverage for urgent and emergency care. In an emergency, seek treatment at the nearest facility that is able to provide the needed care, and that care will be paid at the in-network benefit level as an emergency. For non-emergency, urgent care, call HealthSmart 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 80% of the contracted payment rate. You will be responsible for any copayment, deductible, 20% coinsurance, and non-covered services. PEIA PPB Plan D participants must be WV residents.

Care provided by non-network providers must have prior approval. Services of non-network providers will be paid at 60% of PEIA's maximum allowance, unless approved by HealthSmart 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.

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.

Benefit Design

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

Covered in Full

The following services are covered in full in-network for all PEIA PPB Plans:

Type of Service	Your In-network Cost
Routine prenatal care (physician services)	$0; Covered in full
Well child exams and immunizations as recommended by the American Academy of Pediatrics	$0; Covered in full
High risk birth score program	$0; Covered in full
Annual screening mammogram	$0; Covered in full
Annual Pap smear [1]	$0; Covered in full
Colorectal cancer screening age 50 + above [1]	$0; Covered in full
Prostate cancer screening age 50 + above [1]	$0; Covered in full
Abdominal Aortic Aneurysm one-time screening from men age 65- 75 who have ever smoked	$0; Covered in full
Cholesterol Screening for men age 35 and older and women age 45 and older or others at higher risk	$0; Covered in full
Tobacco Use screening for all adults and cessation interventions for tobacco users (excludes tobacco cessation medications)	$0; Covered in full
HIV screening for all adults at higher risk	$0; Covered in full
Immunization vaccines recommended for adults — doses, recommended ages and recommended populations vary	$0; Covered in full
Syphilis screening for all adults at higher risk	$0; Covered in full
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
BRAC counseling about genetic testing for women at higher risk	$0; Covered in full
Hepatitis B screening for pregnant women at their first prenatal visit	$0; Covered in full
Osteoporosis screening for women over age 60 depending on risk factors	$0; Covered in full
RH Incompatibility screening for all pregnant women and follow- up testing for women at higher risk	$0; Covered in full
Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea and Syphilis for women at increased risk	$0; Covered in full
Alcohol and drug Use assessments for adolescents	$0; Covered in full
Autism Screening for children at 18 and 24 months	$0; Covered in full
Behavorial assessments for children of all ages	$0; Covered in full
Cervical Dysplasia screening for sexually active females	$0; Covered in full
Congenital Hypothyroidism screening for newborns	$0; Covered in full
Developmental screening for children at higher risk of lipid disorders	$0; Covered in full
Dyslipidemia screening for children at higher risk of lipid disorders	$0; Covered in full
Gonorrhea preventive medication for the eyes of all newborns	$0; Covered in full
Hearing screening for all newborns at birth	$0; Covered in full
Height, Weight and Body Mass Index measurements for children	$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
Lead screening for children at risk of exposure	$0; Covered in full
Medical History for all children throughout development	$0; Covered in full
Obesity screening and counseling (does not include the PEIA Weight Management Program)	$0; Covered in full
Oral Health risk assessment for young children	$0; Covered in full

Type of Service	Your In-network Cost
Phenylketonuria (PKU) screening for this genetic disorder in newborns	$0; Covered in full
Tuberculin testing for children at higher risk of tuberculosis	$0; Covered in full
Vision screening for all children	$0; Covered in full
Routine Physical and Screening Exam cover for each member covered annually	$0; Covered in full

[1] Testing covered in full; $10 preventive care office visit copay may apply.

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
Medical Home - preventive care or treat illness or injury	$10 copayment per visit with no deductible
Physician Office Visits - preventive care	$10 copayment per visit with no deductible
Physician Office Visits - treat illness or injury	$15 copayment per visit with no deductible
Specialist Office Visit	$25 copayment per visit with no deductible
Out-of-State Office Visits	$15 copayment per visit with no deductible
Second Surgical Opinions*	$15 copayment per visit with no deductible

* No copayment if required by ActiveHealth.

Copayment, Coinsurance and Deductible

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

Type of Service	Your In-network Cost
Emergency Services (including supplies) at emergency room	$50 copayment + deductible and 20% coinsurance when certified as an emergency (waived if admitted)
Non-emergency services at emergency room*	$100 copayment + deductible and 20% coinsurance
Ambulatory surgery/Outpatient surgery(facility-based)	$50 copayment + deductible and 20% coinsurance
Outpatient Therapy Services visits 1-20	$10 copayment + deductible and 20% coinsurance
Outpatient Therapy Services visits 21+	$25 copayment + deductible and 20% 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.

Coinsurance and Deductible

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

Medical Out-of-Pocket Maximum

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

Once you have met your out-of-pocket maximum, the plan will pay 100% of your covered charges (less applicable copayments) for the remainder of the plan year. Your out-of-pocket maximum amount depends on your employment status, your salary, 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 Out-of-Network* Out-of-Pocket Maximum**
PEIA PPB Plans A and D (Active, State Agency, Colleges and Universities, Boards of Education)	$ 0 - 20,000	$ 800/single;$1,200/family	$1,600/single;$2,400/family
	$20,001 - 30,000	$1,100/single;$1,650/family	$2,200/single;$3,300/family
	$30,001 - 36,000	$1,250/single;$1,875/family	$2,500/single;$3,750/family
	$36,001 - 42,000	$1,500/single;$2,250/family	$3,000/single;$4,500/family
	$42,001 - 50,000	$1,750/single;$2,625/family	$3,500/single;$5,250/family
	$50,001 - 62,500	$1,800/single;$2,700/family	$3,600/single;$5,400/family
	$62,501 - 75,000	$1,850/single;$2,775/family	$3,700/single;$5,550/family
	$75,001 - 100,000	$1,900/single;$2,850/family	$3,800/single;$5,700/family
	$100,001 - 125,000	$2,000/single;$3,000/family	$4,000/single;$6,000/family
	$125,001 +	$2,250/single;$3,375/family	$4,500/single;$6,750/family
PEIA PPB Plan B	Not Applicable	$2,000/single;$4,000/family	$4,000/single;$8,000/family
Non-State Plan A	Not applicable	$1,500/single;$2,250/family	$3,000/single;$4,500/family
Retired, Non-Medicare	Not applicable	$1,500	$3,000

* 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 (includes all benefits listed in this category under What is Covered)	20 visits (total amount allowed for all therapies combined)
Inpatient Rehabilitation	150 days
Skilled Nursing Facility	100 days

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: Precertification/Notification, Preauthorization & Prior Approval

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 appropriate setting by a network provider, if possible. PEIA has three different types of pre-service determinations: precertification/notification, preauthorization and prior approval 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 ActiveHealth, 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.

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 ActiveHealth.

Precertification/Notification Requirements

Precertification of Inpatient Admissions and certain outpatient 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 medical documentation. Notification to ActiveHealth is required to evaluate the admission/service in order to determine if the patient's medical condition will require case management, such as discharge planning for home health care services.

Precertification is required for the following inpatient admissions:

1. Hysterectomy,
2. Laminectomy
3. Laminectomy with spinal fusion surgery,
4. Discectomy with spinal fusion surgery,
5. Spinal fusion surgery,
6. Artificial intervertebral disc surgery,
7. Insertion of implantable devices including, but not limited to; implantable pumps, spinal cord stimulators, neuromuscular stimulators and bone growth stimulators,
8. Cochlear implants.
9. Uvulopalatopharyngoplasty,
10. Elective and 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.
11. Bariatric surgery
12. 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),
13. Mental health and substance abuse treatment, and
14. All admissions to out-of-state hospitals/facilities, and

Precertification is required for the following outpatient services:

1. Any potentially experimental/investigational procedure, medical device, or treatment
2. Cochlear implants.
3. Continuous glucose monitors
4. CT scan of sinuses or brain
5. CTA (CT angiography)
6. Dialysis Services
7. Durable medical equipment purchases and/or rentals of $1,000 or more, and
8. Elective (non-emergent) facility to facility air ambulance transportation
9. Hyperbaric Oxygen Therapy (HBOT)
10. IMRT (intensity modulated radiation therapy)
11. Limited Molecular Diagnostic/Genetic Testing to include the following 5 tests: Hereditary Non-polyposis Colorectal Cancer (HNPCC) testing, BRCA gene testing, Oncotype DX, Familial Adenomatous Polyposis (FAP) testing, Catecholaminergic Polymorphic Ventricular Tachycardia (FPVT) testing.
12. MRI scan of knee and spine (includes cervical, thoracic, and lumbar)
13. Partial/day mental health and substance abuse treatment programs,
14. Services in the home as described under "Medical Case Management" on page 37,
15. Sleep studies, services and equipment. See section on "sleep management services" on page 44.
16. Specialty drugs
17. SPECT (single photon emission computed tomography) of brain and lung

18. Surgeries:
    a) artificial disc surgery
    b) bariatric surgery,
    c) discectomy with spinal fusion surgery,
    d) elective and 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,
    e) hysterectomy,
    f) implantable devices including, but not limited to: implantable pumps, spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators,
    g) laminectomy,
    h) laminectomy with spinal fusion surgery,
    i) spinal fusion surgery,
    j) transplants, and
    k) uvulopalatopharyngoplasty,

Notification

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

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

Failure to precertify or notify ActiveHealth 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 copayment, coinsurance, deductible, and amounts that exceed PEIA's maximum allowance.

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

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

Timely Precertification Requirements	
Type of Admission	**Advance Notice Required**
Scheduled:	
Planned admission	3 business days in advance
Inpatient elective surgery or procedure	3 business days in advance
Maternity (notify ActiveHealth 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
Urgent/Emergency	Within 48 hours of admission
Extended stay	Additional days may be recommended based on medical necessity

Preauthorization (Voluntary)

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

ActiveHealth Management
PO Box 221138
Chantilly, VA 20153-1138

Your provider should include your name, address, telephone number, your ID number, and all information about the procedure that's recommended. ActiveHealth may contact your physician for more information. Remember, if your request for preauthorization is denied, you

will be responsible for paying for the procedure if you choose to have it. Due to specific benefit criteria, preauthorization is recommended for the following procedures:

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

Prior Approval for Out-of-Network 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 80% of the contracted payment rate; you will be responsible for any deductible, copayments and 20% coinsurance.

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

Special arrangements have been made for 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 31 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, ActiveHealth will direct the member to an out-of-state network facility capable of providing the needed services.

Medical Case Management

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

- arrange home care to prevent hospitalization;
- arrange services in the home to facilitate early hospital discharge;
- obtain discounts for special medical equipment;
- locate appropriate services to meet the patient's health care needs; and
- for catastrophic cases, when medically proven as a part of a comprehensive plan of care, allow additional visits for outpatient mental health or Outpatient Therapy Services; and
- under very limited circumstances, allow additional visits for short-term outpatient physical therapy services for treatment of a separate condition which is also a new incident or illness - not an exacerbation of a chronic illness.

For example, a member who receives physical therapy following a stroke and later in the Plan Year has a separate new condition, such as a broken leg, may receive coverage for additional physical therapy visits.

For catastrophic cases involving serious long-term illness or injury resulting in loss or impaired function requiring medically necessary therapeutic intervention, the ActiveHealth 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 38.

ActiveHealth must be notified for medical case management for the following services:

1. home health care, including but not limited to:
   a) skilled nursing of more than twelve (12) visits;
   b) I.V. therapy in the home;
   c) physical therapy, occupational therapy or speech therapy done in the home; and
   d) medication provided or administered by a home health agency.
2. inpatient hospice care
3. skilled nursing facility services;
4. rehabilitation services, and
5. treatment for Autism Spectrum Disorder

Transition of Care Program (New Participants Only)

If you are new to the PEIA PPB Plan, and have been receiving medical treatment from a non-network provider, you may be concerned that your care will be interrupted in your move to this Plan. To assist participants receiving treatment for serious medical conditions from non-network providers, PEIA has a Transition of Care (TOC) program. If you qualify for TOC, you can continue to receive medical treatment from a non-network provider during a transition period specified by ActiveHealth 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, ActiveHealth's nurses will work with you to provide that care. Conditions limited or excluded from coverage are not eligible for TOC benefits.

To apply for the TOC program, request a copy of the TOC form by calling 1-888-440-7342 or 1-304-353-7820 and submit the completed form to ActiveHealth 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 ActiveHealth. 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; an
- providing treatment within the scope or limitation of the license or certification; and
- not under sanction by Medicare, Medicaid or both. Services of providers under sanction will be denied for the duration of the sanction; 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).

Please keep in mind that for most participants, services you receive from non-network providers are subject to higher levels of coinsurance if not prior approved by ActiveHealth to ensure the lowest out-of-pocket expense. If you have questions about coverage of services, call HealthSmart at **1-888-440-7342** or **1-304-353-7820.** 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 31 under "Non-resident PPB Plan A & B Participants".

NOTE: Services marked with a ◊ require precertification from ActiveHealth.

- **Allergy Services.** Including testing and related treatment; in-network care covered at 80% after in-network 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% after in-network deductible. 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 $50 copayment and 20% coinsurance. The copayment and coinsurance amounts apply after the in-network deductible has been met. See "Outpatient Surgery" on page 41.
- **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 in-network deductible is met.
- ◊ **Bariatric surgery.** This benefit is subject to a $500 copayment and 20% coinsurance. The copayment and coinsurance amounts apply after the in-network 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 for the following conditions: heart attack in the 12 months preceding treatment, heart failure, coronary by- pass surgery or stabilized angina pectoris. Covered at 80% after in-network deductible is met.
- **Chelation Therapy.** Benefits for these services are limited. Contact ActiveHealth for preauthorization. If covered, in-network therapy is paid at 80% after the in-network 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 Outpatient Therapy Benefit (see below) and are covered at 80% after the in-network deductible and $10 or $25 copayment are met. 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 per visit. Visits 21 +, if approved by ActiveHealth, require a $25 copayment per visit. Office visits are covered with a $20 copayment and x-rays are covered at 80% after the in-network deductible is met. Maintenance services are not covered. Preauthorization is recommended for services for children under age 16. See Outpatient Therapy Services for more information.
- **Christian Science Treatment.** Treatment for a demonstrable illness or injury if provided in a facility accredited by the Commission for Accreditation of Christian Science Nursing Facilities/Organizations, Inc. or by a practitioner accredited by the Mother Church is covered at 80% after the in-network deductible. No benefits will be paid for the purpose of rest or study, for communication costs, or if the person requiring attention is receiving parallel medical care. Coverage is limited to a maximum cost to the plan of $1,000 per plan year. If required, this benefit may be extended for inpatient care for up to 60 days per plan year. Inpatient care must be precertified.
- **Colorectal Cancer Screenings.** Routine screening to detect colorectal cancer is covered at 100% in-network with no deductible or coinsurance required. The related office visit expenses are subject to the applicable preventive care office visit copayment. This benefit is covered as follows:
  - Fecal-occult blood test—1 in 12 months/age 50 and over
  - Flexible sigmoidoscopy—1 in 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.
- **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 $500 copayment and in-network 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 HealthSmart 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 HealthSmart within the initial six months.
- **Dental Services (impacted teeth).** Medically necessary extraction of impacted teeth is covered at 80% in-network after the $500 copayment and deductible are met. Extractions for the purpose of orthodontia are not covered.
- **DEXA Scans.** Bone mass measurement by DEXA is limited to one scan every 24 months for members who meet one of the following criteria:
  1. Member has received results from a peripheral osteoporosis screen indicating moderate or high risk for osteoporosis; OR
  2. Member has documented clinical risk for osteoporosis.

  Diagnostic testing is covered at 80% after deductible has been met. Routine screening scans are not covered. Complete details of the DEXA scan payment policy are available on the PEIA website at www.wvpeia.com.
- **Diabetes Education.** Services of a diabetes education program that meets the standards of the American Diabetes Association are covered at 80% after in-network deductible is met. Coverage is limited to six (6) visits per patient: three visits with the dietician and three visits with a registered nurse. Contact HealthSmart 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 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 or purchase (at the plan's discretion) of standard DME, when prescribed by a physician. Prosthetics

and DME purchases of $1,000 or more, or rental for more than 3 months must be precertified by ActiveHealth. DME and prosthetics are covered at 80% after the in-network deductible is met. Omnipod and other disposable insulin delivery systems are not covered.

- **Emergency Services (including supplies).** Services received in an emergency room when the condition has been certified as an emergency are subject to a $25 copayment and 20% coinsurance in-network. The copayment and coinsurance amounts apply after the annual deductible has been met.
- **Emergency Room Treatment.** Services received in an emergency room when the condition is determined to be a non-emergency are subject to a $50 copayment and 20% coinsurance in-network. The copayment and coinsurance amounts apply after the annual deductible has been met. 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.

◊ **Home Health Services.** Intermittent health services of a home health agency when prescribed by a physician are covered at 80% after the in-network deductible is met. Services must be provided in the home, by or under the supervision of a registered nurse. The home health services are covered only if they would otherwise have required confinement in a hospital or skilled nursing facility. If more than twelve (12) visits are necessary, precertification is required.

◊ **Hospice Care.** When ordered by a physician; covered at 80% after the in-network deductible is met.

◊ **Hyperbaric Oxygen Therapy.** Covered at 80% after the in-network deductible is met.

- **Hypertension Screening.** The PEIA PPB Plans A, B & D pay for diagnostic screening to determine if you are at risk for high blood pressure, heart disease or stroke. Benefits include coverage for an office visit, blood pressure check, and a blood chemistry profile. The office visit is subject to a $10 copayment and the blood chemistry is covered at 80% after the in-network deductible is met. The blood pressure check is included as part of the office visit. The plan will pay for this screening:
  - One time between the ages of 20 and 30;
  - Once every three years between ages 31 and 39; and
  - Once every two years after age 40.
- **Immunizations.** 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 2nd 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.
  - Meningococcal: At 2-10 years for certain children as recommended by the American Academy of Pediatrics, and 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.

  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 42.

  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 20% coinsurance after the in-network 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 at 20% coinsurance after the in-network deductible is met. In addition to the penalties discussed on page 36, all unapproved out-of-network inpatient admissions are subject to a $500 copayment per admission.

◊ **Inpatient Medical Rehabilitation Services.** When ordered by a physician, coverage is subject to 20% coinsurance after the in-network deductible is met and is limited to 150 days per plan year. In addition to the penalties discussed on page 36, all unapproved out-of-network inpatient admissions are subject to a $500 copayment per admission.

◊ **Intensive Modulated Radiation Therapy (IMRT).** Covered at 80% after the in-network deductible is met.

- **Mammogram.** An annual routine mammogram to detect breast abnormalities is covered at 100% in-network with no coinsurance or deductible required. The related office visit expenses are subject to the applicable copayment. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.

◊ **Massage Therapy.** Therapeutic services of a licensed massage therapist for treatment of neuromuscular-skeletal conditions are covered under the Outpatient Therapy Benefit when ordered by a physician. Covered at 80% after the in-network deductible and $10 or $25 copayment are met. Initial 20 visits require a $10 copayment per visit. Visits 21 +, if approved by ActiveHealth, require a $25 copayment per visit. 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.

◊ **Mastectomy.** If you are receiving benefits in connection with a mastectomy due to cancer and elect breast reconstruction in connection with such benefits, you are entitled to the following procedures:

  - Reconstruction of the breast on which the mastectomy was performed;
  - Reconstructive surgery of the other breast to present a symmetrical appearance; and
  - Prostheses and coverage for physical complications at all stages of the mastectomy procedure including lymphedas.
- **Maternity Services.** See "Maternity Benefits" on page 42 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. Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment. Precertification is required. These services are covered at 80% after the in-network deductible is met. Unapproved out-of-network inpatient admissions are subject to a $500 copayment per admission.
  - Outpatient mental health, chemical dependency and substance abuse services are limited to a maximum of 20 visits per patient per plan year for short-term individual and/or group outpatient mental health and chemical dependency services. This benefit includes evaluation and referral, diagnostic, therapeutic, and crisis intervention services performed on an outpatient basis (includes a physician's office). Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment beyond the 20 visits. This benefit is covered at 80% after the in network deductible is met.
- **MRA.** Magnetic Resonance Angiography services when performed on an outpatient basis are covered at 80% after the in-network deductible is met.
- ◊ **MRI.** Magnetic Resonance Imaging services when performed on an outpatient basis, are covered at 80% after the in-network 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 in-network deductible is met.
- **Oral Surgery.** Only covered for extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction at 80% after the in-network deductible is met. Preauthorization is recommended for orthognathic procedures and ridge reconstruction procedures. Dental implants are not covered.
- ◊ **Organ Transplants.** See "Organ Transplant Benefits" on page 43 for more details.
- **Outpatient Diagnostic and Therapeutic Services.** Laboratory, diagnostic tests, and therapeutic treatments, when ordered by a physician, are covered at 80% after the in-network deductible is met.
- ◊ **Outpatient Surgery.** This benefit is subject to a $50 copayment and 20% coinsurance in-network when performed in a hospital or alternative facility.
- **Outpatient Therapies.** Coverage for the following outpatient therapies are combined into one benefit and are available at 80% after the in-network deductible is met: physical, massage, occupational, speech, and vision therapies, acupuncture, osteopathic manipulations and chiropractic treatment. The benefit is limited to a maximum of 20 visits per person per plan year for all of the therapies combined. Case management is required for more than 20 visits. Initial 20 visits require a $10 copayment per visit. Visits 21 +, if approved by ActiveHealth, require a $25 copayment per visit.
  - **Acupuncture** Is not a covered service as of July 1, 2012.
  - **Chiropractic Treatment.** Services of a chiropractor for acute treatment of neuromuscular-skeletal conditions are included in the Outpatient Therapies benefit (see above) and are covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met. Office visits are subject to a copayment and x-rays are covered at 80% after deductible is met. Maintenance services are not covered. Preauthorization is recommended for services for children under age 16.
  - **Massage Therapy.** When ordered by a physician, therapeutic massage therapy services of a licensed massage therapist are covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met.
  - **Occupational Therapy.** When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met.
  - **Osteopathic Manipulations.** Services of an osteopathic physician to eliminate or alleviate somatic Dysfunction and related disorders are covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met. .
  - **Outpatient Physical Therapy.** When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met.
  - **Outpatient Speech Therapy.** When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met.
  - **Vision Therapy.** Contact ActiveHealth for preauthorization of these services. This benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met.
- **Pain Management Services.** Covered at 80% after the in-network deductible is met.
- **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 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 a copayment for in-network services. See Medical Home later in this section for more details.
- **Professional Services of a physician or other licensed provider** for treatment of an illness, injury or medical condition. Includes outpatient and inpatient services (such as surgery, anesthesia, radiology, and office visits). Office visits for preventive or specialty care are subject to the applicable copayment (see chart on page 33) while other physician services are covered at 80% after the in-network deductible is met.

- **Prostate Cancer Screening.** Coverage is provided for an annual office visit and exam to detect prostate cancer in men age 50 and over. 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. The PSA blood test associated with this screening, when ordered by a physician, is covered at 100% with no deductible or coinsurance in-network.
- **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 deductible and 20% coinsurance will apply to other testing billed with a medical diagnosis. Only the screenings specifically required under PPACA or listed in this "What is Covered" section, will be covered as routine screenings.
- **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 ActiveHealth.
- ◊ **Specialty Injectable Medications.** Coverage is provided for treatments utilizing specialty drugs through a program managed by HealthSmart Benefit Solutions. Injectables covered under the medical benefit plan are covered at 80% after the in-network deductible is met. Injectables covered under the prescription drug program are covered with a $50 copay after the prescription drug deductible is met.
- ◊ **SPECT.** Single Photon Emission Computed Tomography is covered at 80% after the in-network 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 in-network deductible is met. Confinement must be prescribed by a physician in lieu of hospitalization. Coverage is limited to 100 days per plan year. In addition to the penalties discussed on page 36, all unapproved out-of-network inpatient admissions are subject to a $500 copayment per admission.
- ◊ **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 Sleep Management Solutions. Non-resident PPB Plan members should call ActiveHealth for precertification of sleep management services. See further details under Sleep Management Services later in this section.
- **Smoking Cessation.** See "Tobacco Cessation" on page 47 for details.
- **Well Child Care.** For children through age 16, the plan covers routine office visits for preventive care as recommended by the American Academy of Pediatrics. These visits are covered at 100% of allowed 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 Routine Physical and Screening Examination benefit described above..

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 only for the employee or the employee's enrolled spouse.

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

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

Payment Level

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

Maternity Pre-payment Benefit

If your attending provider requests a deposit for maternity care before delivery, 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 HealthSmart 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. ActiveHealth will notify those families who qualify for this benefit.

Enrolling Your Newborn

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

Nursery Charges

If the baby is enrolled for coverage under the PEIA PPB Plan A or B, 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, charges for a normal, healthy newborn's nursery care will be covered 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.

Medical Home

PEIA's Medical Home program allows PEIA PPB Plan A & B members to choose a West Virginia physician from the Medical Home directory to serve as your medical home. Your medical home can be a general practice doctor, family practice doctor, internist, pediatrician, geriatrician, or, for women in the plan, an OB/GYN. When you choose and use your medical home, you will pay a $10 office visit copayment for each visit.

The intent of this program is to connect members with a physician who can oversee and coordinate all of their care. You ARE NOT required to have a referral to see a specialist, and this plan does not limit your ability to see any network doctor you choose. You may name a medical home each year during open enrollment, and you may make one change during the plan year, if you wish, unless there are extenuating circumstances, such as the death of your medical home physician or a move that makes it inconvenient for you to access care from your medical home.

If you are a Resident PPB Plan participant and you do not choose a medical home, you can still see any network physician you choose. Your copayments for preventive care will not change. Office visits to the providers eligible to be medical homes (general practice, family practice, internists, pediatricians, geriatricians and OB/GYNs) for illness or injury will continue to have a $15 copay. Specialist office visits will have a $20 copay per visit.

If you are a non-Resident PPB Plan participant (PEIA PPB Plan participant who resides outside West Virginia and beyond the bordering counties) and you do not choose a medical home (either because you don't want to or because accessing care from a West Virginia provider is not possible), you can still see any network physician you choose. Your benefits and copayments will not be affected by this program.

Organ Transplant Benefits

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

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

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

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

Organ Transplant Network (OTN)

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

PEIA uses Aetna's Institutes of Excellence for its transplant network. ActiveHealth will work with patients and physicians to determine which network facility best serves the patient's medical needs.

OTN Benefits

Reduced Costs: Once the annual deductible and out-of-pocket maximum have been met, you will pay no more coinsurance on the negotiated fees for pre-transplant, transplant, and follow-up services. Copayments for office visits and other services described on page 33 will still apply.

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

Medical Case Management: ActiveHealth 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 ActiveHealth at **1-888-440-7342.**

You should contact ActiveHealth as soon as you learn that you or a member of your family covered by PEIA PPB Plans A or B may need a transplant. All transplants must be precertified through ActiveHealth.

Out-of-Network Organ Transplant Benefits

For patients who choose to use a non-network facility for transplant services, there will be a $10,000 deductible applied to the cost of the hospital admission; this is in addition to your annual deductible and out-of-pocket maximum. This deductible will be waived only if treatment at a non-network facility is approved as medically necessary in advance by ActiveHealth. 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 (if they are filled at a network pharmacy). These are covered through the Prescription Drug Plan and processed by the prescription drug administrator. Details of the PEIA Prescription Drug Plan are found in the "Prescription Drug Benefits" section starting on page 52.

Medical case management of transplant patients includes referral to the prescription drug administrator for waiver of copayment on transplant-related immunosuppressant drugs. ActiveHealth 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 treatment of sleep apnea and other related conditions that can affect your health. In order to ensure compliance and ensure responsible use of all prescribed sleep services, HealthSmart Benefit Solutions, the third-party administrator for PEIA, has contracted with Sleep Management Solutions (SMS) to manage the PEIA's sleep services for resident PPB Plan members All sleep-testing services require prior approval. A precertification process has been established to ensure that the services are medically necessary and appropriate. If your physician says you need a sleep test, ask him/her to call SMS at **1-888-49-SLEEP (75337).** If approved, you will be provided a list of contracted labs that you may use to receive services.

In addition to managing sleep-testing services, SMS is the sole source for CPAP and Bi-Level equipment and supplies. The process is integrated so that patients who have been diagnosed and prescribed CPAP or Bi-level therapy are set up and educated at the lab where they received their sleep study.

Sleep Management Solutions has a 24-hour hotline that PEIA members may access to get information on their sleep illness and how best to use their sleep equipment. A Respiratory Therapist or a trained sleep technician is available to provide support when issues come up, which is generally at bedtime. You may also visit the PEIA Sleep website at www.wvpeiasleep.com.

SMS will contact you regularly to make sure there are no issues which might be impeding compliance. If you have problems with masks or equipment, call SMS for assistance.

Patient care and improved health is the most important aspect of this process.

Non-resident PPB Plan members must call ActiveHealth for precertification of sleep management services.

Specialty Injectable Program

The PEIA PPB Plans cover specialty injectable drugs through a program managed by HealthSmart Benefit Solutions (HealthSmart). 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 HealthSmart at **1-888-440-7342** (Providers press 1, then 7; Members press 2, then 7). HealthSmart will review the drug for medical necessity. If approved, HealthSmart will coordinate the purchase through the approved source and contact you and your physician with additional details including where the physician should call in the prescription, how you will receive the drug and discuss any educational needs. If denied, HealthSmart will contact your physician for additional information which may allow approval of the requested medication.

Healthy Tomorrows

PEIA PPB Plans A, B & D have a program called Healthy Tomorrows that coordinates all of PEIA's continuing lifestyle management programs under one umbrella. The programs included in Healthy Tomorrows are detailed below:

Face-to-Face (f2f) Diabetes Program

PEIA's F2F Diabetes Program for PPB Plan members is available statewide (subject to the availability of pharmacists)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 pharmacist of their choosing for counseling and health education services. The pharmacist works with each member to ensure he/she gets the best diabetes care possible by monitoring: a) recommended testing and treatment of diabetes; b) the member's currently prescribed medicines and knowledge about how to take them; and c) physical activity and nutrition plan to assist the member in achieving optimal health.

Members benefit from participating in the F2F Diabetes program by improving their health and quality of life. Also PEIA PPB Plan A, B and D members benefit by saving money, since copayments are waived for some prescription drugs, lab tests and/or supplies. 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 once-in-a-lifetime benefit (with the exception of gestational diabetes). Prior participation in the Dr. Dean Ornish Program for Reversing Heart Disease or 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 Programs website, www.peiaf2f.com, or call PEIA Customer Service at **1-888-680-7342.**

Hemophilia Disease Management Program

To provide quality care at a reasonable cost, PEIA and the Charleston Area Medical Center (CAMC) have partnered to provide a Hemophilia Care Program to PEIA PPB Plan members. Under the program, members and/or their dependents with hemophilia agree to receive an annual evaluation from the Hemophilia Treatment Center at CAMC. Members who participate in the program will be eligible for the following benefits:

1. An annual evaluation by specialists in the Hemophilia Treatment Center at CAMC 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 medical home provider or specialists.)
2. Hemophilia expenses, including factor replacement products, incurred at CAMC will be paid at 100% with no deductible, copay or coinsurance.
3. Reimbursement for travel and lodging
   - a) Child and 1 or 2 parents
   - b) Adult and an accompanying adult
   - c) Lodging will be at the CAMC travel lodge for a maximum of two (2) nights.
   - d) Gas will be reimbursed at the state rates.
   - 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:

1. Expenses incurred by the patient traveling between his or her home and CAMC to receive services in connection with the PEIA/CAMC Hemophilia Disease Management Program.
2. Expenses incurred by the patient's companion to enable the patient to receive services from the PEIA/CAMC hemophilia Disease Management Program.
   a) For children under the age of 18, lodging will be covered for one (1) or two (2) parents.
   b) For patients over the age of 18, lodging will be covered for one (1) companion.
3. Lodging will be covered at 100% of the charge at CAMC's travel lodge in Kanawha City. Other hotel/motel expenses will be covered, not to exceed the cost at CAMC's travel lodge. The current rate is $57.12 per night.

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 connections with the PEIA/CAMC 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: CAMC Hemophilia Treatment Center at **304-388-8896** or ActiveHealth at **888-440-7342**

Weight Management Program

PEIA offers a facility-based weight management program for PEIA PPB plan A, B and D members who have a Body Mass Index (BMI) of 25 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 once per lifetime benefit that may last up to two years and has a copayment of $20 per month. The benefit is different for members of Plan C. Refer to the Plan C section of this booklet for details.

To enroll, you must complete the application, which includes some medical information, and provide written approval from your physician. For more information or to enroll in the program, call **1-866-688-7493** or go to www.wvpeia.com.

Dr. Dean Ornish Program for Reversing Heart Disease

The Dr. Dean Ornish Program for Reversing Heart Disease is an intensive program for patients who meet the medical criteria for participation: coronary artery disease, Type I or Type II diabetes, or at high risk for these conditions.

The Ornish approach does not use drugs or surgery, but relies upon nutrition, physical activity, group support and stress management as part of an intensive life style change program. Applicants are screened by their local participating Ornish hospital to determine if they meet the medical criteria for participation listed above.

For members of PEIA PPB Plan A, B and D, the program is covered at 100% after a participant copayment of $50 per month, which is refundable after the successful completion of the program. Participants with annual household income below $20,000 per year may qualify for a copayment waiver. The benefit is different for members of Plan C. Refer to the Plan C section of this booklet for details.

For more information about this program, visit PEIA's "Health and Wellness Programs" link on our website or contact PEIA's customer service unit at **1-888-680-7342.**

Dean Ornish spectrum

Dean Ornish Spectrum is a six week lifestyle education program based upon the principles of Dr. Dean Ornish as described in his book of the same title. This benefit is covered with a $48 copay and no deductible or coinsurance for members of PEIA PPB Plan A, B and D. The benefit is different for members of Plan C. Refer to the Plan C section of this booklet for details. This once-in-a-lifetime benefit is available to members who meet any one of the following criteria:

1. Family or personal history of coronary artery disease, hypertension and or diabetes;
2. Aged 50 or older;
3. BMI>25
4. Metabolic syndrome
5. Family or personal history of cancer.

For more information, visit the "Health and Wellness Programs" link on our website at **www.wvpeia.com** for a complete listing of participating hospitals or contact PEIA's customer service unit at **1-888-680-7342.**

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 medical home/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 12 weeks 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) once per year (rolling 12 month period) with a maximum of three attempts per lifetime.

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 with the applicable office visit copayment.

Nicotine patches are covered at no cost to the patient (deductible and copayments are waived) when prescribed by a physician and purchased at a network pharmacy. Other prescription and over-the-counter cessation medications are covered under the prescription drug plan with the applicable generic, preferred or non-preferred prescription copayments after the deductible is met.

PEIA Pathways to Wellness

The PEIA Pathways to Wellness Program provides Improve Your Score health screenings, as well as lifestyle change programs to PEIA PPB Plan insureds at participating worksites. For additional information, visit www.peiapathways.com.

Improve your Score

Improve Your Score Discount. PEIA offers a unique opportunity to understand your health risk factors and improve your health status by offering a $10 per month discount off the standard health premium to active policyholders in the PEIA PPB Plans who participate in the Improve Your Score program. Retired policyholders and members of The Health Plan HMO are not charged the $10 premium increase, and are not eligible for the $10 Improve Your Score premium discount. The Improve Your Score program is a two-step process designed to make you and your doctor aware of individual health risks, including cholesterol, glucose or blood sugar, blood pressure and waist circumference, and then to act on your modifiable risk factors to attempt to improve them. Here's how the program works:

Step One: Screening. You must "know your numbers" and get your report card every 24 months by:

1. Attending a Pathways to Wellness worksite health screening at your worksite. You may also attend a screening at any other PEIA Pathways worksite with prior notice to the PEIA Pathways staff. Standard worksite screenings are offered at no charge to PEIA PPB Plan members. For those just beginning participation in the program, it may take up to 90 days following a screening for your premium discount to begin.
2. Reporting results of a screening by your physician. If you've already had this blood work done through your physician's office or another provider, you may download the Improve Your Score reporting form from www.wvpeia.com. Then, have your provider complete the necessary information and return the form to the address listed on the form. (Remember, you will be responsible for any applicable coinsurance or copayment if your physician performs the screening.)

Participants in Improve Your Score screenings receive a color-coded report card from PEIA using the stop light system: green for healthy; yellow for moderate risk; and red for high risk.

Step Two: Engagement Act on your report card and improve your health status:

Green If your overall score is green, congratulations and keep up the great work! You will maintain your premium discount as long as you get screened at least every 24 months and maintain your green overall score.

Yellow or Red If your overall score is yellow or red, you must take some action every twelve months to improve your modifiable risk factors. The following activities will count as "engagement" to maintain your discount:

- see your medical home or primary care physician;
- participate in PEIA's Face to Face Diabetes Program,
- participate in the PEIA Weight Management Program,
- participate in the Dr. Ornish Program for Reversing Heart Disease;
- participate in the Ornish Spectrum education program or
- visit www.peiapathways.com for other opportunities for "engagement"

You must continue to get screened and receive a new report card at least every 24 months to continue participating in this discount program. If your overall score improves from yellow or red to green, then you follow the instructions for a "green" score above.

To qualify for the discount for the full plan year, by April 30 each year you must have been screened within the past 24 months, and if your score is yellow or red, you must have engaged in one of the activities listed above within the past 12 months.

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 HealthSmart at 1-888-440-7342 or 1-304-353-7820. 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. Birth control drugs, devices, and services for dependent children.
6. Breast pumps.
7. Chemical dependency treatments when a patient leaves the hospital or facility against medical advice.
8. Coma stimulation.
9. 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.
10. 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).
11. Dental implants, whether medically indicated or not.
12. 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.
13. Daily living skills training.
14. Duplicate testing, interpretation or handling fees.
15. Education, training and/or cognitive services, unless specifically listed as covered services.
16. Elective abortions.
17. Electronically controlled thermal therapy.
18. Emergency evacuation from a foreign country, even if medically necessary.
19. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts.
20. Expenses incurred as a result of illegal action, while incarcerated or while under the control of the court system;
21. Experimental, investigational or unproven services, unless pre-approved by ActiveHealth.
22. Fertility drugs and services.
23. Foot care. Routine foot care including:
    - Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), or hypertrophy (growth of tissue under the skin);
    - Cutting, trimming, or partial removal of toenails;
    - Treatment of flat feet, fallen arches, or weak feet; and
    - Strapping or taping of the feet.
24. Genetic testing for screening purposes is generally not covered. See Precertification on page 35 for exceptions.
25. Glucose monitoring devices, except Bayer Ascensia models covered under the prescription drug benefit.
26. Homeopathic medicine.
27. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery.
28. Hypnosis.
29. Incidental surgery performed during medically necessary surgery.
30. 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.
31. Maintenance outpatient therapy services, including, but not limited to:
    - Chiropractic
    - Massage Therapy
    - Occupational Therapy
    - Osteopathic Manipulations
    - Outpatient Physical Therapy
    - Outpatient Speech Therapy
    - Vision Therapy
32. Marriage counseling.
33. Medical equipment, appliances or supplies of the following types:
    - augmentative communication devices.
    - bathroom scales.
    - educational equipment.
    - environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors.
    - equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs(including Hoyer lifts); recliners; contour chairs; adjustable beds; or tilt stands.
    - equipment which is widely available over the counter such as wrist stabilizers and knee supports.
    - exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines.

- hearing aids of any type.
- hygienic equipment such as bed baths, commodes, and toilet seats.
- motorized scooters.
- nutritional supplements, over-the-counter (OTC) formula, 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.
- traction devices.
- vibrators.
- whirlpool pumps or equipment.
- wigs or wig styling.

34. Medical rehabilitation and any other services that are primarily educational or cognitive in nature.
35. Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning.
36. 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
37. Oral appliances, including, but not limited to, those treating sleep apnea.
38. Orientation therapy.
39. Orthodontia services.
40. Orthotripsy.
41. Physical examinations and routine office visits except those covered under the Periodic Physicals benefit.
42. 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.
43. 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.
44. 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.
45. Pregnancy-related conditions for dependent children.
46. Provider charges for phone calls, prescription refills, or physician-to-patient phone consultations.
47. Radial keratotomy and other surgery to correct vision.
48. Reversal of sterilization and associated services and expenses.
49. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities.
50. Screenings, except those specifically listed as covered benefits.
51. 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.
52. Services rendered outside the scope of a provider's license.
53. Sex transformation operations and associated services and expenses.
54. Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit.
55. Stimulation therapy.
56. Take-home drugs provided at discharge from a hospital.
57. 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.
58. The difference between private and semi-private room charges.
59. Therapy and related services for a patient showing no progress.
60. Therapies rendered outside the United States that are not medically recognized within the United States.
61. Transportation other than medically necessary emergency ambulance services, or as approved under the Organ Transplant Network benefit.
62. War-related injuries or illnesses. Treatment in a State or Federal hospital for military or service-related injuries or disabilities.
63. 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 program offered by PEIA.
64. Work-related injury or illness.

How to File a Claim

Filing a Medical Claim

Medical claims are processed by HealthSmart and should be submitted to:

HealthSmart, P.O. Box 2451, Charleston, WV 25329-2451

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

To process a medical claim, HealthSmart 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 received from PEIA. See "Subrogation" on page 103 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 HealthSmart using the special claim forms provided by PEIA. You can also receive all benefit information published by PEIA, and reimbursements for medical claims can be sent directly to you. For prescription drugs, you must use your I.D. card at a participating pharmacy. To make arrangements for this, please contact PEIA at **1-304-558-7850, or toll-free at 1-888-680-7342.**

Claims Incurred Outside of the U.S.A.

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

HealthSmart 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 64.) All appeals must be initiated within 60 days of claim payment or denial

Type of Error	Who to Call	Where to Write
Medical claim denial	HealthSmart 1-888-440-7342	HealthSmart P. O. Box 2451, Charleston, WV 25329-2451
Out-of-state care denial, denial of precertification or case management	ActiveHealth 1-888-440-7342	ActiveHealth Management PO Box 221138 Chantilly, VA 20153-1138
Prescription drug claim	Express Scripts 1-877-256-4680	Express Scripts, Inc. ATTN: STD ACCTS P. O. Box 66583 St. Louis, MO 63166-6583

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 60 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 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, you may have a right to have our decision 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. Exercise this right by submitting 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, 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 be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial.

Managed Care Plan Members

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

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

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

Director, Public Employees Insurance Agency, 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 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 Express Scripts. There are three parts to the program:

• the Retail Pharmacy Program gives you access to local participating pharmacies to get your prescriptions filled.

• the Express Scripts Mail Service Pharmacy Program lets you order your prescriptions through the mail, saving you time and money by having your maintenance medications delivered to your door.

• the HealthSmart 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 a deductible before the plan begins to pay. The deductibles are:

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

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

The family deductible is divided up among the family members. No one member of the family will pay more than the individual deductible. Once that person has met the individual deductible, the plan will begin paying on that person. When another member of the family meets the individual deductible, then the plan will begin paying on the entire family. Alternatively, all members of the family may contribute to the family deductible with no one person meeting the individual deductible; once the family deductible is met, the plan pays on all members of the family. After you meet your deductible, you will pay copayments based on the amount and type of drug you're taking. The following chart shows the copayments.

Copayments

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

Prescription Drug Co-payments			
PEIA PPB Plan A			
	Up to a 30-day supply	31- to 60-day supply*	61- to 90-day supply*
Generic Drug	$5	$10	$15
Brand-name drug listed on the WV Preferred Drug List	$15	$30	$45
Brand-name drug not listed on the WV Preferred Drug List	$75% Coinsurance	$75% Coinsurance	$75% Coinsurance
Common Specialty Medications†	$50	not available	not available
PEIA PPB Plan B			
Generic Drug	$5	$10	$15
Brand-name drug listed on the WV Preferred Drug List	$20	$40	$60
Brand-name drug not listed on the WV Preferred Drug List	$75% Coinsurance	$75% Coinsurance	$75% Coinsurance
Common Specialty Medications†	$50	not available	not available

* For maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. You may be able to get a discount on your generic or preferred brand maintenance medications through a Retail Maintenance Network pharmacy or through Mail Service. Read on for details.

† Should your doctor prescribe or you request the brand-name Specialty Medication when a generic drug is available, you must pay the difference in price, plus the applicable Specialty Medication co-payment
Should your doctor prescribe or you request the brand-name drug when a generic drug is available, you must pay the difference in price, plus the applicable generic co-payment.

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 the copayment structure works:

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

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

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

If you have any questions, please call Express Scripts Member Services at **1-877-256-4680.**

Prescription Out-of-Pocket Maximum

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

Getting Your Prescriptions Filled

Using A Retail Network Pharmacy

Express Scripts has a nationwide network of pharmacies. To get a prescription filled, simply present your medical/ prescription drug ID card at a participating Express Scripts pharmacy. You can purchase both acute and maintenance medications at an Express Scripts network pharmacy. You may refill your prescription when 75% of the medication 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 an Express Scripts pharmacy, you do not have to file a claim form. The pharmacist will file the claim for you online, and will let you know your portion of the cost.

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

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

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

Using the Retail Maintenance Network

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

Maintenance Drug Co-payments				
	PEIA PPB Plan A		PEIA PPB Plan B	
	Up to 30-day supply	31 to 90-day supply*	Up to 30-day supply	31 to 90-day supply*
Generic medication	$5	$10	$5	$10
Brand-name medication listed on the WV Preferred Drug List	$15	$30	$20	$40
Brand-name medication not listed on the WV Preferred Drug List	75% coinsurance	75% coinsurance	75% coinsurance	75% coinsurance

* For generic and preferred brand maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. Should your doctor prescribe or you request the brand-name drug when a generic drug is available, you must pay the difference in price, plus the applicable generic co-payment.

Using Non-Network Pharmacies

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

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

Using the Express Scripts Mail Service Pharmacy Program

Express Scripts provides a convenient mail service pharmacy program for PEIA PPB Plan insureds. You may use the mail service pharmacy if you're taking medication to treat an ongoing health condition, such as high blood pressure, asthma, or diabetes. When you use the mail service pharmacy, you can order up to a 90-day supply of a medication on the maintenance list, as prescribed by your doctor, and pay only two copayments. You may refill your prescription when 66% of the medication is used up. Express Scripts' licensed professionals fill every prescription following strict quality and safety controls. If you have questions about your prescription, registered pharmacists are available around the clock to consult with you.

New Prescriptions and the Mail Service Pharmacy

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

1. Ordering new prescriptions. Ask your doctor to prescribe your medication for up to a 90-day supply for maintenance medications, plus refills if appropriate. Mail your prescription and required copayment along with an order form in the envelope provided. Or ask your doctor to fax your order to **1-800-636-9494.** You will need to give your doctor your member ID number located on your ID card.
2. Refilling your medication. A few simple precautions will help ensure you don't run out of your prescription. Remember to reorder on or after the refill date indicated on the refill slip. Or reorder when you have less than 14 days of medication left.
   a) Refills online: Log on to Express Scripts' website at www.express-scripts.com. Have your member ID number, the prescription number (it's the 9-digit number on your refill slip), and your credit card ready when you log on.
   b) Refills by phone: Call **1-877-256-4680** and use the automated refill system. Have your member ID number, refill slip with the prescription number, and your credit card ready.
   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 or American Express. Debit cards are not accepted for payment. Please note: The pharmacist's judgment and dispensing restrictions, such as quantities allowable, govern certain controlled substances and other prescribed drugs. Federal law prohibits the return of any dispensed prescription medicines.

Prior Authorization

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

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

The medications listed below require prior authorization:

1. adalimumab (Humira®)*
2. ambrisentan (Letairis)*
3. amphetamines (Adderall XR®, Vyvanse®)
4. anakinra (Kineret®)*
5. armodafinil (Nuvigil®)
6. atomoxetine (Strattera®)
7. becaplermin (Regranex®)
8. bimatoprost (Lumigan®)
9. bosentan (Tracleer®)*
10. Brand-name medically necessary prescriptions. If the medication your doctor prescribes is a multi-source drug (more than one manufacturer markets the drug) and there is an FDA-approved or "A-B-rated" generic on the market, then PEIA will pay only for the generic version, unless your physician provides medical justification for coverage of the brand-name drug. If prior authorization is granted, these drugs will be covered as non-preferred brand-name drugs.
11. buprenorphine/naloxone (Suboxone®)
12. chenodiol (Chenodal™)*
13. ciclopirox (Penlac®)
14. clonidine hydrochloride, extended release (Kapvay®)
15. corticotropin (Acthar®)*
16. dabigatran etexilate (Pradaxa®)
17. dalfampridine (Ampyra®)
18. dextromethorphan/quinidine (Nuedexta™)
19. diclofenac sodium gel (Solaraze®)
20. eltrombopag (Promacta®)*
21. enfuvirtide (Fuzeon®)*
22. erythroid stimulants (Epogen®, Procrit®, Aranesp®)*
23. etanercept (Enbrel®)*
24. etravirine (Intelence®)
25. exenatide (Byetta®)
26. fentanyl (Abstral®, Actiq®, Duragesic®, Fentora®, Lazanda®,, and Onsolis®)
27. fingolimod (Gilenya®)
28. fluconazole (Diflucan®)
29. golimumab (Simponi®)*
30. growth hormones*
31. guanfacine extended-release (Intuniv®)
32. ibandronate (Boniva®)*
33. iloprost (Ventavis®)*
34. itraconazole (Sporanox®)
35. latanoprost (Xalatan®)
36. legend oral contraceptives for dependents (covered for treatment of medical conditions only)
37. liragultide (Victoza®)
38. maraviroc (Selzentry®)
39. modafinil (Provigil®)
40. Omega-3-acid ethyl esters (Lovaza®)
41. oxycodone hydrochloride (Oxycontin®)
42. quetiapine (Seroquel®)
43. raltegravir (Isentress®)
44. rilonacept (Arcalyst®)*
45. sacrosidase (Sucraid®)
46. sapropterin hydrochloride (Kuvan®)*
47. sildenafil (Revatio®)*
48. stimulants (Concerta®, Focalin XR®, methylphenidate)
49. tadalafil (Adcirca®)*
50. tazarotene (Tazorac®)
51. terbinafine (Lamisil®)
52. teriparatide (Forteo®)*
53. tetrabenazine (Xenazine®)*
54. tolvaptan (Samsca®)
55. topical testosterone products
56. topiramate (Topamax®)
57. travoprost (Travatan/Z®)
58. treprostinil (Tyvaso®)*
59. tretinoin cream (e.g. Retin-A) for individuals 27 years of age or older
60. vacation supplies of medication for foreign travel (allow 7 days for processing)
61. voriconazole (VFEND®)
62. zonisamide (Zonegran®)

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

This list is subject to change during the plan year if circumstances arise which require adjustment. Changes will be communicated to members 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. Alzheimer's Disease (Aricept®/ODT, Razadyne/ER®, Exelon®, Exelon Patch®, Cognex®)
2. Analgesics (Ultram/ER®, Ultracet®, Ryzolt®, Rybix™ ODT, ConZip®)
3. Angiotensin II Receptor Antagonists (Atacand/HCT®, Avalide®, Avapro®, Azor®, Benicar/HCT®, Cozaar®, Diovan/HCT®, Edarbi®, Edarbyclor®, Exforge®, Hyzaar®, Micardis/HCT®, Teveten/HCT®, Tribenzor™, Twynsta®)
4. Anti-depressants (Cymbalta®, Effexor/XR®, Symbyax®, Wellbutrin XL®, Pristiq®, Aplenzin®, venlafaxine ER, Savella®, Forfivo XL®)
5. Anti-hypertensives (Covera HS®, Verelan PM®, Norvasc®, Cardene SR®, Sular®, DynaCirc CR®, Tekturna®)
6. Benign Prostatic Hypertrophy (Avodart®, Proscar®, Jalyn™, Cardura/XL®, Flomax®, Rapaflo®. Hytrin®, UroXatral®)
7. Beta Blockers (Sectral®, Tenormin®, Kerlone®, Zebeta®, Coreg®, Trandate®, Lopressor®, Toprol XL®, Corgard®, Levatol®, Visken®, Inderal®, Inderal® LA, InnoPran XL®, Blocadren®, Tenoretic®, Ziac®, Lopressor® HCT, Corzide®, Inderide®, Timolide®, Coreg CR®, Bystolic®, Dutoprol™)
8. Bisphosphonates (Fosamax®, Fosamax Plus D™, Actonel®, Actonel® with Calcium, Boniva®, Atelvia™)
9. Cholesterol-lowering medications (Advicor®, Altoprev®, Caduet®, Crestor®, Lescol/XL®, Lipitor®, Pravachol®, Vytorin®, Zetia®, Livalo™)
10. Dipeptidyl peptidase-4 (DPP-4) Inhibitors (Januvia/XR®, Janumet®, Onglyza®, Kombiglyze™ XR, Juvisync®, Tradjenta®, Jentadueto®)
11. Fenofibrates (Tricor®, Lofibra®, Antara®, Triglide®, Lipofen®, Fenoglide®, Trilipix®, Fibricor®)
12. Leukotriene Inhibitors (e.g., Accolate®, Singulair®, Zyflo®, Zyflo CR®)
13. Long-acting Opioids (Avinza™, Embeda™, Exalgo™, Kadian®, MS Contin®, Opana® ER, Oramorph SR™, Nucynta® ER)
14. Lyrica®, Gralise®, Horizant®, Neurontin®
15. Migraines (Imitrex®, Sumavel Dosepro™, Alsuma, Amerge®, Zomig®/ZMT, Maxalt®/MLT, Axert®, Frova®, Relpax®, Treximet®)
16. Mirapex/ER®
17. Nasal Steroids (Rhinocort Aqua™, Flonase®, Beconase AQ®, Nasacort AQ®, Nasarel®, Nasonex®, Veramyst®,Omnaris®)
18. Non-Steroidal Anti-inflammatory Drugs (brand-name NSAID e.g., Celebrex®, Flector®, Pennsaid®, Voltaren®)
19. Overactive Bladder: (Ditropan®, Ditropan XL®, Oxytrol®, Detrol®, Detrol LA®, Sanctura®, Toviaz®, Vesicare®, Enablex®, Sanctura XR®, Gelnique®)
20. Proton Pump Inhibitors (e.g., Prilosec®, Prevacid®, Nexium®, Aciphex®, Protonix®, Zegerid®, Dexilant®, First® –Lansoprazole and First® –Omeprazole)
21. Requip/XL®
22. Sedative Hypnotics (Ambien®, Ambien CR™, Sonata®, Lunesta™, Rozerem™, Edluar™, Zolpimist™, Silenor®, Intermezzo®)
23. Selective Serotonin Reuptake Inhibitors (e.g., Celexa®, Lexapro®, Luvox®, Paxil®, Paxil CR®, Prozac®, Prozac Weekly®, Zoloft®, Sarafem®, Pexeva®, Luvox CR®, Viibyrd®),
24. Strattera®, Intuniv®, Kapvay®
25. Tetracyclines (Adoxa®, Doryx®, Oracea®, Solodyn®, Oraxyl®, Vibramycin®)
26. Thiazolidinedione (TZD) (Actos®, Avandia®, Avandamet®, Duetact®, Avandaryl®, Actosplus/Met XR®)
27. Topical Acne products, kits and cleansers,
28. Topical Steroids -- various, and
29. Xopenex®

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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. Antipsychotic Drugs (Abilify® 30 units, Fanapt™ 60 units, Geodon® 60 units, Invega® varies, Risperdal® 60 units, Saphris® 60 units, Seroquel® varies, Zyprexa® 30 units, and Zyprexa Zydis® 30 units, Latuda® 30 units)
2. Antiemetics:
   - Aloxi® is limited to 1 capsule/vial per prescription
   - Anzemet® is limited to 1 tablet per prescription
   - Cesamet® is limited to 30 capsules per prescription
   - Emend® 40 mg is limited to 1 capsule per prescription.
   - Emend® 80 mg is limited to 2 capsules per prescription.
   - Emend® 115 mg and 150 mg vial are limited to 1 vial per prescription.
   - Emend® 125 mg is limited to 1 capsule per prescription.
   - Emend® Bi-fold Pack is limited to 1 package per prescription.
   - Emend® Tri-fold Pack is limited to 1 package per prescription.
   - Kytril® is limited to 2 tablets/1 bottle per prescription
   - Sancuso® is limited to 1 patch per prescription
   - Zofran® 24 mg is limited to 1 tablet per prescription
   - Zofran® 4mg and 8 mg are limited to 12 tablets per prescription
   - Zofran® ODT 4mg and 8 mg are limited to 12 tablets per prescription
   - Zofran® Solution is limited to 3 bottles per prescription
   - Zuplenz® is limited to 12 films per prescription.
3. Abstral®, Actiq®, OnsolisTM, Fentora®. Coverage is limited to 90 units per 30 days
4. 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)
5. Diflucan® 150 mg. Coverage is limited to 2 tablets per prescription
6. Enbrel®. Coverage is limited to 4 syringes or 8 vials per prescription
7. Humira®. Coverage is limited to 3 syringes/pens per prescription
8. Long-acting Opioids (Avinza® 60 units, Kadian® 90 units, MS Contin® 120 units, Opana® ER 90 units, Oramorph® 120 units, Oxycontin® 90 units, Exalgo® 30 units, Embeda® 90 units, Nucynta® ER 60 units)
9. Migraine medications. Coverage is limited to quantities listed below:

Generic name	Brand name	Quantity Level Limit Per Prescription	Quantity Level Limit for 28-Day Period
Almotriptan tablets 6.25 mg	Axert®	6 tablets	18 tablets
Almotriptan tablets 12.5 mg	Axert®	12 tablets	24 tablets
Dihydroergotamine nasal spray vials, 4 mg/mL vial	Migranal®	1 kits	1 kits = 8 unit dose sprayers
Diclofenac potassium, 50 mg powder packet	Cambia™	9 packets	9 packets
Eletriptan 20 mg, 40 mg	Relpax®	6 tablets	18 tablets
Frovatriptan tablets 2.5 mg	Frova®	9 tablets	27 tablets
Naratriptan tablets 1 mg, 2.5 mg	Amerge®	9 tablets	18 tablets
Rizatriptan tablets 5 mg, 10 mg	Maxalt®	12 tablets	24 tablets
Rizatriptan tablets 5 mg, 10 mg, orally disintegrating tablets	Maxalt-MLT®	12 tablets	24 tablets
Sumatriptan injection pre-filled auto-injectors, 6 mg/0.5 ml	Alsuma®	1 kit (2 syringes)	8 kits (16 syringes)
Sumatriptan injection syringes, 4 mg/0.5 ml and 6 mg/0.5 ml	Imitrex® Statdose System®	1 kit	8 kits = 16 injections
Sumatriptan injection vials, 4 mg/0.5 ml	Generics	2 vials	16 vials
Sumatriptan injection vials, 6 mg/0.5 ml	Imitrex®, generics	2 vials	16 vials
Sumatriptan nasal spray 20 mg	Imitrex®, generics	1 box	3 boxes = 18 unit dose spray devices
Sumatriptan nasal spray 5 mg	Imitrex®, generics	1 box	6 boxes = 36 unit dose spray devices
Sumatriptan needle-free injection vial 6 mg/0.5 mL	Sumavel™ DosePro™	1 box	3 boxes = 18 needle-free devices
Sumatriptan tablets 25 mg, 50 mg, 100 mg	Imitrex®, generics	9 tablets	18 tablets
Sumatriptan (85 mg) and naproxen sodium (500 mg) tablets	Treximet™	9 tablets	18 tablets
Zolmitriptan nasal spray 5 mg	Zomig®	1 box	3 boxes = 18 unit dose spray devices
Zolmitriptan tablets 2.5 mg and 5 mg, orally disintegrating	Zomig-ZMT®	6 tablets	18 tablets
Zolmitriptan tablets 2.5 mg, 5 mg	Zomig®	6 tablets	18 tablets

10. New drugs approved by the FDA that have not yet been reviewed by Express Scripts' Pharmacy and Therapeutics Committee will have a non-preferred status. PEIA reserves the right to exclude a drug or technology from coverage until it has been proven effective.
11. Nuvigil®. Coverage limit varies.
12. Other Antidepressants (Budeprion SR® 60 units, Budeprion XL® 30 units, Bupropion HCL SR® 60 units, Wellbutrin SR® 60 units and Wellbutrin XL® 30 units, Aplenzin® 30 units)
13. Provigil®. Coverage limit varies.
14. Sedative Hypnotics (Ambien®, Ambien CR™, Doral®, estazolam, flurazepam, Lunesta™, Restoril®, Rozerem™, Sonata®, Edluar™, Zolpimist™, Silenor®, temazepam, triazolam). Coverage is limited to 15 units per 30 days.
15. 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)
16. Serotonin and Norepinephrine Reuptake Inhibitors (Cymbalta® varies, Effexor® varies, Effexor XR® varies, Pristiq® 30 units, Savella® varies, venlafaxine ER® varies)
17. Sprix. Coverage is limited to 5 days of therapy per 90 days.
18. Toradol. Coverage is limited to one course of treatment (5 days) per 90-day period.
19. Tamiflu® and Relenza®. Coverage is limited to one course of treatment within 180 days. Additional quantities require prior authorization from RDT.
20. Vasodilator Antihypertensives (Cardura XL® 30 units, doxazosin mesylate® varies, and terazosin HCL® varies)

Maintenance Medications

You may receive up to a 90-day supply of ONLY the medications and classes listed below.

1. alendronate sodium (Fosamax®)
2. antiarthritics
3. anticoagulants
4. anticonvulsants
5. antidementia drugs
6. antihypertensives
7. antiparkinsonism agents
8. antispasmodics: urinary tract
9. benign prostatic hypertrophy/ micturation
10. bronchodilators
11. calcitonin (Miacalcin®)
12. cardiovascular agents
13. cholinergic stimulants (urinary retention)
14. corticosteroids, bronchial
15. cromolyn sodium (Intal®)
16. diabetic therapies
17. digestants
18. disposable needles and syringes
19. diuretics
20. enzymes, systemic
21. estrogens and progestins
22. gastrointestinal, colitis
23. glaucoma agents
24. gout medications
25. hormones, misc.
26. immunosuppressive agents
27. legend vitamins (including legend hematinics, vitamin K)
28. leukotriene receptor antagonists (asthma agents)
29. lipotropics (cholesterol lowering agents)
30. mucolytics (pulmonary agents)
31. oral contraceptives
32. legend potassium
33. raloxifene (Evista®)
34. risedronate (Actonel®)
35. selective serotonin reuptake inhibitors
36. serotonin and norepinephrine reuptake inhibitors
37. thyroid medications
38. tuberculosis medications
39. xanthines (asthma agents)

Common Specialty Medications

All specialty medications require Precertification. The process begins with a call to HealthSmart at **1-888-440-7342**. HealthSmart will review the drug for medical necessity, and if approved, will coordinate the purchase through an approved source. 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 be $50 for any medications in this class. These drugs are not available in 90-day supplies.

If you are prescribed one of these common specialty medications, call HealthSmart at **1-888-440-7342**

Common Specialty Medication List

Drug Name	Category
Acthar® HP	Multiple Sclerosis
Actimmune	Anti-Neoplastic
Adcirca®	Pulmonary Hypertension
Afinitor	Anti-Neoplastic
Ampyra	Multiple Sclerosis
Aranesp®	Anemia
Arixtra®	Anti-Coagulant
Avonex® [QLL]	Multiple Sclerosis
Betaseron® [QLL]	Multiple Sclerosis
Boniva®	Osteoporosis
Cerezyme®	Gaucher Disease
Copaxone® [QLL]	Multiple Sclerosis
Eligard	Anti-Neoplastic
Enbrel® [QLL]	Inflammatory Conditions
Enoxaparin Sodium	Anti Coagulant
Epogen®	Anemia
Forteo®	Osteoporosis
Fragmin®	Anti-Coagulant
Genotropin®	Growth Hormone
Gilenya®	Multiple Sclerosis
Gleevec®	Anti-Neoplastic
Humatrope®	Growth Hormone
Humira® [QLL]	Inflammatory Conditions
Incivek	Hepatitis
Intron A®	Interferons
Kineret®	Inflammatory Conditions
Kuvan	Enzyme deficiencies
Letairis®	Pulmonary Arterial Hypertension
Leukine®	Hematopoietic
Lovenox®	Anti-Coagulant
Lupron Depot®	Endometriosis, Anti-Neoplastic, Precocious Puberty
Lupron Depot® -- Ped	Precocious Puberty
Lupron®	Anti-Neoplastic
Methotrexate	Anti-Neoplastic Anti Arthritis
Neulasta® [QLL]	Neutropenia
Neupogen®	Neutropenia
Nexavar®	Anti-Neoplastic, Immunosuppressant

Drug Name	Category
Norditropin®	Growth Hormone
Nutropin®	Growth Hormone
Octreotide Acetate	Endocrine disorders
Pegasys® [QLL]	Hepatitis C
Peg-Intron® [QLL]	Hepatitis C
Procrit®	Anemia
Pulmozyme®	Cystic Fibrosis
Rebif® [QLL]	Multiple Sclerosis
Revatio®	Pulmonary Arterial Hypertension
Revlimid®	Anti-Neoplastic, Immunosuppres-sant
Riba pak	Hepatitis
Ribavirin®	Hepatitis C
Sandostatin LAR	Endocrine disorders
Simponi®	Rheumatoid Arthritis
Sprycel	Anti-Neoplastic
Sutent®	Anti-Neoplastic
Tarceva®	Anti-Neoplastic
Tasigna	Anti-Neoplastic
Temodar®	Anti-Neoplastic
Tev-Tropin®	Growth Hormone
Thalomid®	Anti-Neoplastic
Thyrogen® Kit	Diagnostic
Tobi® [QLL]	Cystic Fibrosis
Tracleer®	Pulmonary Arterial Hypertension
Tykerb	Anti-Neoplastic
Tyvaso®	Pulmonary Arterial Hypertension
Victrelis®	Hepatitis
Votrient	Anti-Neoplastic
Xeloda®	Anti-Neoplastic
Xenazine®	CNS Disorders
Zoladex®	Anti-Neoplastic
Zolinza	Anti-Neoplastic
Zytiga®	Anti-Neoplastic

All Common Specialty Medications require Precertification from HealthSmart.
[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.

Diabetes Management

Blood Glucose Monitors: Covered diabetic insureds can receive a free Bayer Ascensia Breeze2® or Ascensia Contour® blood glucose monitor with a current prescription. Simply ask your pharmacist, and he or she will contact Bayer by fax or mail to request the monitor.

Glucose Test Strips: The plan covers only Bayer Ascensia® Breeze2 or Ascensia® Contour test strips at the preferred copayment of $15 per 30-day supply. Other brands require a 100% copayment.

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

Coverage	Needles/Syringes	Lancets
At the retail pharmacy:		
Up to a 30-day supply	$10	$5
31- to 60-day supply	$20	$10
61- to 90-day supply	$30	$15
Through the mail service and retail maintenance network pharmacies:		
Up to a 30-day supply	$10	$5
31- to 90-day supply	$20	$10

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 47 in the previous section. 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 one twelve-week cycle per rolling twelve-month period, three cycles per lifetime. Nicotine patches are available at no cost to the member; both the deductible and the copayment are waived on nicotine patches when prescribed by a physician and purchased at a network pharmacy. All other prescription and over-the-counter (OTC) tobacco cessation products will be covered with the applicable generic, preferred or non-preferred copayment, depending on their status on PEIA's Preferred Drug List.

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. Anorexients (any drug used for the purpose of weight loss)
2. Anti-wrinkle agents (e.g., Renova®)
3. Birth control drugs for dependent children
4. Bleaching agents (e.g., Eldopaque®, Eldoquin Forte®, Melanex®, Nuquin®, Solaquin®)
5. Charges for the administration or injection of any drug
6. Contraceptive devices and implants
7. Diagnostic agents
8. Drugs dispensed by a hospital, clinic or physician's office
9. Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs not approved by the FDA, even though a charge is made to the individual
10. Drugs requiring prior authorization when prescribed for uses not approved by the FDA
11. Drugs requiring a prescription by State law, but not by federal law (State controlled) are not covered
12. Erectile dysfunction medications
13. Fertility drugs
14. Fioricet® with Codeine (butalbital/acetaminophen/caffeine with codeine)
15. Fiorinal® with Codeine (butalbital/aspirin/caffeine with codeine)
16. Hair growth stimulants
17. Homeopathic medications
18. Immunizations, biological sera, blood or blood products, Hyalgan®, Synvisc®, Remicade®, Synagis®, Xolair®, Amevive®, Raptiva®, Vivitrol® (these are covered under the medical plan)
19. Latisse™
20. Medical or therapeutic foods.
21. 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
22. Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, or any State or governmental agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member
23. Non-legend drugs (except when included in a compound with a legend drug)
24. Omnipod V-go®, Finesse® or other disposable insulin delivery systems.
25. Pentazocine/Acetaminophen (Talacen®)
26. 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
27. Replacement medications for lost or stolen drugs
28. Requests for more than a 90-day supply of maintenance medications, or requests for more than a 30-day supply of short-term medications
29. Stadol® Nasal Spray (butorphanol)
30. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those listed above
31. Unit dose medications
32. 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.

Other Important Features of Your Prescription Drug Program

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

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

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

Drug Utilization Review

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

Education and Safety

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

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

Health Management

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

Coordination of Benefits

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

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

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

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

1. 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. HealthSmart 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 Express Scripts, Inc. and should be submitted to:

Express Scripts, Inc., P.O. Box 390873, Bloomington, MN 55439-0873

To process a prescription drug claim, ESI 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 received from PEIA. See "Subrogation" on page 103 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 ESI.

ESI 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.

Medicare Part D

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 Express Scripts, Inc.

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"). 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.

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 Express Scripts or RDT (depending on the nature of your complaint) to ask for details. If you are not satisfied with the outcome of your telephone inquiry, the second step is to appeal to Express Scripts or RDT in writing. Please have your physician provide any additional relevant clinical information to support your request. Mail your request with the above information to:

Type of Error	Who to Call	Where to Write
Prior Authorization error or denial (for Physician's offices or pharmacists ONLY)	RDT 1-800-847-3859	Rational Drug Therapy Program WVU School of Pharmacy PO BOX 9511 HSCN Morgantown, WV 26506
Prescription drug claim payment error or denial	Express Scripts 1-877-256-4680	Express Scripts, Inc. Attn: STD ACCTS P. O. Box 66583 St. Louis, MO 63166-6583

Express Scripts 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 Express Scripts 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, taking into account any additional materials that have been provided. A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the covered person or his or her authorized representative. For more information about your drug coverage, please contact Express Scripts at **1-877-256-4680.**

External Review: If we have denied your request for the provision of or payment for a health care service or course of treatment, you may have a right to have our decision 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. Exercise this right by submitting 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, 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 be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial.

How to Reach Express Scripts

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

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

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

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

Benefit Assistance Program

PEIA offers a program to assist Medicare-eligible retired employees with increasing prescription drug costs.

PEIA PPB Plan C

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 - HealthSmart at **1-888-440-7342**
- Precertification, case management, and pre-authorizations, and prior approvals for out-of-state care – ActiveHealth at **1-888-440-7342.**
- Prescription drug claims and benefits - Express Scripts at **1-877-256-4680**
- Common Specialty Medication claims and benefits – HealthSmart 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 Aetna® Signature Administrators℠' PPO. In addition, HealthSmart contracts with some out-of-state providers to serve PEIA participants only. To locate a network provider, call HealthSmart at **1-888-440-7342** or **304-353-7820**. Care provided by non-network providers requires prior approval, or it will be paid at 80% of PEIA's in-network allowed amount. You will be responsible for 20% of PEIA's allowed amount, plus any difference between what the provider charges and what PEIA allows.

Not all hospitals in Aetna Signature Administrators' network may participate with PEIA. PEIA reserves the right to remove providers from the network, so not all providers in the network may be available to you.

Providers 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 HealthSmart 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 requires 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.

What You Pay With The 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 are for PEIA PPB Plan C are:
Employee Only: $1,250
Employee and Child(ren): $2,500
Family $2,500
Family with Employee Spouse: $2,500

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

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

	If you live in WV, you will pay:	If you live in a bordering county of a surrounding state, you will pay:	If you live out-of-state (beyond bordering counties), you will pay:
Access care in WV or in a bordering county of a surrounding state using PPO providers	20% coinsurance	20% coinsurance	20% coinsurance
Access care outside WV (beyond bordering counties) using PPO providers with prior approval	20% coinsurance	20% coinsurance	20% coinsurance
Access care outside WV (beyond bordering counties) using non-PPO providers with prior approval	20% coinsurance + 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.

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 Aetna ASA 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 the Aetna ASA 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 HealthSmart for a referral to a network provider, or for approval to see an out-of-network provider where you are.

Non-resident PPB Plan Participants

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

Benefit Design

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

Covered in Full

The following services are covered in full in-network:

Type of Service	Your In-network Cost
Routine prenatal care (physician services)	$0; Covered in full
Well child exams and immunizations as recommended by the American Academy of Pediatrics	$0; Covered in full
High risk birth score program	$0; Covered in full
Annual screening mammogram	$0; Covered in full
Annual Pap smear [1]	$0; Covered in full
Colorectal cancer screening age 50 + above [1]	$0; Covered in full
Prostate cancer screening age 50 + above [1]	$0; Covered in full
Abdominal Aortic Aneurysm one-time screening from men age 65- 75 who have ever smoked	$0; Covered in full
Cholesterol Screening for men age 35 and older and women age 45 and older or others at higher risk	$0; Covered in full
Tobacco Use screening for all adults and cessation interventions for tobacco users (excludes tobacco cessation medications)	$0; Covered in full
HIV screening for all adults at higher risk	$0; Covered in full
Immunization vaccines recommended for adults — doses, recommended ages and recommended populations vary	$0; Covered in full
Syphilis screening for all adults at higher risk	$0; Covered in full
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
BRAC counseling about genetic testing for women at higher risk	$0; Covered in full
Hepatitis B screening for pregnant women at their first prenatal visit	$0; Covered in full
Osteoporosis screening for women over age 60 depending on risk factors	$0; Covered in full
RH Incompatibility screening for all pregnant women and follow- up testing for women at higher risk	$0; Covered in full
Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea and Syphilis for women at increased risk	$0; Covered in full
Alcohol and drug Use assessments for adolescents	$0; Covered in full
Autism Screening for children at 18 and 24 months	$0; Covered in full
Behavorial assessments for children of all ages	$0; Covered in full
Cervical Dysplasia screening for sexually active females	$0; Covered in full
Congenital Hypothyroidism screening for newborns	$0; Covered in full
Developmental screening for children at higher risk of lipid disorders	$0; Covered in full
Dyslipidemia screening for children at higher risk of lipid disorders	$0; Covered in full
Gonorrhea preventive medication for the eyes of all newborns	$0; Covered in full
Hearing screening for all newborns at birth	$0; Covered in full
Height, Weight and Body Mass Index measurements for children	$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
Lead screening for children at risk of exposure	$0; Covered in full

Type of Service	Your In-network Cost
Medical History for all children throughout development	$0; Covered in full
Obesity screening and counseling (does not include the PEIA Weight Management Program)	$0; Covered in full
Oral Health risk assessment for young children	$0; Covered in full
Phenylketonuria (PKU) screening for this genetic disorder in newborns	$0; Covered in full
Tuberculin testing for children at higher risk of tuberculosis	$0; Covered in full
Vision screening for all children	$0; Covered in full
Routine Physical and Screening Exam cover for each member covered annually	$0; Covered in full

[1] Testing covered in full; charges for the office visit will apply to the deductible and out-of-pocket maximum, unless included in the Routine Physical and Screening Exam.

Deductible and coinsurance

Services not listed in the preceding chart are covered at 80% after the deductible is met. For non-network care which is not approved in advance by ActiveHealth, you pay the deductible, 20% coinsurance, and the difference between what your provider charges 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)
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: Precertification/Notification, Preauthorization and Prior Approval

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 appropriate setting by a network provider, if possible. PEIA has three different types of pre-service determinations: precertification/notification, preauthorization and prior approval 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 ActiveHealth, 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.

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 ActiveHealth.

Precertification/Notification Requirements

Precertification of Inpatient Admissions and Certain Outpatient 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 medical documentation. Notification to ActiveHealth is required to evaluate the admission/service in order to determine if the patient's medical condition will require case management, such as discharge planning for home health care services.

Precertification is required for the following inpatient admissions:

1. Hysterectomy,
2. Laminectomy
3. Laminectomy with spinal fusion surgery,
4. Discectomy with spinal fusion surgery,
5. Spinal fusion surgery,
6. Artificial intervertebral disc surgery,
7. Insertion of implantable devices including, but not limited to; implantable pumps, spinal cord stimulators, neuromuscular stimulators and bone growth stimulators,
8. Cochlear implants.
9. Uvulopalatopharyngoplasty,
10. Elective and 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.
11. Bariatric surgery (gastric bypass, Lap-band, sleeve gastrectomy)
12. 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),
13. Mental health and substance abuse treatment, and
14. All admissions to out-of-state hospitals/facilities.

Precertification is required for the following outpatient services:

1. Any potentially experimental/investigational procedure, medical device, or treatment
2. Cochlear implants.
3. Continuous glucose monitors
4. CT scan of sinuses or brain
5. CTA (CT angiography)
6. Dialysis Services
7. Durable medical equipment purchases and/or rentals of $1,000 or more, and
8. Elective (non-emergent) facility to facility air ambulance transportation
9. Hyperbaric Oxygen Therapy (HBOT)
10. IMRT (intensity modulated radiation therapy)
11. Limited Molecular Diagnostic/Genetic Testing to include the following 5 tests: Hereditary Non-polyposis Colorectal Cancer (HNPCC) testing, BRCA gene testing, Oncotype DX, Familial Adenomatous Polyposis (FAP) testing, Catecholaminergic Polymorphic Ventricular Tachycardia (FPVT) testing.
12. MRI scan of knee and spine (includes cervical, thoracic, and lumbar)
13. Partial/day mental health and substance abuse treatment programs,
14. Services in the home as described under "Medical Case Management" on page 72,
15. Sleep studies, services and equipment. See section on "sleep management services" on page 79.
16. Specialty drugs
17. SPECT (single photon emission computed tomography) of brain and lung
18. Surgeries:
    a) artificial disc surgery
    b) bariatric surgery,
    c) discectomy with spinal fusion surgery,
    d) elective and 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,
    e) hysterectomy,
    f) implantable devices including, but not limited to: implantable pumps, spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators,
    g) laminectomy,
    h) laminectomy with spinal fusion surgery,
    i) spinal fusion surgery,
    j) transplants, and
    k) uvulopalatopharyngoplasty,

Notification

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

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

Failure to precertify or notify ActiveHealth 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 copayment, coinsurance, deductible, and amounts that exceed PEIA's maximum allowance.

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

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

Timely Precertification Requirements	
Type of Admission	**Advance Notice Required**
Scheduled:	
Planned admission	3 business days in advance
Inpatient elective surgery or procedure	3 business days in advance
Maternity (notify ActiveHealth 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
Urgent/Emergency	Within 48 hours of admission
Extended stay	Additional days may be recommended based on medical necessity

Preauthorization (Voluntary)

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

ActiveHealth Management
PO Box 221138
Chantilly, VA 20153-1138

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

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

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

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

Medical Case Management

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

- arrange home care to prevent hospitalization;
- arrange services in the home to facilitate early hospital discharge;
- obtain discounts for special medical equipment;
- locate appropriate services to meet the patient's health care needs; and
- for catastrophic cases, when medically proven as a part of a comprehensive plan of care, allow additional visits for outpatient mental health or Outpatient Therapy Services; and
- under very limited circumstances, allow additional visits for short-term outpatient physical therapy services for treatment of a separate condition which is also a new incident or illness - not an exacerbation of a chronic illness.

For example, a member who receives physical therapy following a stroke and later in the Plan Year has a separate new condition, such as a broken leg, may receive coverage for additional physical therapy visits.

For catastrophic cases involving serious long-term illness or injury resulting in loss or impaired function requiring medically necessary therapeutic intervention, the HealthSmart case manager may, based on medical documentation, recommend additional treatment for certain therapy services. For details of these benefits, see "What Is Covered" below.

ActiveHealth must be notified for medical case management for the following services:

1. home health care, including but not limited to:
   a) skilled nursing of more than twelve (12) visits;
   b) I.V. therapy in the home;
   c) physical therapy, occupational therapy or speech therapy done in the home; and
   d) medication provided or administered by a home health agency.
2. inpatient hospice care;
3. skilled nursing facility services;
4. rehabilitation services; and
5. Treatment for Autism Spectrum Disorder.

Transition of Care Program (New Participants Only)

If you are new to the PEIA PPB Plan, and have been receiving medical treatment from a non-network provider, you may be concerned that your care will be interrupted in your move to this Plan. To assist participants receiving treatment for serious medical conditions from non-network providers, PEIA has a Transition of Care (TOC) program. If you qualify for TOC, you can continue to receive medical treatment from a non-network provider during a transition period specified by ActiveHealth 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, ActiveHealth's nurses will work with you to provide that care. Conditions limited or excluded from coverage are not eligible for TOC benefits.

To apply for the TOC program, request a copy of the TOC form by calling **1-888-440-7342** or **1-304-353-7820** and submit the completed form to ActiveHealth 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 ActiveHealth. 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 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; an
- providing treatment within the scope or limitation of the license or certification; and
- not under sanction by Medicare, Medicaid or both. Services of providers under sanction will be denied for the duration of the sanction; 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 ActiveHealth. If you have questions about coverage of services, call HealthSmart at 1-888-440-7342 or 1-304-353-7820. Special arrangements that have been made for participants who live more than one county beyond the borders of West Virginia are explained on page 67 under "Non-resident PPB Plan Participants".

NOTE: Services marked with a ◊ require precertification from ActiveHealth.

- **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% after in-network deductible. Non-medically necessary, non-emergency ground transportation is not covered. Non-emergency air transportation requires precertification and is generally not covered.
- **Ambulatory Surgery.** Covered at 80% after the deductible is met. See "Outpatient Surgery" on page 76.
- **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 in-network deductible is met.
- **Cardiac or Pulmonary Rehabilitation.** Benefits are limited to 3 sessions per week for 12 weeks or 36 sessions per year for the following conditions: heart attack in the 12 months preceding treatment, heart failure, coronary by- pass surgery or stabilized angina pectoris. Covered at 80% after deductible is met.
- **Chelation Therapy.** Benefits for these services are limited. Contact ActiveHealth for preauthorization. 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 Outpatient Therapy Benefit (see below) 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. Maintenance services are not covered. Preauthorization is recommended for services for children under age 16. See Outpatient Therapy Services for more information.
- **Christian Science Treatment.** Treatment for a demonstrable illness or injury if provided in a facility accredited by the Commission for Accreditation of Christian Science Nursing Facilities/Organizations, Inc. or by a practitioner accredited by the Mother Church is covered at 80% after the 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. Inpatient care must be precertified.
- **Colorectal Cancer Screenings.** Routine screening to detect colorectal cancer is covered at 100% in-network with no deductible or coinsurance required. The related office visit expenses are covered at 80% after the deductible is met. 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. Covered at 80% 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 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 HealthSmart 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 HealthSmart within the initial six months.

- **Dental Services (impacted teeth).** Medically necessary extraction of impacted teeth is covered at 80% in-network after deductible is met. Extractions for the purpose of orthodontia are not covered.
- **DEXA Scans.** Bone mass measurement by DEXA is limited to one scan every 24 months for members who meet one of the following criteria:
  1. Member has received results from a peripheral osteoporosis screen indicating moderate or high risk for osteoporosis; OR
  2. Member has documented clinical risk for osteoporosis.

  Diagnostic testing is covered at 80% after deductible has been met. Routine screening scans are not covered. Complete details of the DEXA scan payment policy are available on the PEIA website at **www.wvpeia.com**.
- **Diabetes Education.** Services of a diabetes education program that meets the standards of the American Diabetes Association are covered at 80% after deductible is met. Coverage is limited to six (6) visits per patient: three visits with the dietician and three visits with a registered nurse. Contact HealthSmart 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 or purchase (at the plan's discretion) of standard DME, when prescribed by a physician. Prosthetics and DME purchases of $1,000 or more, or rental for more than 3 months must be precertified by ActiveHealth. DME and prosthetics are covered at 80% after the deductible is met.

- **Emergency Services (including supplies).** Services received in an emergency room are subject to 20% coinsurance after the annual deductible has been met.
- **Emergency Room Treatment.** 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 Plans.

◊ **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.

- **Hypertension Screening.** The Plan pays for diagnostic screening to determine if you are at risk for high blood pressure, heart disease or stroke. Benefits include coverage for an office visit, blood pressure check, and a blood chemistry profile. The office visit and blood chemistry profile are covered at 80% after the deductible is met. The blood pressure check is included as part of the office visit. The plan will pay for this screening:
  - One time between the ages of 20 and 30;
  - Once every three years between ages 31 and 39; and
  - Once every two years after age 40.
- **Immunizations.** 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, 1-2 months, 6-18 months. If missed 2-3 doses starting at age 7 years depending on vaccine type.
  - **Hepatitis A:** Begin at 6 months, with 2nd 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.
  - **Meningococcal:** At 2-10 years for certain children as recommended by the American Academy of Pediatrics, and 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.

  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 77.

  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 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 at 20% coinsurance after the deductible is met.

◊ **Inpatient Medical Rehabilitation Services.** When ordered by a physician, coverage is subject to 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.** An annual routine mammogram to detect breast abnormalities is covered at 100% in-network with no coinsurance or deductible required. The related office visit expenses are covered at 80% after the deductible is met. 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 of a licensed massage therapist for treatment of neuromuscular-skeletal conditions are covered under the Outpatient Therapy Benefit when ordered by a physician. Covered at 80% after the deductible is met. Combined coverage for these outpatient therapies is limited to a maximum of 20 visits per person per plan year. See Outpatient Therapy Services for more information.
- **Mastectomy.** If you are receiving benefits in connection with a mastectomy due to cancer and elect breast reconstruction in connection with such benefits, you are entitled to the following procedures, 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 lymphedas.
- **Maternity Services.** See "Maternity Benefits" on page 77 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. Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment. Precertification is required. These services are covered at 80% after the 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 in network 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.** Only covered for extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction at 80% after the deductible is met. Preauthorization is recommended for orthognathic procedures and ridge reconstruction procedures. Dental implants are not covered.
- ◊ **Organ Transplants.** See "Organ Transplant Benefits" on page 78 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: physical, massage, occupational, speech, and vision therapies, acupuncture, osteopathic manipulations and chiropractic treatment. The benefit is limited to a maximum of 20 visits per person per plan year for all of the therapies combined. Case management is required for more than 20 visits.
  - Acupuncture is not a covered service as of July 1, 2012.
  - **Chiropractic Treatment.** Services of a chiropractor for acute treatment of neuromuscular-skeletal conditions are included in the Outpatient Therapies benefit (see above) and are covered at 80% after the deductible is met. Office visits and x-rays are covered at 80% after deductible is met. Maintenance services are not covered. Preauthorization is recommended for services for children under age 16.
  - **Massage Therapy.** When ordered by a physician, therapeutic massage therapy services of a licensed massage therapist are covered at 80% after the deductible is met.
  - **Occupational Therapy.** When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the deductible is met.
  - **Osteopathic Manipulations.** Services of an osteopathic physician to eliminate or alleviate somatic dysfunction and related disorders are covered at 80% after the 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.
  - **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.** Contact ActiveHealth for preauthorization of these services. This benefit is included in the Outpatient Therapies benefit and is covered at 80% after the deductible is met.
- **Pain Management Services.** 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 as a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.
- **Annual Routine Physical and Screening Exam.** The PEIA PPB Plan C covers an annual routine physical and screening exam once every year for adults age 18 and over at no cost to the patient. Exams may be provided more often if the patient's medical history indicates a need. This office visit, generally, includes, but is not limited to 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 deductible and 20% coinsurance will apply to other testing billed with a medical diagnosis. Only the screenings specifically required under PPACA or listed in this "What is Covered" section, will be covered as routine screenings.

- **Physician's Office Visits** (treatment for illness, injury, or medical condition). These visits are subject to 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 and other physician services are covered at 80% 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 deductible and 20% coinsurance, 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. If not the "Annual Routine Physical and Screening Exam," the office visit is covered at 80% after the deductible is met.
- **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 ActiveHealth.
- ◊ **Specialty Injectable Medications.** Coverage is provided for treatments utilizing specialty drugs through a program managed by HealthSmart Benefit Solutions. Injectables covered under the medical benefit plan are covered at 80% after the 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 provided through a network of West Virginia providers and require precertification through Sleep Management Solutions. Non-resident PPB Plan members must contact ActiveHealth 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 81 for details.
- **Well Child Care.** For children through age 16, the plan covers routine office visits for preventive care as recommended by the American Academy of Pediatrics. These visits are covered at 100% of allowed charges and are not subject to 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.

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 only for the employee or the employee's enrolled spouse.

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

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

Payment Level

Maternity services for routine prenatal care, delivery and follow-up are paid at 100% of allowed charges under a global fee after the deductible has been met. Other maternity services, including hospital charges and anesthesia services, are paid at 80% of allowed charges 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. ActiveHealth will notify those families who qualify for this benefit.

Enrolling Your Newborn

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

Nursery Charges

If the baby is enrolled for coverage under 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, charges for a normal, healthy newborn's nursery care will be covered 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.

Medical Home

PEIA's Medical Home program allows you to choose a West Virginia physician from the Medical Home directory to serve as your medical home. Your medical home can be a general practice doctor, family practice doctor, internist, pediatrician, geriatrician, or, for women in the plan, an OB/GYN.

The intent of this program is to connect members with a physician who can oversee and coordinate all of their care. You ARE NOT required to have a referral to see a specialist, and this plan does not limit your ability to see any network doctor you choose. You may name a medical home each year during open enrollment, and you may make one change during the plan year, if you wish, unless there are extenuating circumstances, such as the death of your medical home physician or a move that makes it inconvenient for you to access care from your medical home.

If you are a Resident PPB Plan participant and you do not choose a medical home, you can still see any network physician you choose. Your costs for preventive care will not change.

If you are a non-Resident PPB Plan participant (PEIA PPB Plan participant who resides outside West Virginia and beyond the bordering counties) and you do not choose a medical home (either because you don't want to or because accessing care from a West Virginia provider is not possible), you can still see any network physician you choose. Your benefits will not be affected by this program.

Organ Transplant Benefits

Organ transplants are covered when deemed medically necessary and non-experimental. They are subject to precertification and case management by ActiveHealth. You should contact ActiveHealth 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 require precertification for determination of medical necessity. When it is determined by your physician that you are a potential candidate for any type of transplant, ActiveHealth should be contacted immediately. They will identify Institutes of Excellence with experience in the specific type of transplant you require. You should advise your physician that ActiveHealth needs to coordinate the care from the initial phase when considering a transplant procedure, initial workup for transplant through the performance of the procedure and the care following the actual transplant.

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

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

Organ Transplant Network (OTN)

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

PEIA uses Aetna's Institutes of Excellence for its transplant network. ActiveHealth will work with patients and physicians to determine which network facility best serves the patient's medical needs.

OTN Benefits

Reduced Costs: Once the annual deductible and out-of-pocket maximum have been met, you will pay no more coinsurance on the negotiated fees for pre-transplant, transplant, and follow-up services.

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

Medical Case Management: ActiveHealth 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 ActiveHealth at **1-888-440-7342.**

You should contact ActiveHealth 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 precertified through ActiveHealth.

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 PEIA maximum allowance. If treatment at a non-network facility is approved as medically necessary in advance by ActiveHealth, 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. These are covered through the Prescription Drug Plan and processed by the prescription drug administrator. Details of the PEIA Prescription Drug Plan are found in the "Prescription Drug Benefits" section starting on page 85.

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

PEIA PPB Plan C covers services for the treatment of sleep apnea and other related conditions that can affect your health. In order to ensure compliance and ensure responsible use of all prescribed sleep services, HealthSmart Benefit Solutions, the third-party administrator for PEIA, has contracted with Sleep Management Solutions (SMS) to manage the PEIA's sleep services for resident PPB Plan members.

All sleep-testing services require prior approval. A precertification process has been established to ensure that the services are medically necessary and appropriate. If your physician says you need a sleep test, ask him/her to call SMS at **1-888-49-SLEEP (75337).** If approved, you will be provided a list of contracted labs that you may use to receive services.

In addition to managing sleep-testing services, SMS is the sole source for CPAP and Bi-Level equipment and supplies. The process is integrated so that patients who have been diagnosed and prescribed CPAP or Bi-level therapy are set up and educated at the lab where they received their sleep study.

Sleep Management Solutions has a 24-hour hotline that PEIA members may access to get information on their sleep illness and how best to use their sleep equipment. A Respiratory Therapist or a trained sleep technician is available to provide support when issues come up, which is generally at bedtime. You may also visit the PEIA Sleep website at www.wvpeiasleep.com.

SMS will contact you regularly to make sure there are no issues which might be impeding compliance. If you have problems with masks or equipment, call SMS for assistance.

Patient care and improved health is the most important aspect of this process.

Non-resident PPB Plan members must contact ActiveHealth for precertification of sleep management services.

Specialty Injectable Program

The PEIA PPB Plans cover specialty injectable drugs through a program managed by HealthSmart Benefit Solutions (HealthSmart). The program provides comprehensive direction to policyholders and their dependents for treatments utilizing specialty drugs. If your physician prescribes a specialty drug, that physician, your or the pharmacist must call HealthSmart at **1-888-440-7342** (Providers press 1, then 7; Members press 2, then 7). HealthSmart will review the drug for medical necessity. If approved, HealthSmart will coordinate the purchase through the approved source and contact you and your physician with additional details including where the physician should call in the prescription, how you will receive the drug and discuss any educational needs. If denied, HealthSmart will contact your physician for additional information which may allow approval of the requested medication.

Healthy Tomorrows

Healthy Tomorrows is a program that coordinates all of PEIA's continuing lifestyle management programs under one umbrella. The programs included in Healthy Tomorrows are detailed below:

Face-to-Face (f2f) Diabetes Program

PEIA's F2F Diabetes Program for PPB Plan members is available statewide (subject to the availability of pharmacists) to active employees and non-Medicare retirees and their dependents who have diabetes.

Under the program, members and/or their dependents with diabetes or gestational diabetes agree to make regular visits to a participating pharmacist of their choosing, for counseling and health education services. The pharmacist works with each member to ensure he/she gets the best diabetes care possible by monitoring: a) recommended testing and treatment of diabetes; b) the member's currently prescribed medicines and knowledge about how to take them; and c) physical activity and nutrition plan to assist the member in achieving optimal health. For patients who choose to participate in the Face to Face Diabetes program, you will be responsible for the annual deductible and 20% coinsurance for the pharmacist visits. Members benefit from participating in the F2F Diabetes program by improving their health and quality of life. 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 once-in-a-lifetime benefit (with the exception of gestational diabetes). Prior participation in the Dr. Dean Ornish Program for Reversing Heart Disease or 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 Programs website, www.peiaf2f.com, or call PEIA Customer Service at **1-888-680-7342.**

Hemophilia Disease Management Program

To provide quality care at a reasonable cost, PEIA and the Charleston Area Medical Center (CAMC) have partnered to provide a Hemophilia Care Program to PEIA PPB Plan members. Under the program, members and/or their dependents with hemophilia agree to receive an annual evaluation from the Hemophilia Treatment Center at CAMC. Members who participate in the program will be eligible for the following benefits:

1. An annual evaluation by specialists in the Hemophilia Treatment Center at CAMC will be paid at 80% after deductible. (This evaluation is not intended to replace or interrupt care provided by your existing medical home provider or specialists.)
2. Hemophilia expenses, including factor replacement products, incurred at CAMC will be paid at 80% after deductible.
3. Reimbursement for travel and lodging
   - **a)** Child and 1 or 2 parents
   - **b)** Adult and an accompanying adult
   - **c)** Lodging will be at the CAMC travel lodge for a maximum of two (2) nights.
   - **d)** Gas will be reimbursed at the state rates.
   - **e)** Receipts for food will be paid at 80% for the child and parents or for the 2 adults.

Lodging and Travel Expenses:

Lodging expenses include:

1. Expenses incurred by the patient traveling between his or her home and CAMC to receive services in connection with the PEIA/CAMC Hemophilia Disease Management Program.
2. Expenses incurred by the patient's companion to enable the patient to receive services from the PEIA/CAMC hemophilia Disease Management Program.
   - **a)** For children under the age of 18, lodging will be covered for one (1) or two (2) parents.
   - **b)** For patients over the age of 18, lodging will be covered for one (1) companion.
3. Lodging will be covered at 80% of the charge at CAMC's travel lodge in Kanawha City. Other hotel/motel expenses will be covered, not to exceed the cost at CAMC's travel lodge. The current rate is $57.12 per night.

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 connections with the PEIA/CAMC Hemophilia Disease Management Program.
2. Gas receipts are required for reimbursement.
3. Reimbursement of meal expanses 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: CAMC Hemophilia Treatment Center at **304-388-8896** or ActiveHealth at **888-440-7342**

Weight Management Program

PEIA offers a facility-based weight management program for PEIA PPB plan members who have a Body Mass Index (BMI) of 25 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 once per lifetime benefit that may last up to two years. Member cost is $20 per month, after the deductible has been met.

To enroll, you must complete the application, which includes some medical information, and provide written approval from your physician. For more information or to enroll in the program, call **1-866-688-7493** or visit PEIA's website at **www.wvpeia.com**.

Dr. Dean Ornish Program for Reversing Heart Disease

The Dr. Dean Ornish Program for Reversing Heart Disease is an intensive program for patients who meet the medical criteria for participation: coronary artery disease, Type I or Type II diabetes, or at high risk for these conditions.

The Ornish approach does not use drugs or surgery, but relies upon nutrition, physical activity, group support and stress management as part of an intensive life style change program. Applicants are screened by their local participating Ornish hospital to determine if they meet the medical criteria for participation listed above.

The program is covered at 80% after the deductible,

For more information about this program, visit PEIA's "Health and Wellness Programs" link on our website or contact PEIA's customer service unit at **1-888-680-7342.**

Dean Ornish Spectrum Program

The Dean Ornish Spectrum program is a six week lifestyle education program based upon the principles of Dr. Dean Ornish as described in his book of the same title. After deductible, members get six weeks of training subject to 20% coinsurance. The once-in-a-lifetime benefit is available to PEIA members who meet one of the following criteria:

1. Family or personal history of coronary artery disease, hypertension and or diabetes;
2. Aged 50 or older;
3. BMI>25
4. Metabolic syndrome
5. Family or personal history of cancer.

For more information, visit the "Health and Wellness Programs" link on our website at **www.wvpeia.com** for a complete listing of participating hospitals or contact PEIA's customer service unit at **1-888-680-7342.**

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 medical home/primary care provider. After the deductible is met, PEIA will cover an initial and follow-up visit to your physician or nurse practitioner at 80%. PEIA covers both prescription and non-prescription tobacco cessation medications, after the deductible is met and with applicable generic, preferred or non-preferred prescription copayments, if they are dispensed with a prescription.

PEIA will cover a total of 12 weeks 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) once per year (rolling 12-month period) with a maximum of three attempts per lifetime.

PEIA Pathways to Wellness

The PEIA Pathways to Wellness Program provides Improve Your Score health screening and lifestyle change programs to PEIA PPB Plan insureds at participating worksites. For additional information visit: peiapathways.com.

Improve your Score

Improve Your Score Discount. PEIA offers a unique opportunity to understand your health risk factors and improve your health status by offering a $10 per month discount off the standard health premium to active employee policyholders in the PEIA PPB Plans who participate in the Improve Your Score program. Retired policyholders are not charged the $10 premium increase, and are not eligible for the $10 Improve Your Score premium discount. The Improve Your Score program is a two-step process designed to make you and your doctor aware of individual health risks, including cholesterol, glucose or blood sugar, blood pressure and waist circumference, and then to act on your modifiable risk factors to attempt to improve them. Here's how the program works:

Step One: Screening. You must "know your numbers" and get your report card every 24 months by:

1. Attending a Pathways to Wellness worksite health screening at your worksite. You may also attend a screening at any other PEIA Pathways worksite with prior notice to the PEIA Pathways staff. Standard worksite screenings are offered at no charge to PEIA PPB Plan members. For those just beginning participation in the program, it may take up to 90 days following a screening for your premium discount to begin.
2. Reporting results of a screening by your physician. If you've already had this blood work done through your physician's office or another provider, you may download the Improve Your Score reporting form from www.wvpeia.com. Then, have your provider complete the necessary information and return the form to the address listed on the form. (Remember, you will be responsible for any applicable coinsurance or copayment if your physician performs the screening.)

Participants in Improve Your Score screenings receive a color-coded report card from PEIA using the stop light system: green for healthy; yellow for moderate risk; and red for high risk.

Step Two: Engagement Act on your report card and improve your health status:

Green: If your overall score is green, congratulations and keep up the great work! You will maintain your premium discount as long as you get screened at least every 24 months and maintain your green overall score.

Yellow or Red: If your overall score is yellow or red, you must take some action every twelve months to improve your modifiable risk factors. The following activities will count as "engagement" to maintain your discount:

- see your medical home or primary care physician;
- participate in PEIA's Face to Face Diabetes Program,
- participate in the PEIA Weight Management Program,
- participate in the Dr. Ornish Program for Reversing Heart Disease;
- participate in the Ornish Spectrum education program, or
- other opportunities which may be found on www.peiapathways.com.

You must continue to get screened and receive a new report card at least every 24 months to continue participating in this discount program. If your overall score improves from yellow or red to green, then you follow the instructions for a "green" score above.

To qualify for the discount for the full plan year, by April 30 each year you must have been screened within the past 24 months, and if your score is yellow or red, you must have engaged in one of the activities listed above within the past 12 months.

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 HealthSmart at **1-888-440-7342** or **1-304-353-7820**. The following services are not covered:

1. Acupuncture
2. Aqua therapy.
3. Autopsy and any other services performed after death, including transportation of the body or expatriation/repatriation of remains.
4. Biofeedback.
5. Birth control drugs, devices, and services for dependent children.
6. Breast pumps.
7. Chemical dependency treatments when a patient leaves the hospital or facility against medical advice.
8. Coma stimulation.
9. 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.
10. 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.
11. Dental implants, whether medically indicated or not.
12. 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.
13. Daily living skills training.
14. Duplicate testing, interpretation or handling fees.
15. Education, training and/or cognitive services, unless specifically listed as covered services.
16. Elective abortions.
17. Electronically controlled thermal therapy.
18. Emergency evacuation from a foreign country, even if medically necessary.
19. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts.
20. Expenses incurred as a result of illegal action, while incarcerated or while under the control of the court system;
21. Experimental, investigational or unproven services, unless pre-approved by ActiveHealth.
22. Fertility drugs and services.
23. Foot care. Routine foot care including:

24. Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), or hypertrophy (growth of tissue under the skin);
25. Cutting, trimming, or partial removal of toenails;
26. Treatment of flat feet, fallen arches, or weak feet; and
27. Strapping or taping of the feet.
28. Genetic testing for screening purposes is generally not covered. See Precertification on page 70 for exceptions.
29. Glucose monitoring devices, except Bayer Ascensia models covered under the prescription drug benefit.
30. Homeopathic medicine.
31. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery.
32. Hypnosis.
33. Incidental surgery performed during medically necessary surgery.
34. 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.
35. Maintenance outpatient therapy services, including, but not limited to:
    - Chiropractic
    - Massage Therapy
    - Occupational Therapy
    - Osteopathic Manipulations
    - Outpatient Physical Therapy
    - Outpatient Speech Therapy
    - Vision Therapy
36. Marriage counseling.
37. Medical equipment, appliances or supplies of the following types:
    - augmentative communication devices.
    - bathroom scales.
    - educational equipment.
    - environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors.
    - equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs(including Hoyer lifts); recliners; contour chairs; adjustable beds; or tilt stands.
    - equipment which is widely available over the counter such as wrist stabilizers and knee supports.
    - exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines.
    - hearing aids of any type.
    - hygienic equipment such as bed baths, commodes, and toilet seats.
    - motorized scooters.
    - nutritional supplements, over-the-counter (OTC) formula, 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.
    - traction devices.
    - vibrators.
    - whirlpool pumps or equipment.
    - wigs or wig styling.
38. Medical rehabilitation and any other services that are primarily educational or cognitive in nature.
39. Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning.
40. 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
41. Oral appliances, including, but not limited to, those treating sleep apnea.
42. Orientation therapy.
43. Orthodontia services.
44. Orthotripsy.
45. Physical examinations and routine office visits except those covered under the Periodic Physicals benefit.
46. 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.
47. 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.
48. 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.

49. Pregnancy-related conditions for dependent children.
50. Provider charges for phone calls, prescription refills, or physician-to-patient phone consultations.
51. Radial keratotomy and other surgery to correct vision.
52. Reversal of sterilization and associated services and expenses.
53. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities.
54. Screenings, except those specifically listed as covered benefits.
55. 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.
56. Services rendered outside the scope of a provider's license.
57. Sex transformation operations and associated services and expenses.
58. Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit.
59. Stimulation therapy.
60. Take-home drugs provided at discharge from a hospital.
61. 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.
62. The difference between private and semi-private room charges.
63. Therapy and related services for a patient showing no progress.
64. Therapies rendered outside the United States that are not medically recognized within the United States.
65. Transportation other than medically necessary emergency ambulance services, or as approved under the Organ Transplant Network benefit.
66. War-related injuries or illnesses. Treatment in a State or Federal hospital for military or service-related injuries or disabilities.
67. 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 program offered by PEIA.
68. Work-related injury or illness.

Notice Of Appeal Rights

PEIA PPB 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
Medical claim denial	HealthSmart 1-888-440-7342	HealthSmart P. O. Box 2451, Charleston, WV 25329-2451
Out-of-state care denial, denial of precertification or case management	ActiveHealth 1-888-440-7342	ActiveHealth Management PO Box 221138 Chantilly, VA 20153-1138

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 60 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 25304-2345601 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 within 60 days. If you do not receive our decision within 60 days of receiving your appeal, you may be entitled to file a request for external review.

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 requesting it. 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, you may have a right to have our decision 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. Exercise this right by submitting 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, 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 be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial.

Prescription Drug Benefits

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

- the Retail Pharmacy Program gives you access to local participating pharmacies to get your prescriptions filled.
- the Express Scripts Mail Service Pharmacy Program lets you order your prescriptions through the mail, saving you time and money by having your maintenance medications delivered to your door.
- the HealthSmart 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	
	PPB Plan C
Policyholder Only	$1,250
Policyholder & Child(ren)	$2,500
Family	$2,500
Family with Employee Spouse	$2,500

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 based on the amount and type of drug you're taking. The following chart shows the copayments.

Copayments

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

Prescription Drug Co-payments			
PEIA PPB Plan C			
	Up to a 30-day supply	31- to 60-day supply*	61- to 90-day supply*
Generic Drug	$5	$10	$15
Brand-name drug listed on the WV Preferred Drug List	$20	$40	$60
Brand-name drug not listed on the WV Preferred Drug List	$75% coinsurance	75% coinsurance	75% coinsurance
Common Specialty Medications†	$50	not available	not available

* For maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. You may be able to get a discount on your generic or preferred brand maintenance medications through a Retail Maintenance Network pharmacy or through Mail Service. Read on for details.

† Should your doctor prescribe or you request the brand-name Specialty Medication when a generic drug is available, you must pay the difference in price, plus the applicable Specialty Medication co-payment.
Should your doctor prescribe or you request the brand-name drug when a generic drug is available, you must pay the difference in price, plus the applicable generic co-payment.

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 Preventative Drug List

Prescription Drugs on the Preventative Drug List are not subject to the deductible, but will be covered with normal copays of $5, $20 and $50, 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 Preventative Drug List, visit www.wvpeia.com and click on Forms & Downloads > Prescription Drug Information > High Performance Preventative Drug List (Plan C Only).

West Virginia Preferred Drug List (WVPDL)

In addition to the Preventative 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 the copayment structure works:

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

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

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

If you have any questions, please call Express Scripts Member Services at **1-877-256-4680.**

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 for prescription drugs.

Getting Your Prescriptions Filled

Using A Retail Network Pharmacy

Express Scripts has a nationwide network of pharmacies. To get a prescription filled, simply present your medical/ prescription drug ID card at a participating Express Scripts pharmacy. You can purchase both acute and maintenance medications at an Express Scripts network pharmacy. You may refill your prescription when 75% of the medication 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 an Express Scripts pharmacy, you do not have to file a claim form. The pharmacist will file the claim for you online, and will let you know your portion of the cost.

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

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

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

Using the Retail Maintenance Network

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

Maintenance Drug Co-payments		
	PEIA PPB Plan C	
	Up to 30-day supply	31 to 90-day supply*
Generic medication	$5	$10
Brand-name medication listed on the WV Preferred Drug List	$20	$40
Brand-name medication not listed on the WV Preferred Drug List	75% coinsurance	75% coinsurance

* For generic or preferred brand maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. Should your doctor prescribe or you request the brand-name drug when a generic drug is available, you must pay the difference in price, plus the applicable generic co-payment.

Using Non-Network Pharmacies

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

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

Using the Express Scripts Mail Service Pharmacy Program

Express Scripts provides a convenient mail service pharmacy program for PEIA PPB Plan insureds. You may use the mail service pharmacy if you're taking medication to treat an ongoing health condition, such as high blood pressure, asthma, or diabetes. When you use the mail service pharmacy, you can order up to a 90-day supply of a medication on the maintenance list, as prescribed by your doctor, and pay only

two copayments. You may refill your prescription when 66% of the medication is used up. Express Scripts' licensed professionals fill every prescription following strict quality and safety controls. If you have questions about your prescription, registered pharmacists are available around the clock to consult with you.

New Prescriptions and the Mail Service Pharmacy

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

1. Ordering new prescriptions. Ask your doctor to prescribe your medication for up to a 90-day supply for maintenance medications, plus refills if appropriate. Mail your prescription and required copayment along with an order form in the envelope provided. Or ask your doctor to fax your order to 1-800-636-9494. You will need to give your doctor your member ID number located on your ID card.
2. Refilling your medication. A few simple precautions will help ensure you don't run out of your prescription. Remember to reorder on or after the refill date indicated on the refill slip. Or reorder when you have less than 14 days of medication left.
   a) Refills online: Log on to Express Scripts' website at www.express-scripts.com. Have your member ID number, the prescription number (it's the 9-digit number on your refill slip), and your credit card ready when you log on.
   b) Refills by phone: Call **1-877-256-4680** and use the automated refill system. Have your member ID number, refill slip with the prescription number, and your credit card ready.
   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 or American Express. Debit cards are not accepted for payment. Please note: The pharmacist's judgment and dispensing restrictions, such as quantities allowable, govern certain controlled substances and other prescribed drugs. Federal law prohibits the return of any dispensed prescription medicines.

Prior Authorization

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

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

The medications listed below require prior authorization:

1. adalimumab (Humira®)*
2. ambrisentan (Letairis®)*
3. amphetamines (Adderall XR®, Vyvanse®)
4. anakinra (Kineret®)*
5. armodafinil (Nuvigil®)
6. atomoxetine (Strattera®)
7. becaplermin (Regranex®)
8. bimatoprost (Lumigan®)
9. bosentan (Tracleer®)*
10. Brand-name medically necessary prescriptions. If the medication your doctor prescribes is a multi-source drug (more than one manufacturer markets the drug) and there is an FDA-approved or "A-B-rated" generic on the market, then PEIA will pay only for the generic version, unless your physician provides medical justification for coverage of the brand-name drug. If prior authorization is granted, these drugs will be covered as non-preferred brand-name drugs.
11. buprenorphine/naloxone (Suboxone®)
12. chenodiol (Chenodal™)*
13. ciclopirox (Penlac®)
14. clonidine hydrochloride, extended release (Kapvay®)
15. corticotropin (Acthar®)*
16. dabigatran etexilate (Pradaxa®)
17. dalfampridine (Ampyra®)
18. dextromethorphan/quinidine (Nuedexta™)
19. diclofenac sodium gel (Solaraze®)
20. eltrombopag (Promacta®)*
21. enfuvirtide (Fuzeon®)*
22. erythroid stimulants (Epogen®, Procrit®, Aranesp®)*
23. etanercept (Enbrel®)*
24. etravirine (Intelence®)
25. exenatide (Byetta®)
26. fentanyl (Abstral®, Actiq®, Duragesic®, Fentora®, Lazanda®and Onsolis®)
27. fingolimod (Gilenya®)
28. fluconazole (Diflucan®)
29. golimumab (Simponi®)*
30. growth hormones*
31. guanfacine extended-release (Intuniv®)
32. ibandronate (Boniva®)*
33. iloprost (Ventavis®)*
34. itraconazole (Sporanox®)
35. latanoprost (Xalatan®)
36. legend oral contraceptives for dependents (covered for treatment of medical conditions only)
37. liragultide (Victoza®)
38. maraviroc (Selzentry®)
39. modafinil (Provigil®)
40. Omega-3-acid ethyl esters (Lovaza®)
41. oxycodone hydrochloride (Oxycontin®)
42. quetiapine (Seroquel®)
43. raltegravir (Isentress®)
44. rilonacept (Arcalyst®)*
45. sacrosidase (Sucraid®)
46. sapropterin hydrochloride (Kuvan®)*
47. sildenafil (Revatio®)*
48. stimulants (Concerta®, Focalin XR®, methylphenidate)
49. tadalafil (Adcirca®)*
50. tazarotene (Tazorac®)
51. terbinafine (Lamisil®)
52. teriparatide (Forteo®)*
53. tetrabenazine (Xenazine®)*
54. tolvaptan (Samsca®)
55. topical testosterone products
56. topiramate (Topamax®)
57. travoprost (Travatan/Z®)
58. treprostinil (Tyvaso®)*
59. tretinoin cream (e.g. Retin-A) for individuals 27 years of age or older
60. vacation supplies of medication for foreign travel (allow 7 days for processing)
61. voriconazole (VFEND®)
62. zonisamide (Zonegran®)

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

This list is subject to change during the plan year if circumstances arise which require adjustment. Changes will be communicated to members 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. Alzheimer's Disease (Aricept®/ODT, Razadyne/ER®, Exelon®, Exelon Patch®, Cognex®)
2. Analgesics (Ultram/ER®, Ultracet®, Ryzolt®, Rybix™ ODT, ConZip®)
3. Angiotensin II Receptor Antagonists (Atacand/HCT®, Teveten/HCT®, Avapro®, Cozaar®, Benicar/HCT®, Micardis/HCT®, Diovan/HCT®, Edarbi®, Edarbyclor®, Avalide®, Hyzaar®, Azor®, Exforge®, Twynsta®, Tribenzor™)
4. Anti-depressants (Cymbalta®, Effexor/XR®, Symbyax®, Wellbutrin XL®, Pristiq®, Aplenzin®, venlafaxine ER, Savella®, Forfivo XL®)
5. Anti-hypertensives (Covera HS®, Verelan PM®, Norvasc®, Cardene SR®, Sular®, DynaCirc CR®, Tekturna®)
6. Benign Prostatic Hypertrophy (Avodart®, Proscar®, Jalyn™, Cardura/XL®, Flomax®, Rapaflo®. Hytrin®, UroXatral®)
7. Beta Blockers (Sectral®, Tenormin®, Kerlone®, Zebeta®, Coreg®, Trandate®, Lopressor®, Toprol XL®, Corgard®, Levatol®, Visken®, Inderal®, Inderal® LA, InnoPran XL®, Blocadren®, Tenoretic®, Ziac®, Lopressor® HCT, Corzide®, Inderide®, Timolide®, Coreg CR®, Bystolic®, Dutoprol®)
8. Bisphosphonates (Fosamax®, Fosamax Plus D™, Actonel®, Actonel® with Calcium, Boniva®, Atelvia™)
9. Cholesterol-lowering medications (Advicor®, Altoprev®, Caduet®, Crestor®, Lescol/XL®, Lipitor®, Pravachol®, Vytorin®, Zetia®, Livalo™)

10. Dipeptidyl peptidase-4 (DPP-4) Inhibitors (Januvia/XR®, Janumet®, Onglyza®, Kombiglyze™ XR, Juvisync®, Tradjenta®, Jentadueto®)
11. Fenofibrates (Tricor®, Lofibra®, Antara®, Triglid®, Lipofen®, Fenoglide®, Trilipix®, Fibricor®)
12. Leukotriene Inhibitors (e.g., Accolate®, Singulair®, Zyflo®, Zyflo CR®)
13. Long-acting Opioids (Avinza™, Embeda™, Exalgo™, Kadian®, MS Contin®, Opana® ER, Oramorph SR™, Nucynta® ER)
14. Lyrica®, Gralise®, Horizant®, Neurontin®
15. Migraines (Imitrex®, Sumavel Dosepro™, Alsuma, Amerge®, Zomig®/ZMT, Maxalt®/MLT, Axert®, Frova®, Relpax®, Treximet®)
16. Mirapex/ER®
17. Nasal Steroids (Rhinocort Aqua™, Flonase®, Beconase AQ®, Nasacort AQ®, Nasarel®, Nasonex®, Veramyst®,Omnaris®)
18. Non-Steroidal Anti-inflammatory Drugs (brand-name NSAID e.g., Celebrex®, Flector®, Pennsaid®, Voltaren®)
19. Overactive Bladder: (Ditropan®, Ditropan XL®, Oxytrol®, Detrol®, Detrol LA®, Sanctura®, Toviaz®, Vesicare®, Enablex®, Sanctura XR®, Gelnique®)
20. Proton Pump Inhibitors (e.g., Prilosec®, Prevacid®, Nexium®, Aciphex®, Protonix®, Zegerid®, Dexilant®, First® –Lansoprazole and First® –Omeprazole)
21. Requip/XL®
22. Sedative Hypnotics (Ambien®, Ambien CR™, Sonata®, Lunesta™, Rozerem™, Edluar™, Zolpimist™, Silenor®, Intermezzo®)
23. Selective Serotonin Reuptake Inhibitors (e.g., Celexa®, Lexapro®, Luvox®, Paxil®, Paxil CR®, Prozac®, Prozac Weekly®, Zoloft®, Sarafem®, Pexeva®, Luvox CR®, Viibyrd®),
24. Strattera®, Intuniv®, Kapvay®
25. Tetracyclines (Adoxa®, Doryx®, Oracea®, Solodyn®, Oraxyl®, Vibramycin®)
26. Thiazolidinedione (TZD) (Actos®, Avandia®, Avandamet®, Duetact®, Avandaryl®, Actosplus/Met XR®)
27. Topical Acne products, kits and cleansers,)
28. Topical Steroids -- various, and
29. Xopenex®

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. Antipsychotic Drugs (Abilify® 30 units, Fanapt™ 60 units, Geodon® 60 units, Invega® varies, Risperdal® 60 units, Saphris® 60 units, Seroquel® varies, Zyprexa® 30 units, and Zyprexa Zydis® 30 units, Latuda® 30 units)
2. Antiemetics:
   - Aloxi® is limited to 1 capsule/vial per prescription
   - Anzemet® is limited to 1 tablet per prescription
   - Cesamet® is limited to 30 capsules per prescription
   - Emend® 40 mg is limited to 1 capsule per prescription.
   - Emend® 80 mg is limited to 2 capsules per prescription.
   - Emend® 115 mg and 150 mg vial are limited to 1 vial per prescription.
   - Emend® 125 mg is limited to 1 capsule per prescription.
   - Emend® Bi-fold Pack is limited to 1 package per prescription.
   - Emend® Tri-fold Pack is limited to 1 package per prescription.
   - Kytril® is limited to 2 tablets/1 bottle per prescription
   - Sancuso® is limited to 1 patch per prescription
   - Zofran® 24 mg is limited to 1 tablet per prescription
   - Zofran® 4mg and 8 mg are limited to 12 tablets per prescription
   - Zofran® ODT 4mg and 8 mg are limited to 12 tablets per prescription
   - Zofran® Solution is limited to 3 bottles per prescription
   - Zuplenz® is limited to 12 films per prescription.
3. Abstral®, Actiq®, Onsolis™, Fentora®. Coverage is limited to 90 units per 30 days
4. 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)
5. Diflucan® 150 mg. Coverage is limited to 2 tablets per prescription
6. Enbrel®. Coverage is limited to 4 syringes or 8 vials per prescription
7. Humira®. Coverage is limited to 3 syringes/pens per prescription
8. Long-acting Opioids (Avinza® 60 units, Kadian® 90 units, MS Contin® 120 units, Opana® ER 90 units, Oramorph® 120 units, Oxycontin® 90 units, Exalgo® 30 units, Embeda® 90 units, Nucynta® ER 60 units)

9. Migraine medications. *Coverage is limited to quantities listed below:*

Generic name	Brand name	Quantity Level Limit Per Prescription	Quantity Level Limit for 28-Day Period
Almotriptan tablets 6.25 mg	Axert®	6 tablets	18 tablets
Almotriptan tablets 12.5 mg	Axert®	12 tablets	24 tablets
Diclofenac –potassium 50 mg powder packet	Cambia®	9 packets	9 packets
Dihydroergotamine nasal spray vials, 4 mg/mL vial	Migranal®	1 kits	1 kits = 8 unit dose sprayers
Eletriptan 20 mg, 40 mg	Relpax®	6 tablets	18 tablets
Frovatriptan tablets 2.5 mg	Frova®	9 tablets	27 tablets
Naratriptan tablets 1 mg, 2.5 mg	Amerge®	9 tablets	18 tablets
Rizatriptan tablets 5 mg, 10 mg	Maxalt®	12 tablets	24 tablets
Rizatriptan tablets 5 mg, 10 mg, orally disintegrating tablets	Maxalt-MLT®	12 tablets	24 tablets
Sumatriptan injection pre-filled auto-injectors, 6 mg/0.5 ml	Alsuma®	1 kit (2 syringes)	8 kits (16 syringes)
Sumatriptan injection syringes, 4 mg/0.5 ml and 6 mg/0.5 ml	Imitrex® Statdose System®	1 kit	8 kits = 16 injections
Sumatriptan injection vials, 4 mg/0.5 ml	Generics	2 vials	16 vials
Sumatriptan injection vials, 6 mg/0.5 ml	Imitrex®, generics	2 vials	16 vials
Sumatriptan nasal spray 20 mg	Imitrex®, generics	1 box	3 boxes = 18 unit dose spray devices
Sumatriptan nasal spray 5 mg	Imitrex®, generics	1 box	6 boxes = 36 unit dose spray devices
Sumatriptan needle-free injection vial 6 mg/0.5 mL	Sumavel™ DosePro™	1 box	3 boxes = 18 needle-free devices
Sumatriptan tablets 25 mg, 50 mg, 100 mg	Imitrex®, generics	9 tablets	18 tablets
Sumatriptan (85 mg) and naproxen sodium (500 mg) tablets	Treximet™	9 tablets	18 tablets
Zolmitriptan nasal spray 5 mg	Zomig®	1 box	3 boxes = 18 unit dose spray devices
Zolmitriptan tablets 2.5 mg and 5 mg, orally disintegrating	Zomig-ZMT®	6 tablets	18 tablets
Zolmitriptan tablets 2.5 mg, 5 mg	Zomig®	6 tablets	18 tablets

1. New drugs approved by the FDA that have not yet been reviewed by Express Scripts' Pharmacy and Therapeutics Committee will have a non-preferred status. PEIA reserves the right to exclude a drug or technology from coverage until it has been proven effective.
2. Nuvigil®. Coverage limit varies.
3. Other Antidepressants (Budeprion SR® 60 units, Budeprion XL® 30 units, Bupropion HCL SR® 60 units, Wellbutrin SR® 60 units and Wellbutrin XL® 30 units, Aplenzin® 30 units)
4. Provigil®. Coverage limit varies.
5. Sedative Hypnotics (Ambien®, Ambien CR™, Doral®, estazolam, flurazepam, Lunesta™, Restoril®, Rozerem™, Sonata®, Edluar™, Zolpimist™, Silenor®, temazepam, triazolam). Coverage is limited to 15 units per 30 days.
6. 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)
7. Serotonin and Norepinephrine Reuptake Inhibitors (Cymbalta® varies, Effexor® varies, Effexor XR® varies, Pristiq® 30 units, Savella® varies, venlafaxine ER® varies)
8. Sprix. Coverage is limited to 5 days of therapy per 90 days.
9. Toradol. Coverage is limited to one course of treatment (5 days) per 90-day period.
10. Tamiflu® and Relenza®. Coverage is limited to one course of treatment within 180 days. Additional quantities require prior authorization from RDT.
11. Vasodilator Antihypertensives (Cardura XL® 30 units, doxazosin mesylate® varies, and terazosin HCL® varies)

Maintenance Medications

You may receive up to a 90-day supply of ONLY the medications and classes listed below.

1. alendronate sodium (Fosamax®)
2. antiarthritics
3. anticoagulants
4. anticonvulsants
5. antidementia drugs
6. antihypertensives
7. antiparkinsonism agents
8. antispasmodics: urinary tract
9. benign prostatic hypertrophy/micturation
10. bronchodilators
11. calcitonin (Miacalcin®)
12. cardiovascular agents
13. cholinergic stimulants (urinary retention)
14. corticosteroids, bronchial
15. cromolyn sodium (Intal®)
16. diabetic therapies
17. digestants
18. disposable needles and syringes
19. diuretics
20. enzymes, systemic
21. estrogens and progestins
22. gastrointestinal, colitis
23. glaucoma agents
24. gout medications
25. hormones, misc.
26. immunosuppressive agents
27. legend vitamins (including legend hematinics, vitamin K)
28. leukotriene receptor antagonists (asthma agents)
29. lipotropics (cholesterol lowering agents)
30. mucolytics (pulmonary agents)
31. oral contraceptives
32. legend potassium
33. raloxifene (Evista®)
34. risedronate (Actonel®)
35. selective serotonin reuptake inhibitors
36. serotonin and norepinephrine reuptake inhibitors
37. thyroid medications
38. tuberculosis medications
39. xanthines (asthma agents)

Common Specialty Medications

All specialty medications require Precertification. The process begins with a call to HealthSmart at **1-888-440-7342**. HealthSmart will review the drug for medical necessity, and if approved, will coordinate the purchase through an approved source. 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 be $50 for any medications in this class. These drugs are not available in 90-day supplies.

If you are prescribed one of these common specialty medications, call HealthSmart toll-free at **1-888-440-7342**

Common Specialty Medication List

Drug Name	Category
Acthar® HP	Multiple Sclerosis
Actimmune	Anti-Neoplastic
Adcirca®	Pulmonary Hypertension
Afinitor	Anti-Neoplastic
Ampyra	Multiple Sclerosis
Aranesp®	Anemia
Arixtra®	Anti-Coagulant
Avonex® [QLL]	Multiple Sclerosis
Betaseron® [QLL]	Multiple Sclerosis
Boniva®	Osteoporosis
Cerezyme®	Gaucher Disease
Copaxone® [QLL]	Multiple Sclerosis
Eligard	Anti-Neoplastic
Enbrel® [QLL]	Inflammatory Conditions
Enoxaparin Sodium	Anti Coagulant
Epogen®	Anemia
Forteo®	Osteoporosis
Fragmin®	Anti-Coagulant
Genotropin®	Growth Hormone
Gilenya®	Multiple Sclerosis
Gleevec®	Anti-Neoplastic
Humatrope®	Growth Hormone
Humira® [QLL]	Inflammatory Conditions
Incivek	Hepatitis
Intron A®	Interferons
Kineret®	Inflammatory Conditions
Kuvan	Enzyme deficiencies
Letairis®	Pulmonary Arterial Hypertension
Leukine®	Hematopoietic
Lovenox®	Anti-Coagulant
Lupron Depot®	Endometriosis, Anti-Neoplastic, Precocious Puberty
Lupron Depot® -- Ped	Precocious Puberty
Lupron®	Anti-Neoplastic
Methotrexate	Anti-Neoplastic Anti Arthritis
Neulasta® [QLL]	Neutropenia

Drug Name	Category
Neupogen®	Neutropenia
Nexavar®	Anti-Neoplastic, Immunosuppressant
Norditropin®	Growth Hormone
Nutropin®	Growth Hormone
Octreotide Acetate	Endocrine disorders
Pegasys® [QLL]	Hepatitis C
Peg-Intron® [QLL]	Hepatitis C
Procrit®	Anemia
Pulmozyme®	Cystic Fibrosis
Rebif® [QLL]	Multiple Sclerosis
Revatio®	Pulmonary Arterial Hypertension
Revlimid®	Anti-Neoplastic, Immunosuppressant
Riba pak	Hepatitis
Ribavirin®	Hepatitis C
Sandostatin LAR	Endocrine disorders
Simponi®	Rheumatoid Arthritis
Sprycel	Anti-Neoplastic
Sutent®	Anti-Neoplastic
Tarceva®	Anti-Neoplastic
Tasigna	Anti-Neoplastic
Temodar®	Anti-Neoplastic
Tev-Tropin®	Growth Hormone
Thalomid®	Anti-Neoplastic
Thyrogen® Kit	Diagnostic
Tobi® [QLL]	Cystic Fibrosis
Tracleer®	Pulmonary Arterial Hypertension
Tykerb	Anti-Neoplastic
Tyvaso®	Pulmonary Arterial Hypertension
Victrelis®	Hepatitis
Votrient	Anti-Neoplastic
Xeloda®	Anti-Neoplastic
Xenazine®	CNS Disorders
Zoladex®	Anti-Neoplastic
Zolinza	Anti-Neoplastic
Zytiga®	Anti-Neoplastic

[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.

Diabetes Management

Blood Glucose Monitors: Covered diabetic insureds can receive a free Bayer Ascensia Breeze2® or Ascensia Contour® blood glucose monitor with a current prescription. Simply ask your pharmacist, and he or she will contact Bayer by fax or mail to request the monitor.

Glucose Test Strips: The plan covers only Bayer Ascensia® Breeze2 or Ascensia® Contour test strips at the preferred copayment of $20 per 30-day supply. Other brands require a 100% copayment.

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

Coverage	Needles/Syringes	Lancets
At the retail pharmacy:		
Up to a 30-day supply	$10	$5
31- to 60-day supply	$20	$10
61- to 90-day supply	$30	$15
Through the mail service and retail maintenance network pharmacies:		
Up to a 30-day supply	$10	$5
31- to 90-day supply	$20	$10

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 81 in the previous section. 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 one twelve-week cycle per rolling twelve-month period, three cycles per lifetime. All prescription and over-the-counter (OTC) tobacco cessation products will be covered with the deductible and generic, preferred or non-preferred copayment, depending on their status on the WV Preferred Drug List.

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. Anorexients (any drug used for the purpose of weight loss)
2. Anti-wrinkle agents (e.g., Renova®)
3. Birth control drugs for dependent children
4. Bleaching agents (e.g., Eldopaque®, Eldoquin Forte®, Melanex®, Nuquin®, Solaquin®)
5. Charges for the administration or injection of any drug
6. Contraceptive devices and implants
7. Diagnostic agents
8. Drugs dispensed by a hospital, clinic or physician's office
9. Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs not approved by the FDA, even though a charge is made to the individual
10. Drugs requiring prior authorization when prescribed for uses not approved by the FDA
11. Drugs requiring a prescription by State law, but not by federal law (State controlled) are not covered
12. Erectile dysfunction medications
13. Fertility drugs
14. Fioricet® with Codeine (butalbital/acetaminophen/caffeine with codeine)
15. Fiorinal® with Codeine (butalbital/aspirin/caffeine with codeine)
16. Hair growth stimulants
17. Homeopathic medications
18. Immunizations, biological sera, blood or blood products, Hyalgan®, Synvisc®, Remicade®, Synagis®, Xolair®, Amevive®, Raptiva®, Vivitrol® (these are covered under the medical plan)
19. Latisse™
20. Medical or therapeutic foods.
21. 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
22. Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, or any State or governmental agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member
23. Non-legend drugs (except when included in a compound with a legend drug)
24. Omnipod V-go®, Finesse® or other disposable insulin delivery systems.
25. Pentazocine/Acetaminophen (Talacen®)
26. 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
27. Replacement medications for lost or stolen drugs
28. Requests for more than a 90-day supply of maintenance medications, or requests for more than a 30-day supply of short-term medications
29. Stadol® Nasal Spray (butorphanol)
30. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those listed above
31. Unit dose medications
32. 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.

Other Important Features of Your Prescription Drug Program

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

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

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

Drug Utilization Review

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

Education and Safety

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

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

Health Management

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

Coordination of Benefits

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

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

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

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

1. 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. HealthSmart 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 Express Scripts, Inc. and should be submitted to:

Express Scripts, Inc., P.O. Box 390873, Bloomington, MN 55439-0873

To process a prescription drug claim, ESI 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 Express Scripts, Inc. within six (6) months of the date of service to ensure that the covered services will be paid. Later, if you receive payment for the expenses, you will have to repay the amount you received from Express Scripts, Inc. See "Subrogation" on page 103 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 ESI.

ESI will determine, through a local banking institution, the currency exchange rate and you will be reimbursed according to the terms of PEIA PPB Plans C.

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 Express Scripts or RDT (depending on the nature of your complaint) to ask for details. If you are not satisfied with the outcome of your telephone inquiry, the second step is to appeal to Express Scripts or RDT in writing. Please have your physician provide any additional relevant clinical information to support your request. Mail your request with the above information to:

Type of Error	Who to Call	Where to Write
Prior Authorization error or denial (for Physician's offices or pharmacists ONLY)	RDT 1-800-847-3859	Rational Drug Therapy Program WVU School of Pharmacy PO BOX 9511 HSCN Morgantown, WV 26506
Prescription drug claim payment error or denial	Express Scripts 1-877-256-4680	Express Scripts, Inc. Attn: STD ACCTS P. O. Box 66583 St. Louis, MO 63166-6583

Express Scripts 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 Express Scripts 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, 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 within 60 days. If you do not receive our decision within 60 days of receiving your appeal, you may be entitled to file a request for external review.

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 requesting it. 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, you may have a right to have our decision 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 by submitting 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, 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 be entitled to request an **expedited external review** of our denial. If our denial

to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial.

How to Reach Express Scripts

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

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

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

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

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

Preferred Provider Organizations

For services provided outside the State of West Virginia, HealthSmart 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 HealthSmart uses, see "PEIA's Networks" on page 29 or 66.

After you receive medical attention, your claim will be routed to HealthSmart. 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). HealthSmart 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 any Preferred Provider Organization, guidelines have been established to review and approve waiver requests when you are billed for the balance not paid by PEIA and not applied to your out-of-network deductible and out-of-pocket maximum. The first $500 of expenses which exceed the allowed amount will be your responsibility. Amounts in excess of $500 may be eligible for an out-of-state provider waiver when:

1. the PEIA PPB Plan is the primary payor for the services provided; and
2. you are billed for amounts which exceed the fee allowance; and
3. you must receive out-of-state services because:
   a) an emergency arises; or
   b) the insured lives or is traveling out-of-state; or

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 out-of-network deductible, your out-of-network coinsurance amount, penalties, and non-covered services will not be considered for a waiver. To request a waiver, send your balance bill from the provider, a copy of your Explanation of Benefits (EOB) indicating the amount already paid by PEIA, and a written request including the reason you chose an out-of-state provider to:

Director, Public Employees Insurance Agency, 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 **1-304558-7850** 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.

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.

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

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

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 co-pays
- 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.

HealthSmart, 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.

- A) 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;
- B) 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;
- C) 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;
- D) if a person is covered under a right of continuation policy as required by the Consolidated Omnibus Reconciliation Act (COBRA) of 1987, as amended, and is also covered under another plan, the following rules will apply:
  - 1) the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent) will be primary;
  - 2) the benefits under the continuation coverage will be secondary.
- E) if none of the above rules applies, the plan which has covered the employee, member or subscriber the longest will be primary.

How Coordination of Benefits Works

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

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

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

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

* Assumes any deductible has been met.

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

- Prescription Drug Coverage: PEIA's coverage is generous. Compare the benefits of both plans, including deductibles.
- Mental Health Benefits: Many plans pay only 50% or limit the number of admissions per lifetime. The PEIA PPB Plan pays 80% in-network with no limit when services are precertified.
- Maternity Services: PEIA pays 100% of the physician's allowed charges, after the deductible is met.
- Balance Billing Prohibition: PEIA protects you from network providers billing you for amounts which exceed PEIA's allowed amounts, but only if the PEIA PPB plan is the primary payor. In the above example, with the PEIA plan as your primary plan, you would not be responsible for the difference between the total charge and the amount allowed by PEIA. The balance billing provision does not apply when the PEIA PPB plan is the secondary plan or when the provider is not in the PEIA PPB plan network. If the primary plan denies payment and the PEIA PPB plan is the secondary insurer, then PEIA becomes the primary plan, 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 is a voluntary program that 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 through a Medicare Part D plan from Express Scripts, Inc.

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 HealthSmart 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 HealthSmart 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.

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. PEIA's Medicare Advantage Plan cannot give these members credit for deductibles and out-of-pocket maximum amounts met in the PEIA PPB plan. Members enrolled in an HMO when they become Medicare-eligible may be transferred to the Special Medicare Plan or may choose to remain with the HMO in a Medicare Advantage plan.

Under the Special Medicare plan, the member purchases traditional Medicare Parts A and B, and their secondary medical and prescription claims are paid by HealthSmart and Express Scripts, 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 following chart shows the members' costs:

Service Description	Plan Year 2013 Benefit
Primary Care Office Visit	$10
Specialty Office Visit	$20
Emergency Room	$50
Hospital Inpatient care	$100 per admission
Hospital Outpatient Surgery	$50
Other services(testing etc)	$0
Medical Deductible	$25
Out-Of-Pocket Maximum	$750

The benefits described in the previous "What is Covered" section beginning on page 38 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.

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, please send a copy of your Medicare card to PEIA. This notification may allow PEIA to reduce your premiums, and will make the claims payment process go much more smoothly.

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 believe 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: PEIA provides prescription drug coverage for retirees in the Medicare Advantage Plan through a Medicare Part D plan administered by Express Scripts, Inc.

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 eligibles" 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:

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

Your Responsibilities:

It is the obligation of the PEIA insured to:

- **A)** 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;
- **B)** 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;
- **C)** 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
- **D)** 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:

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

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

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

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

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: June 1, 2004

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

Who Must Abide by This Notice

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

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

Our Legal Duties

- We are required by law to maintain the privacy of your health information
- We are required to provide this notice of our privacy practices and legal duties regarding health information to anyone who asks for it.
- We are required to 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.

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

1. Treatment. We may use your health information to provide you with medical care and services. This means that our employees, staff, students, volunteers and others whose work is under our direct control, may read your health information to learn about your medical condition and use it to help you make decisions about your care For instance, a health plan nurse may take your blood pressure at a health fair and use the results to discuss with you 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 administrator may use your health information to help pay your claims. And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the subscriber and each dependent 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. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.
11. Research. We may disclose your health information in connection with medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.
12. Information to Members. We may use your health information to provide you with additional information. This may include sending newsletters or other information to your address. This may also include giving you information about treatment options, alternative settings for care, or other health-related options that we cover.
13. Health Benefits Information. If your enrollment in PEIA's health plan is offered through your employer, your employer may receive limited information, as necessary, for the administration of their health benefit program. The employers will not receive any additional information unless it has been de-identified or you have authorized its release.

Your Rights

1. Authorization. We may use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. 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 s 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 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 April 27, 2011

Public Employees Insurance Agency

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

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