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. Most Medicare-eligible retired employees and Medicare-eligible dependents of retired employees are covered by Coventry's Advantra Freedom MAPD plan, so the benefits described here do not apply to you. Medicare-eligible members enrolled in the Special Medicare Plan receive the benefits described here. ***See "Special Medicare Plan" on page 62 for details.***

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. This next section, entitled the PEIA PPB Plan, will not apply to you.

If you choose the PEIA PPB Plan A or B, your benefits are described on the following pages. This section describes only the benefits offered under the PEIA PPB Plan. PPB Plan B is not offered to retirees.

The PEIA PPB Plan (A or B)

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

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

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

Medical claims, benefits, precertification, case management, preauthorizations and prior approvals for out-of-state care	Wells Fargo TPA	1-888-440-7342
Prescription drug claims and benefits	Express Scripts	1-877-256-4680
Common Specialty Medication claims and benefits	Curascript	1-866-413-4135

PEIA's Networks

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

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

In addition, Wells Fargo TPA contracts with some out-of-state providers to serve PEIA participants only. To locate a network provider in any of the available networks, call Wells Fargo TPA at 1-888-440-7342 or 304-353-7820. Care provided by non-network providers requires prior approval, or it will be paid at the lower out-of-network benefit level (typically 60% of PEIA's maximum allowance with the additional out-of-network deductible).

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

Providers who are under sanction by Medicare, Medicaid or both 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 Wells Fargo TPA at 1-888-440-7342.

Resident PPB Plan Participants

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

- 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 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 "Precertification/Notification Requirements" on page 39 for details.***

What You Pay With The PEIA PPB Plan Medical Deductible

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

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

The family deductible is 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	$375	$750	$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

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

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

Resident PPB Plan Participants

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

For services of non-network providers without prior approval, the plan will pay 60% of PEIA's maximum allowance; you will be responsible for any deductible, 40% coinsurance and any amount which exceeds PEIA's maximum allowance. For non-network providers, PEIA will pay what it would have paid if the services had been provided in-State. You will be responsible for any balance billing, and those 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 Wells Fargo TPA for a referral to a network provider, or for approval to see an out-of-network provider where you are.

Non-resident PPB Plan Participants

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

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

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.

Benefit Design

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

Covered in Full

The following services are covered in full in-network:

Type of Service	Your In-network Cost
Routine prenatal care (physician services) [1]	$0; Covered in full
Well child exams and immunizations as recommended by the American Academy of Pediatrics	$0; Covered in full
High risk birth score program	$0; Covered in full
Annual screening mammogram	$0; Covered in full
Annual Pap smear [2]	$0; Covered in full
Colorectal cancer screening age 50 + above [2]	$0; Covered in full
Prostate cancer screening age 50 + above [2]	$0; Covered in full

1 Deductible applies only if not met with charges for hospital or other services.
2 Testing covered in full; $10 preventive care office visit copay applies.

Copayment Only

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

Type of Service	Your In-network Cost
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	$20 copayment per visit with no deductible
Out-of-State Office Visits	$15 copayment per visit with no deductible
Adult Routine Physical Exams	$10 copayment per visit with no deductible
Second Surgical Opinions*	$15 copayment per visit with no deductible

* No copayment if required by Wells Fargo TPA.

Copayment, Coinsurance and Deductible

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

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

Coinsurance and Deductible

Services not listed in the three preceding charts are covered at 80% after the deductible is met for in-network care and at 60% after the out-of-network deductible is met for non-network care which is not approved in advance by Wells Fargo TPA. 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, 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 Plan A (Active, State Agency, Colleges and Universities, Boards of Education)	$ 0 - 20,000	$800	$1,600
	$20,001 - 30,000	$1,100	$2,200
	$30,001 - 36,000	$1,250	$2,500
	$36,001 - 42,000	$1,500	$3,000
	$42,001 - 50,000	$1,750	$3,500
	$50,001 - 62,500	$1,800	$3,600
	$62,501 - 75,000	$1,850	$3,700
	$75,001 - 100,000	$1,900	$3,800
	$100,001 - 125,000	$2,000	$4,000
	$125,001 +	$2,250	$4,500
PEIA PPB Plan B	Not Applicable	$2,000/single;$4,000/family	$4,000/single;$8,000/family
Non-State Plan A	Not applicable	$1,500	$3,000
Retired, Non-Medicare	Not applicable	$1,500	$3,000

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.

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

Pre-existing Medical Conditions

A pre-existing medical condition is one which has been diagnosed or treated, or for which you or your dependents have incurred expenses within the three months immediately before the effective date of the PEIA PPB Plan coverage. Expenses for a pre-existing condition will not be covered by the PEIA PPB Plan for the first twelve months your coverage is in effect. This limitation is waived if you had creditable coverage under another health plan which terminated no more than 62 days prior to the effective date of the PEIA PPB Plan coverage.

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

PEIA PPB Plan Fee Schedules and Rates

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

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

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

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 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 Wells Fargo TPA, 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 Wells Fargo TPA's customer service unit.

Precertification/Notification Requirements

Precertification of Inpatient Admissions (Mandatory)

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

Precertification is required for the following inpatient admissions:

1. hysterectomy,
2. laminectomy
3. insertion of implantable devices including, but not limited to vascular access, implantable defibrillators, implantable pumps, spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators,
4. uvulopalatopharyngoplasty,
5. Leforte osteotomy,
6. elective and cosmetic surgeries including, but not limited to breast reduction, blepharoplasty,
7. abdominoplasty, breast reconstruction, and surgery for varicose veins,
8. bariatric surgery (gastric bypass, etc.),
9. transplants,
10. mental health, and
11. all admissions to out-of-state hospitals/facilities, and

Precertification is required for the following outpatient services:

1. allergy testing for more than 70 skin pricks and/or intradermal sticks,
2. home health care services as described under ***"Medical Case Management" on page 41,***
3. partial/day mental health programs,
4. multi-disciplinary pain management programs,
5. durable medical equipment purchases and/or rentals of $1,000 or more, and
6. surgeries:
   a. hysterectomy,
   b. implantable devices including, but not limited to vascular access, implantable defibrillators, implantable pumps, spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators,
   c. uvulopalatopharyngoplasty,
   d. Leforte osteotomy,
   e. elective and cosmetic surgeries including, but not limited to, breast reduction, blepharoplasty, abdominoplasty, breast reconstruction, and treatment for varicose veins,
   f. bariatric surgery (gastric bypass, etc.), and
   g. transplants.
7. sleep studies, services and equipment. ***See section on "Sleep Management Services" on page 51.***

Notification

Notification to Wells Fargo TPA 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 Wells Fargo TPA 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 Wells Fargo TPA inappropriately denied an admission or the extension of an admission, or that extenuating circumstances existed that prevented notification to Wells Fargo TPA within the timeframes set forth, the insured or provider may file an appeal.

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

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

Preauthorization (Voluntary)

Preauthorization is a program which allows you to contact Wells Fargo TPA 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 Wells Fargo TPA assures that your claim will be paid when it's submitted. To obtain preauthorization, ask your provider to send your request to:

Wells Fargo TPA
P. O. Box 2451
Charleston, WV 25329-2451

Your provider should include your name, address, telephone number, your ID number, and all information about the procedure that's recommended. Wells Fargo TPA 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, copayments and 20% coinsurance.

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

Special arrangements have been made for participants who live more than one county beyond the borders of West Virginia. ***See "Non-resident PPB Plan Participants" on page 35 for more details.***

Medical Case Management

If you are experiencing a serious or long-term illness or injury, Wells Fargo TPA'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 Wells Fargo TPA 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 Wells Fargo 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 43.***

Wells Fargo TPA must be notified for medical case management for the following services:

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

Transition of Care Program (New Participants Only)

If you are new to the PEIA PPB Plan, and have been receiving medical treatment from a non-network provider, you may be concerned that your care will be interrupted in your move to the PEIA PPB Plan. To assist participants receiving treatment for serious medical conditions from non-network providers, PEIA has a Transition of Care (TOC) program. If you qualify for TOC, you can continue to receive medical treatment from a non-network provider during a transition period specified by Wells Fargo TPA 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, Wells Fargo TPA'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 Wells Fargo TPA 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 Wells Fargo TPA. You must apply for TOC within three months of your effective date of coverage in the PEIA PPB Plan.

What Is Covered

Medically-Necessary Services

Covered services must be medically necessary or be one of the specifically listed preventive care benefits. Medically necessary health care services and supplies are those provided by a hospital, physician or other licensed health care provider to treat an injury, illness or medical condition. A service is considered medically necessary if it is:

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

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

Who May Provide Services

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

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

Types of Services Covered

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

Please keep in mind that for most participants, services you receive from non-network providers are subject to higher levels of coinsurance if not prior approved by Wells Fargo TPA to ensure the lowest out-of-pocket expense. If you have questions about coverage of services, call Wells Fargo TPA 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 35 under "Non-resident PPB Plan Participants".***

- **Acupuncture.** Services of a licensed acupuncturist for treatment of medical conditions are included in the Outpatient Therapy Benefit (see below) and are covered at 80% after the in-network deductible. Contact Wells Fargo TPA for specific benefit limitations. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. Office visits are covered with a $15 copayment and treatments are covered at 80% after the in-network deductible is met.
- ◊ **Allergy Services.** Including testing and related treatment; in-network care covered at 80% after in-network deductible is met. Allergy testing (for more than 70 tests) requires precertification.
- **Ambulance Services.** Emergency ground or air ambulance transportation, when medically necessary, to the nearest facility able to provide needed treatment; in-network care covered at 80% after in-network deductible. Non-emergency transportation is not covered.
- **Ambulatory Surgery.** This benefit is subject to a $50 copayment and 20% coinsurance. The copayment and coinsurance amounts apply after the in-network deductible has been met. ***See "Outpatient Surgery" on page 46.***
- **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 Wells Fargo TPA for preauthorization. If covered, in-network therapy is paid at 80% after the in-network deductible has been met.

Services marked with a ◊ require precertification from Wells Fargo TPA.

- **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. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. Office visits are covered with a $15 copayment and x-rays are covered at 80% after the in-network deductible is met. Maintenance services are not covered. Preauthorization is recommended for services for children under age 16. ***See Outpatient Therapy Services for more information.***
- **Christian Science Treatment.** Treatment for a demonstrable illness or injury if provided in a facility accredited by the Commission for Accreditation of Christian Science Nursing Facilities/Organizations, Inc. or by a practitioner accredited by the Mother Church is covered at 80% after the in-network deductible. No benefits will be paid for the purpose of rest or study, for communication costs, or if the person requiring attention is receiving parallel medical care. Coverage is limited to a maximum cost to the plan of $1,000 per plan year. If required, this benefit may be extended for inpatient care for up to 60 days per plan year. Inpatient care must be precertified.
- **Colorectal Cancer Screenings.** Routine screening to detect colorectal cancer is covered at 100% in-network with no deductible or coinsurance required. The related office visit expenses are subject to the applicable preventive care office visit copayment. This benefit is covered as follows:
  - Fecal-occult blood test—1 in 12 months/age 50 and over
  - Flexible sigmoidoscopy—1 in 48 months/age 50 and over
  - Colonoscopy for high risk—1 in 24 months/high risk patients*; 1 in 10 years/age 50 and over
  - X-ray, barium enema—1 in 48 months/age 50 and over
  - X-ray, barium enema—1 in 24 months/high risk patients*

  ** High risk is defined as a patient who faces high risk for colorectal cancer because of family history; prior experience of cancer or precursor neo-plastic polyps; history of chronic digestive disease condition (inflammatory bowel disease, Crohn's disease, ulcerative colitis); and presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors.*
- **Cosmetic/Reconstructive Surgery.** Services provided 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 in-network deductible is met. The initial treatment must be provided within 72 hours of the accident. Biting and chewing accidents are not covered. Services provided more than six (6) months after the accident are not covered. 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 Wells Fargo TPA 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 Wells Fargo TPA 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 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 Wells Fargo TPA 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: diabetes, hypertension, hyperlipidemia, heart disease, kidney disease, and metabolic syndrome. 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 Wells Fargo TPA. DME and prosthetics are covered at 80% after the in-network deductible is met.

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

◊ **Home Health Services.** Intermittent health services of a home health agency when prescribed by a physician are covered at 80% after the in-network deductible is met. Services must be provided in the home, by or under the supervision of a registered nurse. The home health services are covered only if they would otherwise have required confinement in a hospital or skilled nursing facility. If more than 3 visits are necessary, precertification is required.

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

- **Hypertension Screening.** The PEIA PPB Plan pays for diagnostic screening to determine if you are at risk for high blood pressure, heart disease or stroke. Benefits include coverage for an office visit, blood pressure check, and a blood chemistry profile. The office visit is subject to a $10 copayment and the blood chemistry is covered at 80% after the in-network deductible is met. The blood pressure check is included as part of the office visit. The plan will pay for this screening:
  - One time between the ages of 20 and 30;
  - Once every three years between ages 31 and 39; and
  - Once every two years after age 40.
- **Immunizations.**
  Following is a list of immunizations and the ages at which PEIA covers them.
  - Polio (IPV): At 2 months, 4 months, 6-18 months, and 4-6 years.
  - Diphtheria-Tetanus-Pertussis (DTaP): At 2 months, 4 months, 6 months, 15-18 months, and 4-6 years.
  - Tetanus-Diphtheria (Td): At 11-18 years.
  - Measles-Mumps-Rubella (MMR): At 12-15 months and EITHER 4-6 years OR 7-18 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.
  - Chicken Pox (VZV): At 12-18 months. If missed, get between ages 11 and 12 years.
  - Hepatitis A: At 24 months-12 years in selected areas.
  - Pneumococcal disease (Prevnar™): At 2 months, 4 months, 6 months, and 12-15 months. If missed, talk to your health care provider.
  - 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; also for previously unvaccinated college freshmen.
  - Gardasil (HPV): At 11-23 years.

  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 47.***

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

◊ **Inpatient Hospital and Related Services.** Confinement in a hospital including semi-private room, special care units, confinement for detoxification, and related services and supplies during the confinement are covered at 20% coinsurance after the in-network deductible is met. In addition to the penalties discussed on page 40, all unapproved out-of-network inpatient admissions are subject to a $500 deductible per admission.

◊ **Inpatient Medical Rehabilitation Services.** When ordered by a physician, coverage is subject to 20% coinsurance after the in-network deductible is met and is limited to 150 days per plan year. In addition to the penalties ***discussed on page 40***, all unapproved out-of-network inpatient admissions are subject to a $500 deductible per admission.

- **Mammogram.** An annual routine mammogram to detect breast abnormalities is covered at 100% in-network with no coinsurance or deductible required. The related office visit expenses are subject to the applicable copayment. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.
- **Massage Therapy.** Services of a licensed massage therapist for treatment of neuromuscular-skeletal conditions are covered under the Outpatient Therapy Benefit when ordered by a physician. Covered at 80% after the in-network deductible is met. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year.

Services marked with a ◊ require precertification from Wells Fargo TPA.

- **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 47 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 deductible per admission.
  - Outpatient mental health, chemical dependency and substance abuse services are limited to a maximum of 20 visits per patient per plan year for short-term individual and/or group outpatient mental health and chemical dependency services. This benefit includes evaluation and referral, diagnostic, therapeutic, and crisis intervention services performed on an outpatient basis (includes a physician's office). Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment beyond the 20 visits. This benefit is covered at 80% after the in network deductible is met.

- **MRA.** Magnetic Resonance Angiography services when performed on an outpatient basis are covered at 80% after the in-network deductible is met.
- **MRI.** Magnetic Resonance Imaging services when performed on an outpatient basis are covered at 80% after the in-network deductible is met.

◊ **Neuromuscular stimulators and bone growth stimulators** when criteria are met are covered at 80% after the in-network deductible is met.

- **Oral Surgery.** Only covered for extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction at 80% after the in-network deductible is met. Preauthorization is recommended for orthognathic procedures and ridge reconstruction procedures. Dental implants are not covered.

◊ **Organ Transplants.** ***See "Organ Transplant Benefits" on page 49 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.
  - **Acupuncture.** Services of a licensed acupuncturist for treatment of medical conditions are covered at 80% after the in-network deductible. Contact Wells Fargo TPA for specific benefit limitations. Office visits are covered with a copayment and treatments are covered at 80% after the in-network deductible is met.
  - **Chiropractic Treatment.** Services of a chiropractor for acute treatment of neuromuscular-skeletal conditions are included in the Outpatient Terapies benefit (see above) and are covered at 80% after the in-market deductable is 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, services of a licensed massage therapist are covered at 80% after the in-network deductible is met.
  - **Occupational Therapy.** When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible is met.
  - **Osteopathic Manipulations.** Services of an osteopathic physician to eliminate or alleviate somatic Dysfunction and related disorders are covered at 80% after the in-network deductible is met.
  - Outpatient Physical Therapy. When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible is met.
  - **Outpatient Speech Therapy.** When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible is met.
  - **Vision Therapy.** Contact Wells Fargo TPA for preauthorization of these services. This benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible is met.

◊ **Pain Management Services.** Covered at 80% after the in-network deductible is met. Only Multi-disciplinary Pain Management services require precertification.

Services marked with a ◊ require precertification from Wells Fargo TPA.

- **Pap Smear.** An annual Pap smear and the associated office visit to screen for cervical abnormalities are covered. The Pap smear is covered at 100% in-network with no deductible or coinsurance, and the office visit is subject to a $10 preventive care office visit copayment. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.
- **Periodic Physicals (for Adults).** The PEIA PPB Plan covers a routine physical exam once every two years for adults age 18 and over. Routine physicals are subject to a $10 copayment per visit. Exams may be provided more often if the patient's medical history indicates a need. This office visit, generally, includes, but is not limited to:
  - height and weight measurement;
  - blood pressure check;
  - health risk and prevention counseling; and
  - physical examination.

  Diagnostic testing, lab and x-rays, provided in conjunction with a periodic physical are covered, if medically necessary and billed with a medical diagnosis. The deductible and 20% coinsurance will apply. Only the screenings specifically listed in this ***"What is Covered"*** section, will be covered as routine screenings.
- **Physician's Office Visits (treatment for illness, injury, or medical condition).** These visits are subject to a 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 36) 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 with a $10 preventive care office visit copayment. The PSA blood test associated with this screening is covered at 100% with no deductible or coinsurance in-network.
- **Second Surgical Opinions.** Office visits for second surgical opinions are subject to a copayment per visit. Second surgical opinions are paid at 100% if required by Wells Fargo TPA.

◊ **Skilled Nursing Facility Services.** Confinement in a skilled nursing facility including semi-private room, related services and supplies is covered at 80% after the in-network deductible is met. Confinement must be prescribed by a physician in lieu of hospitalization. Coverage is limited to 100 days per plan year. In addition to the penalties discussed on page 40, all unapproved out-of-network inpatient admissions are subject to a $500 deductible per admission.

◊ **Sleep Management Services.** All sleep testing, equipment and supplies are covered through a network of West Virginia providers and require precertification through Sleep Management Solutions. See further details under Sleep Management Services later in this section.

- **Smoking Cessation.** ***See "Tobacco Cessation" on page 50 for details.***
- **Well Child Care.** For children through age 16, the plan covers routine office visits for preventive care as recommended by the American Academy of Pediatrics. These visits are covered at 100% of allowed charges and are not subject to copayment or coinsurance or deductible. This office visit, generally, includes, but is not limited to:
  - height and weight measurement;
  - blood pressure check;
  - vision and hearing screening;
  - developmental/behavioral assessment; and
  - physical examination.

  There is a $10 copayment for routine preventive care office visits for adolescents over the age of 16. Well Child Care office visits are recommended by the American Academy of Pediatrics at the following ages:
  - Infancy: 1 month, 2 months, 4 months, 6 months, 9 months and 12 months.
  - Early childhood: 15 months, 18 months, 24 months, 3 years and 4 years.
  - Late childhood: 5 years, 6 years, 8 years, 10 years, 11 years and 12 years.
  - Adolescence: 13 years, 14 years, 15 years and 16 years.

Maternity Benefits

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

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

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

Payment Level

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

Maternity Pre-payment Benefit

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

High Risk Birth Score Program

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

Enrolling Your Newborn

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

Nursery Charges

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

Organ Transplant Benefits

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

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

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

Organ Transplant Network (OTN)

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

PEIA uses a specialized transplant network called LifeTrac, as well as special contracts with West Virginia University hospitals for bone marrow transplants, and with Charleston Area Medical Center for kidney transplants. Wells Fargo TPA 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 36*** will still apply.

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

Medical Case Management: Wells Fargo TPA 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 Wells Fargo TPA at 1-888-440-7342 or 1-304-353-7820.

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

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 Wells Fargo TPA. No travel benefits will be provided for out-of-network transplants (except medically necessary ambulance transport).

Transplant-Related Prescription Drugs

The PEIA PPB Plan covers transplant-related immunosuppressant prescription drugs at 100%, after you have met your prescription drug deductible (if they are filled at a network pharmacy). These are covered through the Prescription Drug Plan and processed by the prescription drug administrator. Details of the PEIA Prescription Drug Plan are found in the "Prescription Drug Benefits" section starting on page 64.

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

Tobacco Cessation

The PEIA PPB Plan provides benefits for participants who wish to quit smoking or using smokeless tobacco products. 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 products if they are dispensed with a prescription.

PEIA will cover a total of 12 weeks of therapy, even if more than one type of therapy is used. If extended therapy is required, the member or 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 (employees and spouses only), PEIA will provide 100% coverage for the tobacco cessation benefit during any pregnancy in the participant's lifetime.

Payment Level

PEIA will 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 products are covered with the applicable generic, preferred or non-preferred copayments after the deductible is met.

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 being at high risk of heart disease. 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 100% after a participant copayment of $50 per month. Participants with annual household income below $20,000 per year may qualify for a copayment waiver.

For more information about this program, 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 Advantage Prevention Program

For members who do not qualify for the Dr. Dean Ornish Program for Reversing Heart Disease, PEIA offers the Dean Ornish Advantage Prevention Program. For a $48 copay, members get six weeks of training. The once-in-a-lifetime benefit is available to PEIA members who meet the following criteria:

- Age 50 or older;
- Family history of coronary artery disease or hypertension;
- Personal history of cancer;
- Body mass index greater than 25;
- Metabolic syndrome, but not meeting requirements for Ornish reversal.

This program is less rigorous than the Dr. Dean Ornish Program for Reversing Heart Disease. For example, the dietary portion of the prevention program allows you to have fish and chicken while fat can constitute up to 15 percent of food intake per day. The heart disease reversal program limits fat to 10 percent of food intake and is entirely vegetarian. Participants meet weekly for training, including physical activity and relaxation training. In addition to weekly training, participants receive:

- Full lipid profile, personal wellness profile, blood pressure screening, body fat composition and body mass index both before training and at 12 weeks;
- Wellness center health history;
- Everyday Cooking cookbook;
- CD on stress management;

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.

Face-to-Face (F2F) Care Management

Face-to-Face is PEIA's program of pharmacist-delivered, community based services to promote self management of diseases.

Face-to-Face: Diabetes

PEIA's F2F Diabetes Program for PPB Plan members is available statewide (subject to the availability of pharmacists) for those who have diabetes.

Under the program, members and/or their dependents with 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 not only by improving their health and quality of life, but also 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.

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 at 1-888-680-7342.

Renal Care Management

PEIA's Renal Care Management Program is handled by Wells Fargo TPA. The PEIA Renal Care Management Nurse works with members and their health care teams to coordinate quality, cost-effective care. Currently, participation is open to any PEIA member who may be at risk for or has been diagnosed with kidney disease. In addition, program information is mailed to potential participants who are identified through routine claims analysis or through the F2F Care Management Programs.

Participants in the F2F Diabetes Program who have chronic kidney disease (CKD) or are at high risk of developing CKD are required to participate in the Renal Care Management Program. Members may reach the Renal Care Management Nurse by calling 1-304 353-8746 or toll-free 1-800-624-8605, extension 8746; by fax at 1-304 353-7609; or by email to nancy_sigmon@wellsfargotpa.com.

Sleep Management Services

The PEIA PPB Plan 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, Well Fargo TPA, the third-party administrator for PEIA, has contracted with Sleep Management Solutions (SMS) to manage the PEIA's sleep services.

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 will be the sole source for CPAP and Bi-Level equipment and supplies. The process will be integrated so that patients who have been diagnosed and prescribed CPAP or Bi-level therapy can be set up and educated at the lab where they received their sleep study.

Sleep Management Solutions will have 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 will be 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.

Weight Management Program

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

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.

What Is Not Covered

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

1. Aqua therapy.
2. Biofeedback, except in the case of mental health services.
3. Birth control drugs, devices, and services for dependent children.
4. Breast pumps.
5. Chemical dependency treatments when a patient leaves the hospital or facility against medical advice.
6. Coma stimulation.
7. Cosmetic or reconstructive surgery when not 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.
8. Custodial care, intermediate care (such as residential treatment centers), domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living, or for behavioral modification.
9. Dental implants, whether medically indicated or not.
10. 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.
11. Daily living skills training.
12. Duplicate testing, interpretation or handling fees.
13. Education, training and/or cognitive services, unless specifically listed as covered services.
14. Elective abortions.
15. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts.
16. Expenses incurred as a result of illegal action, while incarcerated or while under the control of the court system;
17. Experimental, investigational or unproven services, unless pre-approved by Wells Fargo TPA.
18. Fertility drugs and services.
19. 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.
20. Genetic testing.
21. Glucose monitoring devices, except Bayer Ascensia models covered under the prescription drug benefit.
22. Homeopathic medicine.
23. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery.
24. Hypnosis.
25. Incidental surgery performed during medically necessary surgery.
26. 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.
27. Maintenance chiropractic services.
28. Marriage counseling.
29. Medical equipment, appliances or supplies of the following types:
    - augmentative communication devices.
    - bathroom scales.
    - educational equipment.
    - environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors.
    - equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs; recliners; contour chairs; adjustable beds; or tilt stands.

- equipment which is widely available over the counter such as wrist stabilizers and knee supports.
- exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines.
- hearing aids.
- hygienic equipment such as bed baths, commodes, and toilet seats.
- motorized scooters.
- nutritional supplements, food liquidizers or food processors.
- orthopedic shoes, unless attached to a brace.
- professional medical equipment such as blood pressure kits or stethoscopes.
- supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags.
- traction devices.
- vibrators.
- whirlpool pumps or equipment.
- wigs or wig styling.

30. Medical rehabilitation and any other services that are primarily educational or cognitive in nature.
31. Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning.
32. 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
33. Orientation therapy.
34. Orthodontia services.
35. Orthotripsy.
36. Physical examinations and routine office visits except those covered under the Periodic Physicals benefit.
37. 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.
38. 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.
39. 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.
40. Pregnancy-related conditions for dependent children.
41. Provider charges for phone calls, prescription refills, or physician-to-patient phone consultations.
42. Radial keratotomy and other surgery to correct vision.
43. Reversal of sterilization and associated services and expenses.
44. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities.
45. Screenings, except those specifically listed as covered benefits.
46. 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.
47. Services rendered outside the scope of a provider's license.
48. Sex transformation operations and associated services and expenses.
49. Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit.
50. Stimulation therapy.
51. Take-home drugs provided at discharge from a hospital.
52. 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.

53. The difference between private and semi-private room charges.
54. Therapy and related services for a patient showing no progress.
55. Therapies rendered outside the United States that are not medically recognized within the United States.
56. Transportation other than medically necessary emergency ambulance services, or as approved under the Organ Transplant Network benefit.
57. War-related injuries or illnesses. Treatment in a State or Federal hospital for military or service-related injuries or disabilities.
58. 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.
59. Work-related injury or illness.

How to File a Claim

Filing a Medical Claim

Medical claims are processed by Wells Fargo TPA and should be submitted to:

Wells Fargo TPA
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 Wells Fargo TPA post office boxes. This will only delay their processing.

To process a medical claim, Wells Fargo TPA 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 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 62 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 Wells Fargo TPA 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 Wells Fargo TPA or the prescription drug administrator.

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

Appealing A Claim

PEIA PPB Plan

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

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

If your medical claim or service has been denied, or if you disagree with the determination made by Wells Fargo TPA, the second step is to appeal in writing within 60 days of the denial to Wells Fargo TPA. 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. Wells Fargo TPA 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 Wells Fargo TPA. 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
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, WV 25305-0710

When your request for review arrives, the PEIA will reconsider the entire case, taking into account any additional materials which have been provided. A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the insured or his or her authorized representative. If additional information is required to render a decision, this information will be requested in writing. The additional information must be received within 60 days of the date of the letter. If the additional information is not received, the case will be closed.

Managed Care Plan Members

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

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

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

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

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

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

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