PEIA Indemnity Plan
Summary Plan Description

Welcome to your PEIA Indemnity Plan Summary Plan Description. This booklet replaces the grey booklet you received in Spring, 1995. Please keep this booklet close at hand and refer to it often if you have questions about your PEIA Indemnity Plan benefits.

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

The PEIA Indemnity Plan contracts with third party administrators (TPAs) to process health, drug and fringe benefit claims. If you have a question about a specific claim or benefit, the fastest way to obtain information is to contact the TPA directly:

Health Claims, Benefits, Precertification and Utilization Management

Mountain State Blue Cross & Blue Shield (MSBCBS) 1-800-688-6568

Mountaineer Flexible Benefits (Dental, vision, and disability insurance and flexible spending accounts)

Fringe Benefits Management Company 1-800-342-8017

First Help (Answers to common medical questions from a registered nurse)

Mountain State Blue Cross & Blue Shield (MSBCBS) 1-800-688-6568

Prescription Drug Benefits, Claims and Prior Authorizations

Please refer to your Prescription Drug Benefit Booklet for details.

PEIA (Answers to questions about eligibility, life insurance and second level claim appeals)

WV Public Employees Insurance Agency (304) 558-7850

What PEIA Offers

PEIA offers the Indemnity Plan, several managed care plans, a life insurance plan and a cafeteria plan. The Indemnity Plan includes benefits for hospital, surgical, prescription drug, and other medical expenses. Managed care plans offer benefits similar to those of the PEIA Indemnity Plan, but with lower out-of-pocket costs, in most cases.

If you live in an area where PEIA offers a managed care plan, you may be eligible to enroll in a managed care plan or in the PEIA Indemnity Plan. Please contact your benefits coordinator to determine what managed care plans are offered in your area.

If you enroll for any health coverage, a basic $10,000 decreasing term life policy with accidental death and dismemberment (AD&D) benefits is automatically included. If you choose not to enroll for health benefits, you may still choose to enroll for basic life insurance. You must be enrolled for basic life insurance before you elect any of the optional life insurance coverages. For a complete description of the life insurance benefits, please see the life insurance booklet.

The PEIA Indemnity Plan uses a coordination of benefits provision that determines how PEIA will pay if you have other health insurance available to you. See page 68 for a more complete description of this provision. The PEIA Indemnity Plan may be of little or no value to you if it will be the secondary payor.

Mountaineer Flexible Benefits

Mountaineer Flexible Benefits is a “cafeteria plan” which offers additional optional benefits. This plan is available to active employees of all State agencies, colleges, universities, and those county boards of education which elect to participate. This plan is not available to retired employees or county and municipal employees. If you’re not sure whether you’re eligible, contact your benefits coordinator.

The Mountaineer Flexible Benefits Plan enables employees to choose among several options for dental, vision and disability insurance, as well as medical care and dependent care flexible spending accounts, and to pay for these benefits on a pre-tax basis.

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

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

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

Important Terms

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

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

Annual Deductible: The amount you must pay each year before the plan pays any portion of the cost. Only the allowed amounts for covered expenses will be applied to your deductible.

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

Blue Card℠ Program: The Blue Cross & Blue Shield program available to PEIA Indemnity Plan participants that allows access to discounts for covered services from participating out-of-state providers.

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

Co-insurance: The portion of eligible expenses which you are required to pay after the deductible has been met. This is the amount applied to your out-of-pocket maximum. You are responsible for paying the co-insurance and deductible amounts directly to the provider of services.

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

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

Eligible Expense: A necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Allowable expenses under this Plan are calcu-

lated according to PEIA fee schedules, rates and payment policies in effect at the time of service or claim submission.

Emergency: An acute medical condition resulting from injury, sickness, pregnancy, or mental illness which arises suddenly and requires immediate care and treatment to prevent the death or severe disability of an insured.

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

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

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

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

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

Medical Case Management: A process by which MSBCBS assures appropriate and

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

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

MSBCBS: Mountain State Blue Cross & Blue Shield, the third party administrator which is handling claims processing, customer service, precertification, medical case management and other utilization management functions for the PEIA Indemnity Plan.

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

Plan: The benefit plan of the West Virginia Public Employees Insurance Agency.

Plan Year: A calendar year period beginning January 1 and ending December 31.

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

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

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

Pre-existing condition: A physical or mental condition that had been diagnosed, treated or for which the patient had incurred expenses before the patient became covered by the plan.

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

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

Secondary Payor: The plan or coverage whose benefits are determined after the primary plan has paid. Order of payment is determined by rules described under Which Plan Pays First on page 69.

Third Party Administrator (TPA): Company with whom PEIA has contracted to provide customer service, utilization management and claims processing services to PEIA insureds.

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

Who Is Eligible

Employers

The PEIA offers a range of benefits to these West Virginia employers:

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

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

Active Employees

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

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

Temporary and part-time employees generally are not eligible.

Retired Employees

If you are a retired public employee, you are eligible for PEIA health and life benefits, provided you meet the minimum eligibility requirements of the applicable State retirement system.

Dependents

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

- your legal spouse;
- your biological or adopted children under age 19;
- stepchildren who live with you and are under age 19;
- children under age 19 who are members of your household and fully dependent upon you for support and maintenance; and
- children or stepchildren over age 19 who are incapacitated and cannot support themselves due to a physical or mental disability which began before age 19 (or age 25 if a full-time student).

Coverage for dependent children may be extended to age 25 if they are full-time students. See page 28, "Student Verification," for details.

Married children are not eligible for coverage.

Surviving Dependents

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

How To Enroll

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

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

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

When To Enroll/When Coverage Begins

If you enroll during the month of or the month following an enrollment event (new employment, new dependent, retirement, death of employee, etc.), generally you will not be subject to limitations which may apply if you wait to enroll at a later date.

New Employees

You may enroll for health and life coverage during the month you are hired and the following month and no medical information form will be required.

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

If you choose not to enroll for life insurance during this initial period, but want life coverage later (basic, optional or dependent optional) for you or your dependents, you will have to submit a med-

ical information form and be approved by PEIA's life insurance carrier. Coverage will become effective the first day of the month following approval.

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

Health Coverage

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

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

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

Life Insurance Coverage

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

a) have completed a full day of active work on that date;

b) have completed a full day of active work on their last regularly scheduled work day and be able to work on the date they become eligible.

If the employee doesn't meet the requirements of a) and b) above, the coverage will become effective on the date he or she returns to active work.

Active work and actively at work mean:

1. performing regular duties for a full work day for the policyholder; and

2. not being absent from work because of illness or injury during the 3-week period ending on the date coverage is to become effective.

Retired Employees

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

Continuous coverage is necessary if you wish to use your accrued sick and / or annual leave for extended PEIA coverage.

If you were not covered as an active employee or if you allow your coverage to lapse, you may choose to enroll for health coverage at any time as long as you meet the minimum qualifications on page 13. Coverage will be effective on the first day of the month following enrollment.

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

You may continue dependent optional life insurance after retirement by completing the Retired Employee Optional Life Insurance enrollment form during the month of retirement or the following month.

Dependents

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

If any dependent (except your biological newborn) is in a hospital, nursing home or other health care facility on the date coverage would otherwise begin, the effective date of coverage is delayed until the date of discharge.

Additional Dependents

If you wish to add new dependents, such as a new spouse, your biological newborn or adopted child, you must complete enrollment forms for them to be added to your coverage. Coverage is not automatic even if you already have family coverage and pre-certified your pregnancy through MSBCBS.

You should enroll new dependents during the month of or the month following the date they become eligible (i.e., date of marriage, date of birth or adoption). Otherwise, you will have to submit a medical information form and be approved to obtain dependent optional life insurance coverage, and your dependents may be subject to pre-existing condition limitations for health coverage.

Newborn or Adopted Children

If you enroll your biological newborn child during the month of birth or the following month, coverage can be made effective retroactive to the date of birth. Otherwise, coverage will be effective on the first day of the month following enrollment and may be subject to pre-existing condition limitations.

If you enroll an adopted child during the month the child is placed in your home or the following month, coverage can be made effective retroactive to the date of placement. Otherwise, coverage will be effective on the first day of the month following enrollment and may be subject to pre-existing condition limitations.

Surviving Dependents

In the event of the death of an active or retired policyholder, dependents who were covered at the time of death are eligible to enroll for health coverage as surviving dependents. To continue coverage without interruption, surviving dependents must complete enrollment forms in the month death occurs or the following month. Surviving dependents are not eligible for life insurance.

Annual Open Enrollment

Each Fall PEIA holds an open enrollment period during which PEIA insureds may choose between managed care plans and the PEIA Indemnity Plan. During Open Enrollment participants may move between plans without penalty; no pre-existing condition limitations will be applied. The policyholder and all dependents must all enroll in the same plan. Choices made during the open enrollment period are effective on January 1 of the following year.

During Open Enrollment, eligible active or retired policyholders who have not taken advantage of any health coverage from PEIA also have the opportunity to enroll in the PEIA Indemnity Plan or any managed care plan, subject to the deadlines and rules in force for that enrollment period. See "When to Enroll / When Coverage Begins" on page 14 for details about life insurance in this case.

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

Prior to the Open Enrollment, PEIA mails a *Health Care Plan Shopper's Guide (Shopper's Guide)* to all eligible policyholders. The *Shopper's Guide* provides a side-by-side comparison of the general attributes of all plans offered. It is intended as a general guide to the available plans. Members requiring further information about a specific plan should contact that plan directly.

Medical Identification Cards

You will receive a medical identification card within 30 to 60 days after you enroll in the PEIA Indemnity plan or one of the managed care plans.

Your PEIA Indemnity Plan ID card verifies that you have coverage through PEIA. On the back we've listed important phone numbers you may need. Two cards will be issued. The employee's name

and Social Security number will be printed on all cards. If you want additional cards for children not residing with you, or if you need to replace a lost card, please contact MSBCBS.

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

When Coverage Ends

Certain events will cause PEIA benefits for you and / or your covered dependents to terminate. Generally, coverage will end if you or a dependent become ineligible.

In most cases you have the option to extend health coverage under the Federal COBRA law, or convert your health and / or life benefits into private insurance policies. All of these options are at your expense and require you to act within a specified time. Please see the section on "Options After Termination of Coverage" beginning on page 31.

Voluntary Termination

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

Involuntary Termination

A policyholder who is terminated from employment involuntarily or through a reduction of work force may continue coverage for 3 additional months after the end of the month in which employment ends.

If you are discharged for misconduct and you choose to contest the charge, you may extend your coverage for up to 3 months while you pursue available administrative remedies. If the charge is upheld you must reimburse the full premium cost of your extended coverage to your employer.

Retired Employees

Coverage for a retired policyholder will terminate at the end of the month in which the retiree elects no longer to participate.

Dependents/Surviving Dependents

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

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

Failure To Pay Premium

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

Employer Withdrawal From The Plan

If a participating county or municipal government or other employer withdraws or is terminated from the PEIA plan, coverage for all affected insureds ends on the effective date of that employer's withdrawal/termination.

Your Responsibility To Make Changes

It is your responsibility to keep your PEIA enrollment records up to date. You should notify your benefits coordinator immediately of any changes in your family situation. Examples of such changes

include a change of address, a change in your marital status, or a dependent child no longer qualifying for coverage.

You should do this whether you belong to the PEIA Indemnity Plan, a managed care plan or if you've only elected life insurance coverage.

Paying For Benefits

Each year the PEIA Finance Board sets premium rates for the PEIA Indemnity Plan. Premiums are set at a level which ensures that the premiums collected from employers and employees will pay the anticipated claims for that year.

Active Employees

If you are an active employee of a State agency, college, university or county board of education, most of your health insurance premium (85-95%) is paid by your employer. The amount of your contribution is determined by your salary and the type of coverage you choose.

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

Retired Employees Who Retired Before July 1, 1997

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

Retired Employees Who Retire On or After July 1, 1997

Employees who retire on and after July 1, 1997 will pay premiums for the PEIA Indemnity Plan based on the plan they choose, their

eligibility for Medicare and their credited years of service. These premiums are adjusted annually for medical inflation. Managed care plan premiums will not be set in this manner. Employees with 25 or more years of service will be charged the same premium as those who retired before July 1, 1997. Those with fewer than 25 years of service will pay higher premiums. If you are using accrued sick and / or annual leave or years of service to extend your employer-paid insurance, all, or a portion of this increased premium will be covered by your accrued leave.

Extending Employer-Paid Insurance Upon Retirement

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

Using Accrued Sick and Annual Leave to Extend Coverage

If you are an employee of a state agency or a county board of education, (or a local agency that offers this benefit) with health coverage through the PEIA Indemnity Plan or any of the managed care plans, and have accrued sick and / or annual leave when you retire, you may use that accrued leave to extend your employer-paid insurance coverage. This extended coverage must be for full months. The amount of this benefit depends on when you came into the PEIA plan.

Before July 1, 1988:

If you have been continuously covered by PEIA since before July 1, 1988, then your additional coverage is calculated as follows:

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

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

After July 1, 1988:

If you came into the PEIA after July 1, 1988, or if you had a lapse in coverage after July 1, 1988, then your additional coverage is calculated as follows:

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

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

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

You may also have the option to use your accrued leave to increase your retirement benefits from your retirement system. You must choose between additional retirement benefits and extended employer-paid insurance coverage. You may not use some of your accrued leave to increase your retirement benefit and the rest to extend your employer-paid insurance coverage.

Extending Coverage for Higher Education Faculty

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

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

5 years of teaching service = 1 year of family coverage

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

Premium Assistance Program

Retired employees whose total annual income is less than 200% of the current federal poverty level may receive assistance in paying a portion of their PEIA monthly health premium through a grant provided by the PEIA. Applicants must be enrolled in the PEIA Indemnity Plan. Managed care plan members are not eligible for this program. Retired employees using accrued sick and / or annual leave to pay their premiums are not eligible for this program until their accrued leave is exhausted. Applications are mailed to all retired employees each Spring.

Life Insurance Premiums

Life insurance premiums for all employees are set by PEIA's life insurance carrier. Basic life insurance premiums are included in the health premium if you have health coverage through the PEIA Indemnity Plan or a managed care plan offered by PEIA. Optional life insurance premiums are paid by the employee and are based on age and amount of coverage. See your Life Insurance Booklet for further details of the options available to you.

Managed Care Plans

If you enroll in a managed care plan offered by the PEIA for your health coverage, your premium contribution is set by the managed care plan. Premiums are published in the *Health Care Plan Shopper's Guide (Shopper's Guide)* each year prior to Open Enrollment. The published premiums are set for one year. Your employer will contribute up to the same amount toward your coverage as if you were enrolled in the PEIA Indemnity Plan. If the managed care plan's premium is higher than this amount, you will be responsible for the difference.

To find the amount of your premium contribution, check the *Shopper's Guide* for the current year or contact your benefit coordinator.

The managed care plans being offered by your employer are part of the PEIA benefits package and you may enroll for any plan in which you meet the eligibility guidelines. Your plan choice is binding for one year unless you move outside the service area of the plan you have chosen.

Premium Conversion:

Paying Premiums With Pre-Tax Dollars

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

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

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

With premium conversion, your premiums are deducted from your salary before federal, state and Social Security taxes are calculated. This reduces the amount of your income subject to tax. You must agree to pay the premiums through this plan for a full calendar year, unless you have a change in family status that allows you to change your benefits. This example demonstrates how premium conversion can reduce your taxes and increase your take-home pay:

In the example above, taxes do not include state tax and assume a 15% federal income tax bracket.

How to Participate

If your employer offers the premium conversion plan, your premiums automatically will be deducted on a pre-tax basis. If you do not wish to participate in the premium conversion plan, you must complete a premium conversion plan waiver form available from your benefits coordinator.

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

Limits on Benefit Changes

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

Qualifying changes in family status are:

‡ marriage or divorce of the employee;

‡ death of the employee's spouse or dependent;

‡ birth or adoption of the employee's child;

‡ commencement or termination of employment of the employee's spouse;

‡ a change from full-time to part-time employment status, or vice versa, by the employee or his or her spouse;

‡ an unpaid leave of absence taken by the employee or spouse; or

‡ a significant change in the health coverage of the employee or spouse attributable to the spouse's employment.

You may make a change in your coverage (add a dependent, for example) that increases your insurance premium, or that has no effect on your premium, without having one of these events, but you'll

pay any resulting increased premium on an after-tax basis until the next open enrollment period.

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

To make a change in your coverage, you'll need a Health and Life Insurance Change-in-Status form which you can get from your benefits coordinator. Two types of changes require additional documentation.

Special Eligibility Situations

If You And Your Spouse Are Both State Employees

If you and your spouse are both public employees, and both eligible to enroll for PEIA coverage, one spouse will be enrolled as the policyholder and the other spouse will be enrolled as a dependent under the policyholder. The matter of who will be the dependent and who will be the policyholder is up to the employees to decide at the time of enrollment; if no policyholder is chosen, PEIA will issue coverage in the name of the person who has been employed longest. Children, if any, will be enrolled as dependents under the chosen policyholder. The premium for this coverage will be based on the average of the two employees' salaries.

The employee spouse who is enrolled as a dependent may enroll for the $10,000 basic life insurance policy and may choose to enroll for optional and dependent life insurance as well.

Full-time Students Over Age 19 — Student Verification

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

“Enrolled as a full-time student” means the child is attending courses full-time (as determined by the institution) in a graduate or undergraduate college or university (other than a U.S. military academy) or attending a trade or professional school as the child’s full-time occupation.

Verification of full-time student status will be requested by PEIA when your child turns age 19. Once a year thereafter you may be asked to verify your child’s full-time student status, by providing a letter from the school’s registrar.

If it becomes medically necessary for your child to withdraw temporarily from school, he or she may continue to be covered under the PEIA plan. You will be asked to provide documentation from your child’s physician verifying the illness or injury and the date your child may be expected to return to school.

If your child loses eligibility because he or she is no longer a full-time student, you should notify your benefits coordinator promptly. Continued coverage under COBRA will be available, see page 31.

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

Incapacitated Child

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

To be eligible:

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

You will be asked to provide documentation when the child reaches age 19 and periodically thereafter.

Court-Ordered Dependent (COD)

If a PEIA-insured employee and his or her spouse divorce, and the employee is not the custodial parent for the dependent child(ren), the employee may continue to provide medical benefits for the child(ren) through the PEIA plan, if ordered to do so by the court. Medical claims for these Court-ordered dependents may be submitted by the custodial parent, and benefits may be paid directly to the custodial parent. Special claim forms are required. The custodial parent will also receive explanations of benefits (EOBs) for the CODs as claims are processed.

A packet of information about this benefit is available. Please contact your benefit coordinator or the PEIA to obtain a copy.

Leaves of Absence

Medical Leave (Non-Workers' Compensation)

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

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

Medical Leave (Worker's Compensation)

Any employee who is on a leave of absence and is receiving temporary total disability benefits from Workers' Compensation is entitled to continue PEIA coverage until he or she returns to work.

The employer and employee must continue to pay their respective proportionate shares of the premium cost for as long as the employee receives temporary total disability benefits.

Personal Leave

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

Family Leave

An employee may continue insurance coverage during an approved family leave. Contact your benefits coordinator for further details regarding the federal Family and Medical Leave Act (FMLA).

Military Leave

An employee who is on an approved military leave of absence without pay is entitled to continue health benefit coverage for as long as premium payments are made. The employee is responsible for paying 100 percent of the premium costs for each month during the leave of absence.

Leaves of Absence for Teachers and Service Personnel

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

Options After Termination of Coverage

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

Continuing Health Coverage Under COBRA

You and your enrolled dependents may have the right to continue your current health coverage for a limited time under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

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

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

‡ divorce or legal separation;

‡ loss of eligibility of dependent children; and

‡ death of employee.

An election to continue coverage under COBRA must be made within 60 days of the end of the coverage. If you elect to continue

coverage under COBRA, you will be responsible for paying the full premium plus a 2% administrative fee.

Coverage may be continued under COBRA for up to 18 months in the event of termination of employment or reduction of hours, or up to 36 months for all other events listed above.

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

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

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

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

Converting Health Coverage to an Individual Policy

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

You are not eligible for an individual policy if:

* you are age 65 or older; or

* your coverage ended because you failed to pay the premium.

If you were covered under one of the managed care plans, contact the managed care plan for instructions on this conversion.

If you were covered under the PEIA Indemnity Plan, you must submit an application and remit the first premium within 31 days after the termination of PEIA coverage. Coverage under the individual policy will become effective the day after PEIA coverage ends.

To obtain a Health Conversion Application Form, please call PEIA at (304) 558-7850. The individual health policy is issued by MSBCBS, not PEIA.

Once you have completed the application form, mail it to the address printed on the application form.

Benefits under an individual policy are determined by MSBCBS, and may differ substantially from the PEIA plan. Premiums for individual policies are generally higher than rates for a group plan like the PEIA Indemnity Plan.

If your PEIA Indemnity Plan coverage has been continued under COBRA, then you may apply for an individual policy if you submit a written application within 31 days after your COBRA coverage ends.

Converting Life Insurance to an Individual Policy

When employment ends, or when the amount of life insurance decreases due to age or retirement, you may convert all or part of the life insurance coverage into an individual policy. Dependents who lose eligibility for the PEIA Indemnity Plan coverage may convert optional dependent life insurance to an individual policy.

You must submit an application and remit the first premium within 31 days after the termination of the PEIA Indemnity Plan coverage. Coverage under the individual policy will become effective the day after the PEIA Indemnity Plan coverage ended.

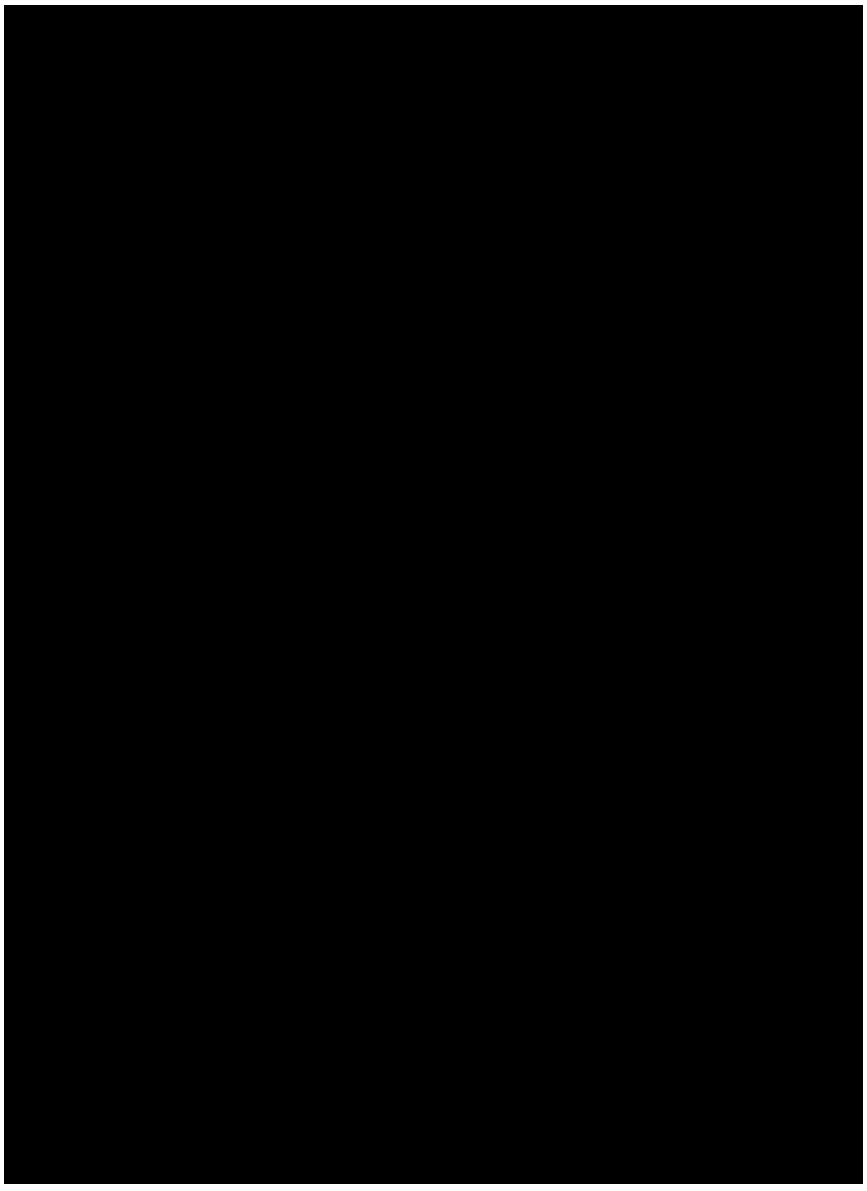
To obtain a Life Insurance Conversion Application Form, please call PEIA at (304) 558-7850. The individual life insurance policy is

issued by Provident, not PEIA. Once you have completed the application form, mail it to the address printed on the application form.

Premiums for individual policies are generally higher than rates for a group plan like the PEIA Indemnity Plan.

Health Care Benefits

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



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

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

The PEIA Indemnity Plan

The PEIA Indemnity 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.

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.

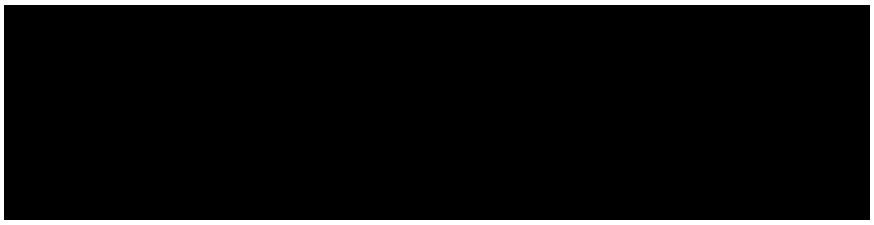
If you have any questions about coverage or payment for health care services, please call:

What You Pay With The PEIA Indemnity Plan

Medical Deductible

During any calendar year, if you or your eligible dependents incur expenses for covered medical services, you must meet a deductible before the plan begins to pay. The deductible is the amount you must pay before the plan begins to pay for covered services.

Medical deductibles are shown below:



Prescription drug benefits are subject to a separate deductible. Please see the Prescription Drug benefit booklet for information.

Co-Insurance

After you have met your deductible, you and the plan share the cost of covered charges. For most services, the plan pays 80% of the allowed expense, and you pay 20%. For certain services, the plan pays a higher percentage of allowed charges, and you pay a lesser amount. Your co-insurance amounts are shown in the chart on the next page.

You pay your deductibles, co-insurance, and any charges for services not covered by the plan, directly to your health care provider.

Out-of-Pocket Maximum

The out-of-pocket maximum is the most you pay in co-insurance in a calendar year. Amounts you pay toward your annual deductibles, for precertification penalties, for prescription drugs and for services that are not covered under the plan do not apply toward your annual out-of-pocket maximum. It includes only your medical charges; prescriptions are handled separately - see your prescription drug booklet for details.

Once you have met your out-of-pocket maximum, the plan will pay 100% of your covered charges for the remainder of the calendar year. Your out-of-pocket maximum amount depends on your employment status and your salary.

The out-of-pocket maximum amount is the same whether you have a single plan or a family plan. It is a per-contract amount which doesn't change regardless of whether there is just the policyholder

on the contract, or the policyholder and several dependents. The chart below shows the out-of-pocket maximum amounts.

Benefit Maximums

For certain types of services, the plan will pay up to a set amount per calendar year. Those services and the specific annual maximums are listed on the chart on the next page.

For services marked on the chart with an "*", additional benefits may be recommended by MSBCBS, when they are medically necessary and appropriate. Approval must be obtained before additional services are rendered. You must seek approval for additional services at least seven days in advance to allow time for medical review. For more information about these benefits, see “What Is Covered.”

Lifetime Maximum

The PEIA Indemnity Plan will pay a maximum of $1,000,000 in benefits per person during the person's lifetime.

Pre-existing Medical Conditions

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

Expenses for a pre-existing condition will not be covered by the PEIA Indemnity Plan for the first twelve months your coverage is in effect. This limitation is waived if you had coverage under another health plan which terminated no more than 61 days prior to the effective date of the PEIA Indemnity Plan coverage. Pregnancy and any

condition meeting the definition of handicap are not considered pre-existing medical conditions.

PEIA Indemnity Plan Fee Schedules and Rates

The PEIA Indemnity Plan pays health care providers according to a maximum fee schedule and rates established by the PEIA Finance Board. 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 charge" 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 amounts of work, overhead and malpractice insurance expense involved. All physicians in West Virginia have been provided a copy of PEIA's fee schedule, and updates are provided annually.

Most inpatient hospital services are paid on a "prospective" basis, that is, West Virginia hospitals know in advance what PEIA will pay per day or per admission. West Virginia hospitals have been provided specific information about their reimbursement rates from PEIA. These rates are also adjusted annually.

Precertification

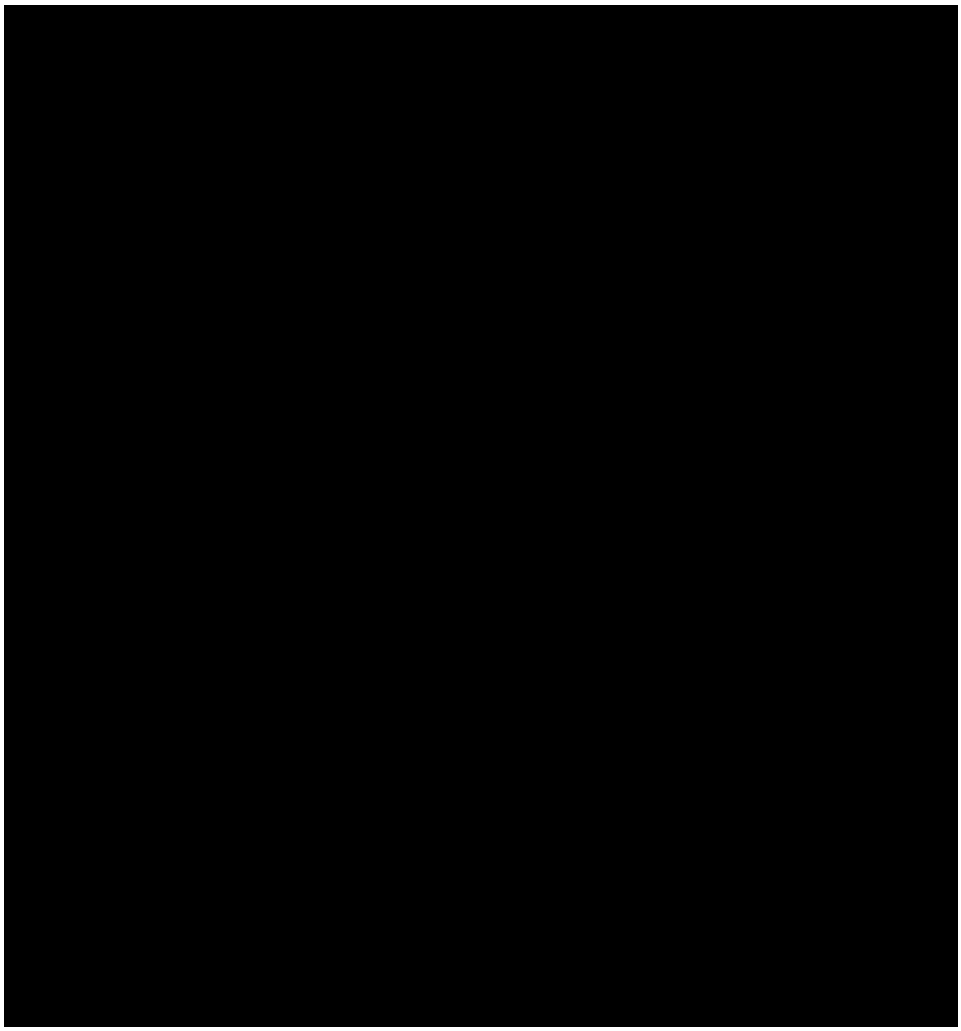
Inpatient Admissions

If you are going to be admitted to a hospital, a skilled nursing facility, or other inpatient facility, you must call MSBCBS in advance to get approval for, or "precertify", your admission. Admissions to partial hospitalization and day programs also require prior approv-

al. For planned admissions, you should call MSBCBS at least 7 days in advance.

If the admission is an emergency, you, a family member, or other designated person must call MSBCBS within 48 hours of the admission, even if you are discharged in less than 48 hours.

Please call MSBCBS within the timeframes specified below:



* Notify MSBCBS within the first trimester, or as soon as your pregnancy is confirmed.

Outpatient Procedures and Services

The outpatient procedures and services listed below also require precertification. You **must** contact MSBCBS at least 7 days in advance if you are scheduled for one of these outpatient surgical or diagnostic procedures:

- arthroscopy (knee only)
- cataract surgery
- colonoscopy
- durable medical equipment (DME) purchase or rental, regardless of duration or cost
- laparoscopy (except for sterilization)
- magnetic resonance angiography (MRA)
- magnetic resonance imaging (MRI)
- pain management services
- PETT Scan
- septoplasty or submucous resection
- tonsillectomy with or without adenoidectomy

Precertification does not assure eligibility or payment of benefits under this Plan.

Preauthorization

Preauthorization is a voluntary program which allows you to contact MSBCBS in advance of certain procedures to verify that the charges will be covered so that you can make an informed decision about the procedure. Obtaining preauthorization from MSBCBS assures that your claim will be paid when it's submitted. To get preauthorization, send your request to:

MSBCBS Preauthorizations
P. O. Box 1353
Charleston, WV 25325.

Include your name, address, telephone number, your Social Security Number, any information you have about the procedure that's been recommended, and the name and address of the provider who has recommended the service. MSBCBS 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.

Preauthorization is recommended for the following procedures:

- DEXA scans (performed to diagnose osteoporosis)
- Orthotics
- Chelation Therapy,
- Massage Therapy
- Vision Therapy
- Accident-related Dental Services

Medical Case Management

If you are experiencing a serious or long-term illness or injury, MSBCBS'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 medical case management MSBCBS can:

» arrange home care to prevent hospitalization;

» arrange services in the home to facilitate early hospital discharge;

» obtain discounts for special medical equipment; and

» locate appropriate services to meet the patient's health care needs.

MSBCBS **must** be notified for medical case management for the following services:

‡ home health care, including but not limited to:

a. skilled nursing visits;

b. I.V. therapy in the home;

c. physical therapy, occupational therapy or speech therapy done in the home;

d. hospice care; and

e. medication provided or administered by a home health agency.

‡ skilled nursing facility services

‡ rehabilitation services

‡ physical, occupational or speech therapies when proposed beyond the plan benefit maximum.

First Help

First Help is your 24-hour-a-day, 7-day-a-week link to an experienced emergency room nurse who can answer your questions and provide information. You can call First Help for assistance in evaluating a medical situation, sorting out next steps in an emergency, or when your own doctor is not available. You can reach First Help at 800-541-8586.

What Is Covered

Medically Necessary Services

To be 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:

º consistent with the diagnosis and treatment of the illness or injury;

º 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 Indemnity 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

PEIA Indemnity Plan will pay for 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.

Types of Services Covered

Your PEIA Indemnity Plan covers a wide range of health care services. Some major categories are listed below. Most services are covered at 80% after the deductible is met, unless otherwise noted below. If you have questions about coverage of services, call MSBCBS at 800-688-6568.

- Allergy Services. Including testing and related treatment.
- Ambulance Services. Ground or air ambulance transportation, when medically necessary, to the nearest facility able to provide needed treatment.

Services marked with "☆" MUST be precertified by MSBCBS.

- Cardiac 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, coronary bypass surgery or stabilized angina pectoris.
- Chelation Therapy, Massage Therapy and Vision Therapy. Benefits for these services are limited. Check with MSBCBS to determine if benefits will be payable for your condition. The plan will pay up to $750 per calendar year for massage therapy and vision therapy.
- Childhood Immunizations. Immunizations for children through age 16 are covered at 100% of allowed charges, including the office visit. This benefit is not subject to the deductible.
- Chiropractic Services. Services of a chiropractor, including office visits and x-rays, for treatment of neuromuscular-skeletal conditions. Coverage limited to a maximum cost to the plan of $1,000 per person per year.
- 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. 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 calendar year. If required, this benefit may be extended for inpatient care for up to 60 days per year.
- Dental Services (accident-related only). Services provided within 6 months of an accident and required to restore tooth structures damaged due to that accident. Contact MSBCBS for more information.

☆ Durable Medical Equipment 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 durable medical equipment, when prescribed by a physician. Prosthetics and Durable Medical Equipment purchases or rentals must be pre-certified by MSBCBS.

Services marked with "☆" MUST be precertified by MSBCBS.

☆ Home Health Services. Intermittent health services of a home health agency when prescribed by a physician. Services must be provided in the home, by or under the supervision of a registered nurse, and be care and treatment which would otherwise require confinement in a hospital or skilled nursing facility.

☆ Hospice Care. When ordered by a physician.

■ Hypertension Screening. The PEIA Indemnity 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 plan will pay for this screening:

- One time between the ages of 20 and 30;
- Once every three years between ages 31 and 39; and
- Once every two years after age 40.

■ Immunizations

- For children through age 16. The plan covers immunizations and the associated office visit with no deductible or coinsurance required. For details, see Well Child Care below.
- For adults and children over age 16. The plan covers immunizations for adults and children over age 16. The associated office visit is not covered.

☆ 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.

☆ Inpatient Rehabilitation Services. When ordered by a physician, coverage is limited to 150 days per calendar year.

☆ Inpatient, Partial Hospitalization and Day Programs for Mental Health and Chemical Dependency. When ordered by a licensed provider.

Services marked with "☆" MUST be precertified by MSBCBS.

- Mammogram. An annual routine mammogram to detect breast abnormalities is covered. No prescription is required for this service, so office visit expenses are not covered.
- Maternity Services. See "Maternity Benefits" on page 51.
- ☆ MRI and MRA. Magnetic Resonance Imaging and Magnetic Resonance Angiography services when performed on an outpatient basis must be pre-certified by MSBCBS.
- Oral Surgery. Only covered for extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction.
- Organ Transplants. See "Organ Transplant Network Benefits" on page 52.
- Outpatient Diagnostic and Therapeutic Services. For pre-scheduled laboratory and diagnostic tests and therapeutic treatments, when ordered by a physician.
- Outpatient Mental Health and Chemical Dependency Services. Coverage is limited to a maximum of 26 visits per calendar year, for short-term individual or group outpatient mental health and chemical dependency evaluation and referral, diagnostic, therapeutic, and crisis intervention services. Additional visits may be covered if approved in advance and case managed by MSBCBS.
- Outpatient Physical Therapy. When ordered by a physician. Limited to 20 visits in a calendar year, unless further therapy is approved in advance and case managed by MSBCBS.
- Outpatient Speech Therapy and Occupational Therapy. When ordered by a physician. Limited to $1,000 each year for each therapy unless further therapy is approved in advance and case managed by MSBCBS.
- ☆ Outpatient Surgery. Performed in a hospital, alternative facility or physician's office. The following outpatient procedures require precertification by MSBCBS:
  - * arthroscopy of the knee
  - * cataract extraction

* colonoscopy
* laparoscopy (except for sterilization)
* septoplasty or submucous resection
* tonsillectomy with or without adenoidectomy

☆ Pain Management Services.

■ Pap Smear. The PEIA Indemnity Plan covers an annual Pap smear and the associated office visit to screen for cervical abnormalities.

■ Periodic Physicals (for Adults). The PEIA Indemnity Plan covers a routine physical exam once every two years for adults age 18 and over. Exams may be provided more often if the patient's medical history indicates a need.

■ 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).

■ Prostate Cancer Screening. Coverage is provided for an annual office visit and exam to detect prostate cancer in men age 50 and over. The PSA blood test is also covered.

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

■ Well Child Care. For children through age 12, the plan covers routine office visits for preventive care as recommended by the American Academy of Pediatrics. These visits are covered at 90% of allowed charges after the deductible is met. Covered preventive care includes, but is not limited to:

* height and weight measurement;
* blood pressure check;
* vision and hearing screening;
* developmental/behavioral assessment; and
* physical examination.

Services marked with "☆" MUST be precertified by MSBCBS.

Maternity Benefits

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

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

You will need to contact MSBCBS 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

Benefits for routine pre-natal care, delivery and follow-up are paid at 100% of allowed charges under a global fee. An obstetrical profile and one ultrasound are also paid at 100% of allowed charges. Other maternity services, including hospital charges are paid at the regular PEIA Indemnity Plan level of 80% of allowed charges.

Maternity Pre-payment Benefit

If your attending provider requests a deposit for maternity care before delivery, the PEIA Indemnity 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 MSBCBS 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 Indemnity Plan will pay for six office visits in addition to PEIA's regular Well Child benefits. These additional visits are paid at 100% of allowed charges and are not subject to the deductible. MSBCBS will notify those families who qualify for this benefit.

Enrolling your Newborn

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

Organ Transplant Network Benefits

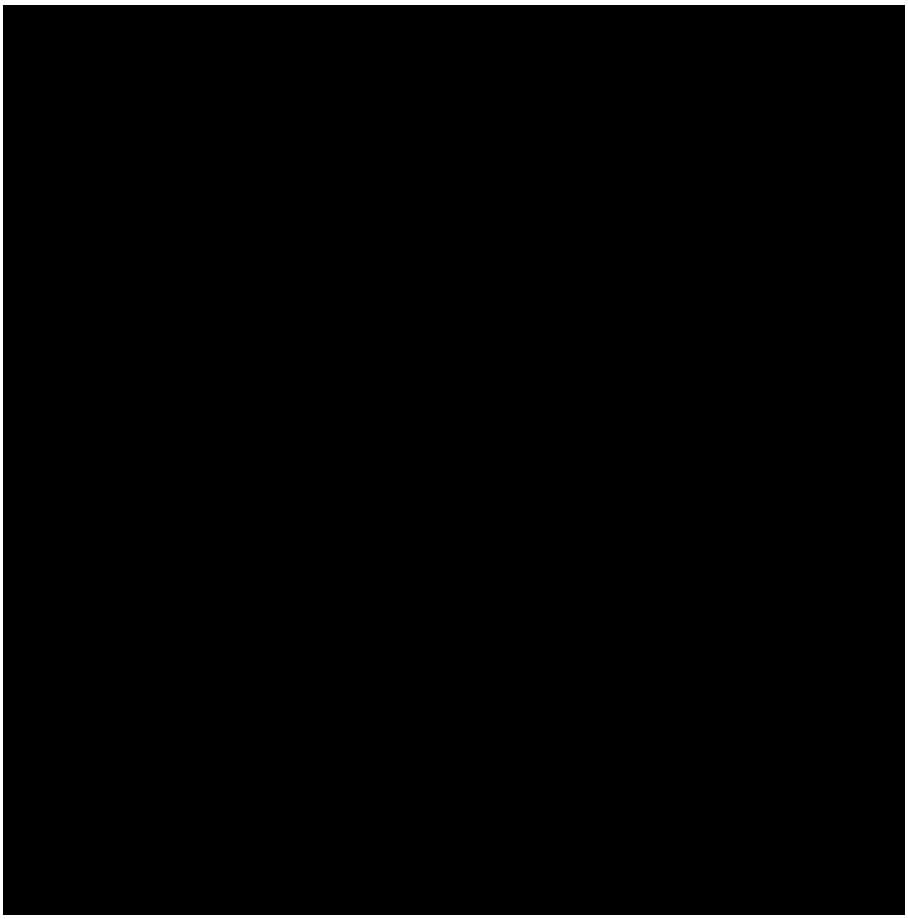
Organ transplants can literally be lifesaving procedures. They can also be very expensive. The PEIA Indemnity Plan uses the network of providers developed for MSBCBS for organ transplant services. This helps to control health care costs for both you and the Plan.

The PEIA Indemnity Plan participates with the Blue Cross Association's National Transplant Network to ensure you access to forty-nine facilities representing ninety-three centers of excellence throughout the United States. These centers of excellence have met and maintained the highest standards in the performance of all types of transplants.

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, the Transplant Coordinator for MSBCBS should be contacted immediately. You should advise your physician that MSBCBS needs to coordinate the care from the initial phase of the transplant procedure, through the performance of the procedure and the care following the actual transplant.

When the need for a transplant presents itself, call MSBCBS at 1-800-688-6568 to begin the process.

The facilities listed on the following chart participate in the Network. There are many other network facilities across the country, we've only listed the ones in West Virginia and surrounding states. If you'd like information about the other facilities, please call MSBCBS.



Note: Kidney transplants will be considered "in-network" if they are performed in any facility which participates in the Blue Card Program. For details of the Blue Card Program, see page 63

OTN Benefits

Reduced Costs - Once the annual deductible and out-of-pocket maximum have been met, the plan will pay 100% of the negotiated fees for pre-transplant, transplant, and one year of follow-up services.

Travel Allowance - Because network facilities may be located some distance from the patient's home, network benefits include up to $5,000 for patient travel, lodging and meals. A portion of this ben-

efit is available to cover the travel, lodging and meals for one member of the patient's family or a friend providing support. Receipts are required for payment of this benefit. Mileage and cost estimates are not acceptable.

Medical case management - MSBCBS will assist you and your physician in obtaining information about the Network. MSBCBS also offers support and assistance in evaluating treatment options, locating OTN facilities 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.

You should contact MSBCBS as soon as you learn that you or a member of your family covered by the PEIA Indemnity Plan may need a transplant. As with any hospital admission, a transplant must be pre-certified through MSBCBS.

Out-of-Network Organ Transplant Benefits

For patients who choose to use a non-Network facility for transplant services, there will be a $3,000 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 MSBCBS. No travel benefits will be provided for out-of-network transplants (except medically necessary ambulance transport).

Note: Kidney transplants will be considered "in-network" if they are performed in any out-of-state facility which participates in the Blue Card Program. For details of the Blue Card Program, see page 63

Transplant-Related Prescription Drugs

The PEIA Indemnity 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 booklet.

Medical case management of transplant patients includes referral to the prescription drug administrator for waiver of co-payment on transplant-related immunosuppressant drugs. You should contact MSBCBS as soon as you learn that a transplant is necessary. MSBCBS will then make arrangements with the prescription drug administrator to waive co-payments on drugs used to sustain the transplant.

For more information about the organ transplant network, contact MSBCBS.

What Is Not Covered

Some services are not covered by the PEIA Indemnity Plan regardless of medical necessity. Specific exclusions are listed below. If you have questions, please contact MSBCBS at 1-800-688-6568. The following services are not covered:

1) Acupuncture, unless for anesthesia associated with a covered procedure.

2) Birth control drugs, devices, and services for dependent children.

3) Chemical dependency treatments when a patient leaves the hospital or facility against medical advice.

4) Cosmetic or reconstructive surgery when not required as the result of accidental injury or disease, or unless the surgery is performed to correct birth defects.

5) Custodial care, intermediate care, domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living.

6) Dental services including routine dental care, x-rays, treatment of cysts or abscesses associated with the teeth, or any other dentistry and dental procedures.

7) Duplicate testing, interpretation or handling fees.

8) Expenses for which you are not responsible, such as patient discounts and contractual discounts.

9) Experimental, investigational or unproven services, unless pre-approved by MSBCBS.

10) 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), 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.

11) Homeopathic medicine.

12) Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery.

13) Hypnosis.

14) Incidental surgery performed during medically necessary surgery.

15) Infertility services of in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, and donor semen.

16) Marriage counseling.

17) Medical equipment, appliances or supplies of the following types:

- augmentative communication devices.
- equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs; recliners; contour chairs; or adjustable beds.

- exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines.
- educational equipment.
- environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors.
- equipment which is widely available over-the-counter such as wrist stabilizers and knee supports.
- hygienic equipment such as bed baths, commodes, and toilet seats.
- whirlpool pumps or equipment.
- supplies such as tape, alcohol, Q-tips / swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags.
- professional medical equipment such as blood pressure kits or stethoscopes.
- nutritional supplements, food liquidizers or food processors.
- hearing aids, wigs or wig styling, vibrators or bathroom scales.

18) Medical rehabilitation which is primarily educational or cognitive in nature.

19) Mental health services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning.

20) Optical services. Routine eye examinations, refractions, eye glasses, contact lenses and fittings.

21) Physical examinations and routine office visits except those covered under the Periodic Physicals benefit.

22) 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.

23) Physical conditioning. Expenses related to physical conditioning programs such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation.

24) Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered under the plan, when such services are:

- related to employment;
- to obtain or maintain insurance;
- needed for marriage or adoption proceedings;
- related to judicial or administrative proceedings or orders;
- conducted for purposes of medical research;
- to obtain or maintain a license or official document of any type; or
- for participation in athletics.

25) Pregnancy-related conditions for dependent children.

26) Radial keratotomy and other surgery to correct vision.

27) Reversal of sterilization and associated services and expenses.

28) Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities.

29) 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.

30) Services rendered outside the scope of a provider's license.

31) Sex transformation operations and associated services and expenses.

32) TMJ. Treatment of temporomandibular joint (TMJ) disorders. Including intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for temporomandibu-

lar joint dysfunction not caused by documented organic disease or acute physical trauma.

33) The difference between private and semi-private room charges.

34) Therapy and related services for a patient showing no progress.

35) Therapies rendered outside the United States that are not medically recognized within the United States.

36) Transportation other than medically necessary ambulance services, or as approved under the Organ Transplant Network Benefit.

37) War-related injuries or illnesses. Treatment in a state or federal hospital for military or service-related injuries or disabilities.

38) 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.

39) Work-related injury or illness.

How To File A Claim

Filing A Medical Claim

Medical claims are processed by Mountain State Blue Cross & Blue Shield (MSBCBS) and should be submitted to:

MSBCBS
P. O. Box 1388
Parkersburg, WV 26102

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

1. the patient's name;

2. the nature of the illness or injury;
3. date(s) of service;
4. type of service(s);
5. charge for each service;
6. diagnosis and procedure codes;
7. identification number of the provider; and
8. the policyholder's identification number (including the Social Security Number).

If the necessary information is printed on your itemized bill, you do not need to use a PEIA claim form.

Cash register receipts and canceled checks are not acceptable proof of your claim.

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

You have one year from the date of service to file a medical claim. If Medicare is your primary insurer, you have 18 months 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 should file a claim with PEIA within 12 months of the date of service to ensure that the claim 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 74 for details.

Medicare Crossover Claims

If you are a PEIA Indemnity Plan participant who has Medicare as the primary payor, MSBCBS offers a program that allows providers to bill PEIA electronically as your secondary insurance after Medi-

care has adjudicated the claim. This program, called Medicare Crossover, saves you the time and trouble of filing the claim yourself. To participate in this program you must sign an agreement with MSBCBS. To get a copy of the agreement, call MSBCBS.

Filing Claims for Court-ordered Dependents (COD)

If you are the custodial parent for 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 MSBCBS 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 (304) 558-7850.

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 on pages 59-60 from your provider and submit the bill to MSBCBS or the prescription drug administrator along with a claim form.

MSBCBS 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 Indemnity Plan.

Appealing A Claim

If you are a PEIA Indemnity Plan participant and think that an error has been made in processing your claim, the first step is to call the Third Party Administrator to ask whether or not a mistake has been made.

If your medical claim has been denied, or if you disagree with the determination made by MSBCBS, the second step is to appeal in writing within 60 days of the denial to MSBCBS, explaining what you think the problem is, and why you disagree with the decision. MSBCBS will respond to you in writing, 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. You or your covered dependents must request a review in writing within sixty (60) days of getting the decision from MSBCBS. Third step appeals should be mailed to:

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

Facts, issues, comments, letters, explanations of benefits (EOBs), and all pertinent information about the claim and review should be included.

When your request for review arrives, 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 policyholder or his or her authorized representative.

Controlling Costs

Prohibition of Balance Billing

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

The prohibition of balance billing applies when services are provided in West Virginia and when the PEIA Indemnity Plan is the primary payor. When the PEIA Indemnity Plan is the secondary payor, the provider may bill you for the disallowed amounts and for the provider discounts. Remember, you are always responsible for deductible and co-insurance amounts and for non-covered services.

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

Out-of-State Providers

Although some providers outside West Virginia do honor PEIA's prohibition of balance billing, there are many who do not. The PEIA Indemnity Plan has programs in place to help control costs for you, as well as PEIA, when medically necessary services are provided out-of-state.

Blue Card Program

Mountain State Blue Cross & Blue Shield has a service called the **Blue Card℠ Program** for PEIA policyholders and insureds that could save you time, money and paperwork when you see a doctor or go to a hospital out of state. Your PEIA identification card with the Blue Cross and Blue Shield logo and special code tells any participating physician, hospital or other health care provider that Mountain State

Blue Cross & Blue Shield issued your card. This ensures that you receive all of the **Blue Card℠ Program** conveniences. If you are treated by **Blue Card℠ Program** participating providers:

a) your claims will be filed for you.

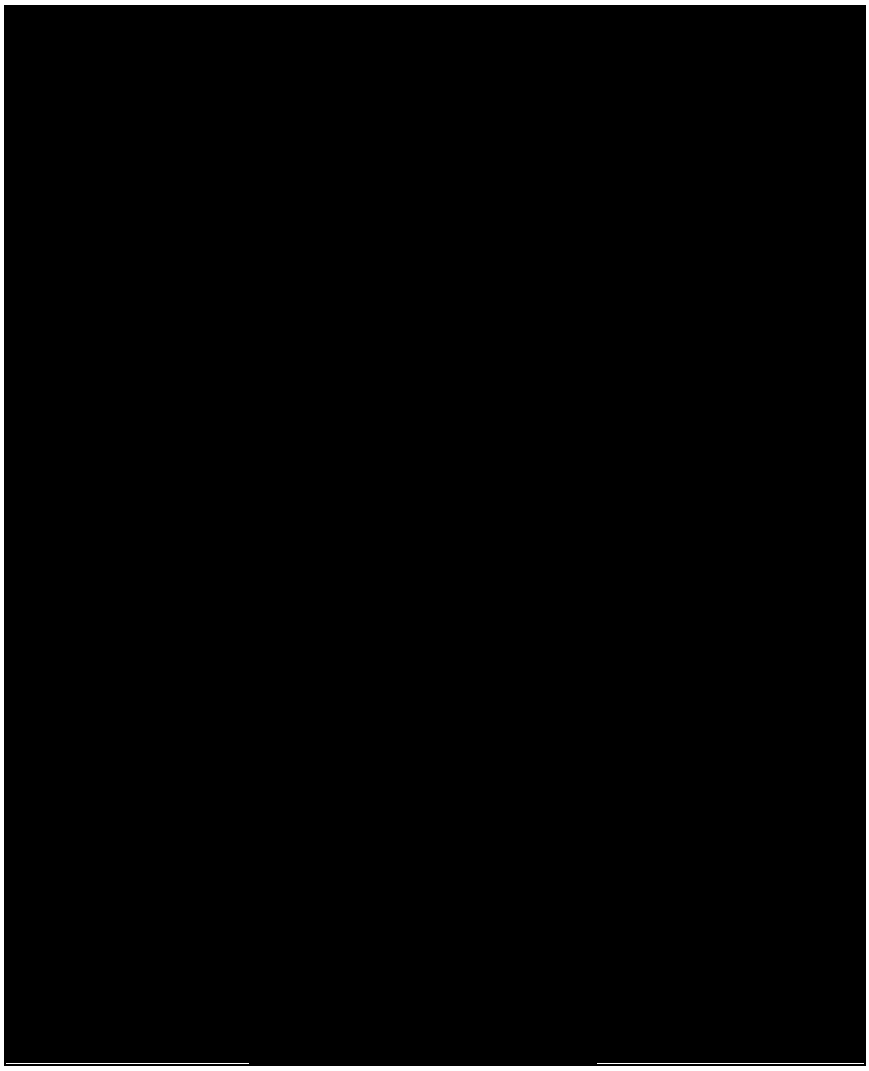
b) you will only be responsible for your deductible and coinsurance; and

c) you will not need to file for an out-of-state waiver or pay the additional $500 out-of-state deductible.

After you have met your annual deductible, the amount that you pay for covered services is, in most instances, calculated on the lower of these two:

1. the amount the physician, hospital or other health care provider charges for your covered service, or
2. the *negotiated price* that the independent on-site Blue Cross and / or Blue Shield Plan passes on to Mountain State Blue Cross & Blue Shield.

Approximately 85% of providers nationwide participate with a Blue Cross and / or Blue Shield Plan. You will receive the most savings by having your medical treatment at participating providers. You received a list of out-of-state participating providers in nearby counties as well as those providers most frequently seen by PEIA policyholders. To check on the status of your out-of-state provider, call the appropriate plan as follows:



Contact Mountain State Blue Cross & Blue Shield at **1-800-688-6568** for the telephone numbers of other Blue Cross and Blue Shield Plans nationwide.

Negotiated Discounts

MSBCBS negotiates prices and discounts for out-of-state services which require precertification and/or medical case management and the provider is not participating with a Blue Cross or Blue Shield plan. Through utilization management, MSBCBS works with your

providers so you may receive the most appropriate and efficient level of care.

Organ Transplant Network

The PEIA Indemnity Plan participates with the Blue Cross Associations's National Transplant Network to ensure you access to forty-nine facilities representing ninety-three centers of excellence throughout the United States. These centers of excellence have met and maintained the highest standards in the performance of all types of transplants.

Out-of-State Provider Waiver

To assist insureds who receive medical treatment outside West Virginia from providers who do not participate in any Blue Cross or Blue Shield plan, guidelines have been established to review and approve waiver requests when you are billed for the balance not paid by PEIA. You are eligible for an out-of-state provider waiver when:

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

Expenses eligible for waivers are provider discounts and amounts which exceed PEIA's maximum fee allowances. Provider discounts include amounts discounted from a provider's charge (these discounts are usually related to hospital and facility claims) and amounts dis-

counted from a provider's payment amount (these are usually claims for professional expenses and medical equipment/supply purchases).

Disallowed amounts are expenses that exceed the PEIA maximum fee allowance. These disallowed amounts are waived if they exceed $500 in a calendar year and may be accumulated by one individual or by the family.

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

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

You may obtain a PEIA Out-of-State Waiver Form by calling PEIA at (304) 558-7850. A waiver form is not required if you send the above requested information.

The request for an Out-of-State Waiver must be submitted within one year of the date on the Explanation of Benefits (EOB) to be eligible for additional payments.

Patient Audit Program

The Patient Audit Program offers rewards when you help detect and correct overcharges or other mistakes on your health care bills. Here's how you can participate...

Examine your medical bills for these two types of mistakes:

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

Reported errors must be at least $50.00 to qualify for the Patient Audit Program and must be submitted within 60 days of the date on the Explanation of Benefits (EOB) statement.

Complete the Patient Audit Report Form (supplied by the PEIA) and submit it, along with an itemized bill from the provider, the corrected bill (or explanation of disagreement), and a copy of the Explanation of Benefits to PEIA.

PEIA and MSBCBS will investigate and recover the overpayment, if justified, from the provider of services. When the overpayment is processed you will be paid 50% of the recovered amount, up to $1,000 annually.

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

Coordination Of Benefits

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

If you have health insurance coverage in addition to the PEIA Indemnity Plan, it is important to understand how the coordination of benefits provision works. In many instances, if the PEIA Indemnity Plan is determined to be secondary and your primary plan is other than Medicare, PEIA will pay little or nothing of the balance of your medical bill. An example of this situation is provided on page 72. In some cases it may be financially advisable to elect only one insurance coverage. If, after reviewing this section, you have questions concerning how PEIA's coordination of benefits provision may affect you, contact a PEIA claims representative.

What Plans Does PEIA Coordinate With

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

- ‡ any government program or other coverage required or provided by law;
- ‡ any plan covering individuals as a group, including insured, uninsured and pre-payment arrangements;
- ‡ automobile insurance, whether individual or group, "fault" or "no fault";
- ‡ group-type hospital indemnity benefits exceeding $100 per day;
- ‡ for spouses and dependents only*, individual hospital and surgical or major medical insurance in which that spouse or dependent is the policyholder.

* Individual and surgical or major medical insurance does not include any individual supplemental accident and sickness policy which meets the definition of a "limited benefits policy or certificate" under W. Va. Code §3-16E-2(a). These individual policies must meet all of the following conditions:

1. the policy covers a specified disease, accident only, disability, or other limited benefits;
2. the policy is specifically designed, represented and sold as a supplement to other basic sickness and accident coverage; and
3. the entire premium for the policy is paid by the insured or insured's family.

Which Plan Pays First

For active employees, the PEIA Indemnity Plan is your primary health plan in almost every circumstance. If your spouse is covered through his or her employer, that plan is usually the primary plan for your spouse.

The primary plan is determined by the first of the following rules which applies:

a. any plan with no coordination of benefits provision is always primary;

b. the plan which covers the person as an active or retired employee, member or subscriber (other than as a dependent) is always primary to a plan which covers the person as a dependent. When two public employees, both eligible to enroll for PEIA coverage in their own names, are married and covered under one PEIA family plan, then the spouse, covered as a dependent, will be treated as an employee under these rules;

c. for a dependent child of parents not separated or divorced, if two or more plans cover the child as a dependent:

   1. the plan of the parent whose birthday falls earlier in the year will be primary; or

   2. if both parents have the same birthday, the plan which has covered one parent longer will be primary; or

   3. if the other plan uses the parent's gender to determine benefits, and the plans do not agree on the order of benefits, then the rule of the other plan will determine the order of benefits.

d. for a dependent child of parents who are separated or divorced, if two or more plans cover the child as a dependent, benefits are determined in this order:

   1. the plan of the parent who has custody will pay first;

   2. the plan of the spouse of the parent who has custody will pay next;

   3. the plan of the parent who does not have custody will pay next.

Exception: If a court decree states that one of the parents is responsible for the health care expenses of the child, and the plan of that parent has knowledge of those terms, then that plan is primary. The plan of the other parent will then be secondary, and the plan of the spouse of the parent with custody of the

child will pay third. For PEIA to pay according to this paragraph, you need to provide a copy of the court decree.

e. for a dependent child of divorced parents with joint custody, if the court decree does not specify which parent is responsible for health care coverage, then Rule "c." above will apply.

f. for a dependent child of separated parents with joint custody, if the court decree does not specify which parent is responsible for health care coverage, then Rule "c." above will apply.

g. a plan which covers an employee (and, consequently, his or her dependents) as an active employee, rather than as a laid-off employee or retired employee, will pay before a plan which covers a laid-off or retired employee. If the other plan does not have this rule, and the plans disagree about the order of benefits, this paragraph is disregarded.

h. if a person is covered under a right of continuation policy as required by the Consolidated Omnibus Reconciliation Act (COBRA) of 1987, as amended, is also covered under another plan, the following rules will apply:

   1. First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

   2. Second, the benefits under the continuation coverage.

i. if none of the above rules applies, the plan which has covered the employee, member or subscriber the longest will be primary.

How Coordination of Benefits Works

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

To calculate the amount PEIA will pay as a secondary plan, you subtract the amount your primary plan pays from the amount PEIA would have paid if there were no other insurance. If the other plan paid as much or more than PEIA would have paid as the primary

plan, then PEIA will pay nothing as the secondary plan. If the other plan paid less than PEIA, then PEIA when secondary will pay the difference up to what it would have paid if there had been no other insurance.

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

*ASSUMES ANY DEDUCTIBLE HAS BEEN MET

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

Prescription Drug Coverage: PEIA's coverage is generous. Compare the benefits of both plans.

Mental Health Benefits: Many plans pay only 50% or limit the number of admissions per lifetime. The PEIA Indemnity Plan pays 80% with no limit when services are pre-certified.

Maternity Services: PEIA pays 100% of the physician's charges.

Balance Billing Prohibition: PEIA protects you from providers billing you for amounts which exceed PEIA's allowed amounts, but only if the PEIA Indemnity Plan is the primary payor. In the above example, with the PEIA Indemnity Plan as your primary plan, you would not be responsible for the difference between the total charge and the

amount allowed by PEIA. The balance billing provision does not apply when the PEIA Indemnity Plan is the secondary plan.

Blue Card℠ Program and Out-of-State Waivers: The PEIA Indemnity Plan only provides the benefits of the **Blue Card℠ Program** and additional payment to out-of-state providers under the waiver program if the PEIA Indemnity Plan is the primary payor.

If you have questions about your coverage, or need help comparing plans, you may call the PEIA Claims Unit at (304) 558-7850.

Medicare Coordination

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

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

Medicare for Active Employees

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

Recovery Of Incorrect Payments

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

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

Subrogation

If the PEIA pays your medical expenses for an illness, injury, disease or disability, and another person is legally liable for those expenses, then the PEIA has the right to be reimbursed for the expenses already paid, if the responsible person pays you, or pays a provider on your behalf. PEIA can only collect amounts that are related to that illness, injury, disease or disability. This is known as subrogation.

PEIA has the right to seek repayment of expenses from, among others, the party that caused the sickness, injury, disease, or disability, his or her liability carrier or the policyholder's own auto insurance carrier in cases of uninsured / underinsured motorist coverage, or medical pay provisions. Subrogation applies, but it is not limited to, the following circumstances:

a. payments made directly by the person who is liable for your sickness, injury, disease, or disability, or any insurance company which pays on behalf of that person, or any other payments on his or her behalf;

b. any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured motorist policy or medical pay provisions on your behalf; and

c. any payments from any source designed or intended to compensate you for sickness, injury, disease, or disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.

This right of subrogation shall constitute a lien against any settlement or judgment obtained by or on behalf of an insured for recovery of such benefits.

Your Responsibilities

It is your obligation to:

a. notify the PEIA in writing of any injury, sickness, disease or disability for which the PEIA has paid medical expenses on your behalf that may be attributable to the wrongful or negligent acts of another person;

b. notify the PEIA in writing if you retain services of an attorney, and of any demand made or lawsuit filed on your behalf, and of any offer, proposed settlement, accepted settlement, judgment, or arbitration award;

c. provide the PEIA or its agents with any information it requests concerning circumstances that may involve subrogation; provide any reasonable assistance required in assimilating such information and cooperate with the PEIA or its agents in defining, verifying or protecting its rights of subrogation and reimbursement; and

d. promptly reimburse the PEIA for benefits paid on your behalf attributable to the sickness, injury, disease, or disability, once you have obtained money through settlement, judgment, award, or other payment.

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

1. the PEIA's withholding payment of further benefits, and

2. your obligation to pay attorneys' fees and/or other expenses incurred by the PEIA in obtaining the required information or reimbursement.

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

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

Amending The Benefit Plan

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