



WEST VIRGINIA INFORMATIONAL LETTER

NO. 186

TO: All Insurance Companies Authorized to Sell Health Insurance Plans in West Virginia's Small Group and Individual Markets

RE: Providing Essential Health Benefits in West Virginia

In March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 were signed into law. The two laws are collectively referred to as the Affordable Care Act ("ACA"). Among the many reforms in the ACA, as part of an amendment to the Public Health Services Act ("PHSA"), the ACA requires all qualified health plans ("QHP's") as well as all health care plans sold in the United States in the small group or individual markets to include "essential health benefits" ("EHB"), defined as ten (10) categories of benefits. (See ACA §2707 codified at 42 USC §300gg-6; ACA §1301 codified at 42 USC §18021). Aside from the ten basic categories, discretion on how to define EHB was left to the U.S. Department of Health and Human Services ("HHS"). The HHS ultimately used a "benchmark" approach, permitting each state to select a benchmark plan from various options of plans offered in the state or federal plans. West Virginia did not specifically select a benchmark, therefore, under the HHS procedure, West Virginia's largest small group plan, the "Highmark Blue Cross BlueShield West Virginia \$1000 Deductible Super Blue Plus 2000 PPO Plan" was selected. This plan's selection as West Virginia's benchmark plan is set forth in a final rule the HHS promulgated on EHB. (See 45 CFR §§147, 155 and 156.)

The purpose of this informational letter is to provide all health insurance carriers in West Virginia who issue policies in the QHP¹, small group and individual market some more specific guidance as to how to comply with the ACA EHB requirement based on West Virginia's benchmark. The final EHB rule referenced above clarifies that for a health care policy to be deemed to provide EHB, it must generally "provide benefits that...[a]re substantially equal to the EHB benchmark plan including: (i) Covered benefits; [and] (ii) Limitations on coverage including coverage of benefit amount, duration and scope..." See 45 CFR §156.115. Following the publication of this final rule, the West Virginia Offices of the Insurance Commissioner ("OIC") had communication with officials from the HHS to seek clarity on what "substantially equal" means. The HHS clarified that the purpose of the language was to permit some flexibility among various plans as compared to the benchmark within the states' discretion. The HHS also clarified, however, that the "starting point" for EHB was the actual language of the benchmark policy, not just the general guidelines of the benchmark set forth in the EHB rule (the EHB rule has a matrix of each state's benchmark with some information as to each).

¹ Until 2017, all QHP's are in the individual or small group market; however large group plans may enter the QHP market in 2017.

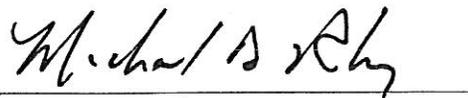


As such, the OIC directs all health insurance carriers required to provide EHB in West Virginia to use the benefits as outlined in the “Highmark Blue Cross BlueShield West Virginia \$1000 Deductible Super Blue Plus 2000 PPO Plan” Certificate of Coverage, attached to this letter as Appendix 1, as a starting point for determining how to provide EHB. However, pursuant to the goal of flexibility embedded in the term “substantially equal”, some deviation is permitted. For example, a carrier may want to slightly alter the number of visits or treatments permitted within a certain benefit type. As long as the deviation is deemed by the OIC to be “substantially equal”, it would be permissible. The OIC will ultimately address whether deviations from the benchmark are “substantially equal” on a case-by-case basis. Carriers may be asked to provide additional justification² for deviating significantly from the benchmark.

In addition to the above, carriers who issue policies that must be EHB compliant need to also be aware of the following “backfills” (benefits that had to be “filled in” as the West Virginia benchmark plan did not contain them) for the West Virginia benchmark:

- Pediatric Dental Benefits – the West Virginia CHIP schedule of benefits needs to be provided consistent with the “WV Children’s Health Insurance Program Dental Provider Guide 2012-2013”, attached to this letter as Appendix 2;
- Pediatric Vision Benefits – the vision benefits available to children under the Blue Cross-Blue Shield Federal Employee Program plan need to be provided consistent with the “FEP Blue Vision” document, attached to this letter as Appendix 3;
- Habilitative Benefits – These benefits need to be provided consistent with OIC’s Informational Letter No. 184, published on March 28, 2013;
- Infertility Treatment – These benefits need to be provided on a limited basis by HMO’s only (consistent with West Virginia law); see OIC’s Informational Letter No. 185, published on March 28, 2013.

Questions regarding this informational letter should be directed to Jeremiah Samples, Director of Health Policy for the OIC, at 304-558-6279 ext. 1131 or jeremiah.samples@wvinsurance.gov.



Michael D. Riley
Insurance Commissioner

² As evidenced by the example, this is referring to deviating in amount, duration and scope *within* a specific type of benefit. In addition to this, the federal EHB rule also permits deviation *between* benefit types within an EHB category as long as changes provide actuarially equivalent benefits to the benchmark. For example, a carrier could potentially greatly reduce or eliminate benefit type A within an EHB category if they provided a new benefit type and/or grossly increased an existing benefit type in a manner that was actuarially equivalent to the reduction in the other benefit type. Deviation between benefits types such as this must be justified actuarially.

HIGHMARK[®]
West Virginia



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SUPERBLUE *Plus*SM
2000

**HEALTH CARE
CERTIFICATE**

\$1,000 DEDUCTIBLE

APPENDIX 1 – WVIL 186

**YOUR HEALTH CARE BENEFITS
AND
HOW TO USE THEM**

**Super Blue Plussm
Comprehensive Major Medical
Health Care Certificate
with
Preferred Prescription Drug**

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I. Super Blue Plus 2000 Health Care Certificate

A. GROUP CONTRACT AND CERTIFICATE

This Certificate describes the health care benefits available to you as part of a Group Contract (or "Contract"). This Certificate is part of and subject to the terms and conditions of the Group Contract.

The actual Group Contract is between Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield West Virginia ("Highmark WV") and the employer or organization that pays or forwards the premiums that pays your claims and administrative costs to Highmark WV. Highmark WV may be referred to throughout this Certificate as **we, us, or our**. The employer or organization will be called the **Group, Plan, Plan Sponsor, or Plan Administrator**. The benefits provided under the Contract are referred to as **Plan or Group Health Plan**. Certain words used in this Certificate have special meaning. They will be capitalized throughout the text so that you will pay special attention to them. They are either defined in Section IX, or where used in the text.

Premiums are computed in accordance with Highmark WV's rating formula; which reflects, among other things, costs and charges associated with the selected program of benefits. These rates also include various product enhancements, such as health reimbursement account administration.

The Group shall have the right to return the Contract within 10 days of its delivery and to have the premium refunded if, after examination of the Contract, the Group is not satisfied for any reason. This does not apply to groups with 51 or more employees that are negotiated. In the event the Group exercises this right, Highmark WV shall not be obligated to pay any benefits under the policy for claims submitted to Highmark WV during such 10-day period.

B. FINANCING ARRANGEMENT

The benefits are underwritten and insured by Highmark WV through a Contract with your Group. Highmark WV also performs administrative functions related to payment and processing of claims and provides Network access.

C. CRITERIA FOR COVERED PERSONS

All persons who meet the following criteria are covered by the Group Contract. They are referred to as **Covered Persons, you or your**. They must:

- . Apply for coverage under the Group Contract.
- . Pay a portion of the premium if necessary.
- . Satisfy the conditions specified in Section IV.
- . Be approved by us.

D. IMPORTANT INFORMATION ABOUT THIS COVERAGE

1. **Preexisting Condition Limitation and Exclusion Period.** This Certificate contains a Preexisting Condition Limitation as described in the General Provisions and in Section III.
2. **Not a Provider of Services.** We do not furnish Covered Services. We only pay for Covered Services you receive from Providers. We are not liable for any act or omission of any Provider, and we have no responsibility for a Provider's failure or refusal to give Covered Services to you. Any decision to receive care is solely between you and your Provider. Any action by Highmark WV pursuant to any utilization management, referral management, discharge planning, Medical Necessity determination or other functions in no way absolves the Provider of the responsibility to provide appropriate Medical Care to the Covered Person.

3. **Pre-Certification Review.** This Certificate contains a Pre-Certification Review limitation. It is described in Sections III and VIII. Pre-Certification Review is limited solely to determining Medical Necessity. It is not a guarantee of coverage or payment.

Remember, in an emergency, always go to the nearest appropriate medical facility.

4. **Mastectomy Benefits.** See Section V for more information.
5. **Highmark WV Discretionary Authority**

The Group designates Highmark WV to be a fiduciary under the Plan for the following purposes:

- Determining questions of eligibility.
- Determining the amount and type of benefits payable under the Plan.
- For responsibility for claim and appeal procedures established by the Department of Labor under Claims Rules.

In carrying out these functions, Highmark WV has the exclusive right and discretionary authority to interpret the terms and provisions of the Plan and this Contract and to determine any and all questions arising under the Plan or this Contract. Highmark WV has without limitation, the right to remedy or resolve possible ambiguities, disputes, inconsistencies, or omission by general rule or particular decision. Highmark WV has the exclusive right and discretionary authority to make any finding necessary or appropriate for the purpose of these functions, including, but not limited to, the determination of the eligibility for, and the amount, manner, and time of payment of, any benefit payable under the Plan or this Contract. Benefits will be paid only if Highmark WV decides in its discretion that the claimant is entitled to them.

6. **Blue Cross and Blue Shield Association**

The Group, on behalf of itself and all Certificate Holders, hereby expressly acknowledges its understanding that this agreement constitutes a Contract solely between the Group and Highmark Blue Cross Blue Shield West Virginia (“Highmark WV”) which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the “Association”), permitting Highmark WV to use the Blue Cross and Blue Shield Service Marks in the State of West Virginia, and that Highmark WV is not contracting as the agent of the Association.

The Group, on behalf of itself and its Certificate Holders, further acknowledges and agrees that it has not entered into this agreement based upon representations by any person or entity, other than Highmark WV and that no person, entity or organization other than Highmark WV shall be held accountable or liable to the Group for any of Highmark WV’s obligations to the Group created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Highmark WV other than those obligations created under other provisions of this agreement.

7. **Address**

Highmark Blue Cross Blue Shield West Virginia
614 Market Street
Parkersburg, WV 26101

II. How to Use Your Certificate

This Certificate gives you the details you need in order to understand your health care benefits. We have tried to write it in simple terms that are easy to understand. Please read this Certificate carefully.

III. Summary of Benefits

This Section briefly describes how and when your benefits pay. This Section provides additional information such as the amount of Deductibles, Fees, Coinsurances, and benefit limits.

IV. Eligibility

This Section outlines how and when you become eligible for coverage. It also describes how and when your coverage becomes effective and when it terminates.

V. Benefits

This Section explains each type of health care benefit in your coverage. It tells you what services are covered.

VI. Exclusions

This Section lists what Services and Supplies are not covered. *Please review this section carefully*

VII. Coordination of Benefits, Right of Recovery, and Right of Reimbursement/Subrogation

This Section describes when and how your benefits may coordinate with other coverage. It also describes certain obligations you have to us for overpayments or when benefits are the responsibility of another party.

VIII. General Provisions

This Section tells you such things as: how to apply for benefits, how claims are paid and other general information.

IX. Definitions

If a word or phrase starts with a capital letter, it either has a special meaning or is a title. If the word or phrase has a special meaning, it is defined in this Section or where used in the text.

X. Prescription Drug Benefits

This Section describes your coverage for Prescription Drugs, if applicable.

XI. Statement of ERISA Rights

This Section explains your rights under the Employee Retirement Security Act of 1974 (ERISA) if your benefits are subject to ERISA.

XII. Plan Information

This Section provides information about your Plan, Plan Administrator and applicable contacts.

III. Super Blue Plus 2000 Summary of Benefits

IMPORTANT - Read this Section carefully. See Section V for a detailed description of benefits.

This Section indicates the amounts for Coinsurances, Deductible, Fees, reimbursement percentages, and Benefit Maximums. Should your benefits change you will receive either an amendment describing what has changed or an updated Certificate Book.

A. PROVIDER NETWORKS AND DIRECTORY

The choice of a Provider is solely yours. All Providers are designated as either Network or Non-Network. In addition, some Providers are further designated as Participating or Non-Participating. **The amount of benefits that you will receive for Covered Services will vary depending upon whether the Provider is in the Network and whether it is Participating.**

Your financial responsibility will vary between these Provider designations. You will receive the **most** benefits by seeking Covered Services from **Network Providers**. **This section tells you how much we will pay for Covered Services at Network and Non-Network Providers.**

Remember, in an emergency, always go to the nearest appropriate medical facility.

Network Provider online directory information is available by accessing www.highmarkbcbswv.com or you may also obtain network Provider information by logging on to www.mybenefitshome.com or www.bcbs.com/healthtravel/finder/html. **The Network status of Providers listed in a directory may change from time to time. You should be sure of the status of the Provider before receiving Covered Services.** The number to call to check the status of a Provider is in your Provider Directory and on your ID Card. See Section VIII.K for more information on the meaning of Provider status.

B. OUT-OF-POCKET EXPENSES (MEMBER LIABILITY)

The expenses you may incur include, but are not limited to, those briefly defined and described below. Further detail is provided later on in this Section III or Sections VIII and IX.

- 1. Benefit Accumulation.** Some employers may offer more than one health insurance policy through Highmark WV. Should you decide to change policies within the same company, for example, from a \$500 Deductible to a \$1,000 Deductible option, any Deductibles, Coinsurances and Lifetime Maximums earned on the \$500 Deductible option shall apply to the \$1,000 Deductible option. This provision does not apply if you change employment and both employers offer group health insurance through Highmark WV. If you have any questions about this provision, contact Customer Service.
- 2. Benefit Maximums.** Benefit Maximums are stated either in dollar amounts, Treatments, or Visits per Benefit Period. Once the Benefit Maximum is met for a Covered Service within the Benefit Period, any additional charges Incurred will be your responsibility. They will **not** apply to any Fees, Deductibles, Network and Non-Network Coinsurances, or other Covered Person responsibilities.
- 3. Coinsurance and Coinsurance Limits.** This is a percentage of the Reimbursement Allowance or Actual Charge after your Deductible has been satisfied. The percentages may differ when receiving Covered Services from Network Providers (**Network Coinsurance**) as opposed to Non-Network Providers (**Non-Network Coinsurance**). Normally you receive greater benefits from Network Providers. There are separate limits for Network Coinsurance (**Network Coinsurance Limits**) and Non-Network Coinsurance (**Non-Network Coinsurance Limits**). See Section D below for more detail.
- 4. Co-Pay.** An upfront set amount that is the responsibility of the Covered Person for Office Visits and other Services as specified in this section or on your ID Card.

5. **Deductible.** This is the amount you are required to pay for Covered Services, usually stated in dollars, before we begin to pay.
6. **Maximum Out-of-Pocket.** The maximum amount of expenses incurred for Deductibles and Coinsurances for a Benefit Period per individual or family.
7. **Non-Covered Services.** Certain Services that may be Incurred or recommended by a Provider may not be a Covered Service under your Plan. As a result, you will be responsible for the cost of such Services. These Services will **not** apply towards any Fees, Deductibles, and Coinsurances.
8. **Non-Network Liability.** In addition to any Deductible and Non-Network Coinsurance, you may be responsible for some, or all, of the amount of Actual Charges in excess of our agreed Network Provider payment rate, when you obtain services from Non-Network Providers.
9. **Office Visit Fees.** An upfront charge, usually stated in dollars, for Office Visits with Physicians and Professional Other Providers. The Office Visit Fee applies to Charges for the Visit only. This Fee does not apply to other Services received during a Visit, except as specified. Office Visit Fees are in addition to, and do not apply toward any other Deductibles, Fees, or Coinsurances unless there is no Fee indicated. The Office Visit Fee applies per Visit and is payable at the time Covered Services are received.
10. **Pre-Certification Review Penalty.** A financial penalty that you are required to pay for most Inpatient Admissions if you do not contact us as required in Section VIII.B.
11. **Waivers.** In some instances, a Network or Participating Provider may ask you to sign a “waiver” or other document prior to receiving care. This waiver may state that you accept responsibility for the Charges above the applicable Reimbursement Allowance with Highmark WV or for Services deemed not Medically Necessary by Highmark WV. Generally, Network or Participating Providers are prohibited from this practice. See Section V.A for circumstances where you may be responsible for non-Medically Necessary Services.

C. **SUMMARY OF BENEFITS DESCRIPTIONS** The following summary provides details regarding specific benefit amounts and limits, including:

1. **Benefit Period**
2. **Deductible**
3. **Eligible Dependent Age Limit**
4. **Office Visit Fee**
5. **Benefit Maximums**
In some circumstances, the Benefit Maximums are combined for Network and Non-Network Services.
6. **Organ Transplant Services**
7. **Bone Marrow Procedures**
8. **Pre-Certification Penalty**
Refer to Section VIII for additional information and requirements.
9. **Treatment Plans**
Refer to Section VIII for additional information and requirements.
10. **Preexisting Condition Limitation and Exclusion Period**
Refer to Section VIII for additional information and requirements.

11. Coinsurances and Coinsurance Limits

Except as otherwise specified, after you have paid any applicable Deductibles or Fees, Covered Services will be paid at the percentage applicable to the Provider Network status.

- a. **Non-Network Coinsurance and Liability Limits.** The Non-Network Coinsurance is in addition to your Network Coinsurance Limit. Also Non-Network Liability amounts will **not** be applied to either your Network Coinsurance Limit or Non-Network Coinsurance Limits.
- b. **Exceptions Regarding the Coinsurance Limits.** The amounts you pay as a Network or Non-Network Coinsurance for the following services do **not** apply to your Network or Non-Network Coinsurance limits.
 - Outpatient Physical Therapy Services, Chiropractic (Spinal Manipulation) Services, or Outpatient Occupational Therapy Services.
- c. **After your Network Coinsurance Limit is met, but before your Non-Network Coinsurance Limit is met, the amount you are responsible to pay is:**
 - For Covered Services provided by a Network Provider
No further Coinsurance is required for the remainder of the Benefit Period. Benefits are then payable by Highmark WV at 100% of the Actual Charge or the Reimbursement Allowance, unless otherwise stated.
 - For Covered Services provided by a Non-Network Provider
 - ❖ but a Participating Provider
Covered Services provided by a Non-Network Provider will be paid at the Non-Network percentage as indicated. In addition, you may be responsible for a Non-Network Liability – the difference between the Network Reimbursement Allowance and Participating Reimbursement Allowance.
 - ❖ and Non-Participating Provider
Covered Services provided by a Non-Network Provider will be paid at the Non-Network percentage as indicated. In addition, you may be responsible for a Non-Network Liability – the difference between the Network Reimbursement Allowance and Non-Participating Provider’s Actual Charge.
- d. **After both your Network and Non-Network Coinsurance Limits are met, benefits for Covered Services provided by a Network or Non-Network Provider are payable by Highmark WV at 100% of the Reimbursement Allowance or Actual Charge, unless otherwise stated. You are responsible though for payment of some or all of the amounts in excess of the Reimbursement Allowance for Covered Services received from a Non-Network Provider (Non-Network Liability).**

SuperBlue Plus 2000

SUMMARY OF BENEFITS

IMPORTANT: PLEASE READ THE SUMMARY OF BENEFITS SECTION. THIS IS PART OF YOUR CERTIFICATE AND SUBJECT TO CHANGE. FOR FURTHER EXPLANATION REFER TO YOUR CERTIFICATE BOOK.

Group Effective Date	
Benefit Period (used for Deductible and Coinsurance limits)	January 1 through December 31 (Calendar Year)
Deductible (Applies to Network and Non-Network Benefits combined) Individual Family (may be met collectively) Note: All services are subject to the Deductible unless otherwise specified.	\$1,000 \$2,000
Carry-Over Deductible Period	October, November and December
Network Coinsurance Limit: (Network and Non-Network Coinsurance dollars cross apply.) Individual Family (may be met collectively)	\$1,000 \$2,000
Deductible and Network Coinsurance Limit: Individual Family (may be met collectively)	\$2,000 \$4,000
Non-Network Coinsurance Limit: (In addition to the Deductible and Network Coinsurance limits) Individual Family (may be met collectively)	\$2,500 \$5,000
Maximum Out of Pocket (Deductible, Network and Non-Network Coinsurance Limits combined): Individual Family (may be met collectively)	\$4,500 \$9,000
Lifetime Maximum Benefit for all Covered Services	UNLIMITED

BENEFIT HIGHLIGHTS

	NETWORK	NON-NETWORK
Medical Office Visit / Office Consultation - Applies to charge for visit only. Does not apply to other services received during visit. Office Visit Fees do not apply to Deductible or Coinsurance limits. Co-pays do not apply for certain preventive visits. See the Preventive section for this information.	\$10 per Office Visit, 100% thereafter, No Deductible	\$10 per Office Visit, 60% thereafter, No Deductible
Emergency Accident Care and /or Emergency Medical Care provided in the ER	First \$500 paid at 100%, No Deductible, 80% thereafter Subject to Deductible	First \$500 paid at 100%, No Deductible, 80% thereafter Subject to Deductible
Prescription Drugs are provided through a Preferred Pharmacy Network – If you the member, choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your coinsurance, unless the physician writes "brand necessary" (DAW) on the prescription, or if no generic equivalent exists. Maximum 34 day supply.	Member pays 30% or \$10 minimum Coinsurance, whichever is greater. No Deductible	No Benefits
Additional Benefits with Prescription (Retail or Mail Order) - Adults: Aspirin, Smoking Cessation, Folic Acid, Children: Iron Supplements and Oral Fluoride (guidelines as determined by certain Governmental Agencies) – You may access this information at www.healthcare.gov . You may also contact Customer Service using the number on the back of your ID Card.	100%, No Deductible	No Benefits
Mail Order Drugs – If you, the member, choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your coinsurance, unless the physician writes "brand necessary" (DAW) on the prescription, or if no generic equivalent exists. Maximum 90 day supply.	Member pays 30% or \$30 minimum Coinsurance, whichever is greater, No Deductible	No Benefits

PREVENTIVE CARE SERVICES		
	NETWORK	NON-NETWORK
Annual Gynecological Exam - one per calendar year. Office Visit Co-Pay does not apply to Deductible or Coinsurance limits.	100%, No Deductible	\$10 per Office Visit, 60% thereafter, No Deductible
Routine Pap Smear - one per calendar year	100%, No Deductible	60%
Routine HPV Testing - one every 3 years age 30 and older	100%, No Deductible	60%
Routine Mammogram - per schedule age 35 and older	100%, No Deductible	60%
Prostate Exam - one per calendar year for males over age 50.	100%, No Deductible	\$10 per Office Visit, 60% thereafter, No Deductible
Prostate Specific Antigen (PSA) Test - one per calendar year	100%, No Deductible	60%
Colorectal Cancer Exam - for individual's age 50 and older or a symptomatic person under age 50. One per calendar year.	100%, No Deductible	\$10 per Office Visit, 60% thereafter, No Deductible
Fecal occult blood test - one per calendar year	100%, No Deductible	60%
Flexible Sigmoidoscopy - one every 5 years	100%, No Deductible	60%
Colonoscopy - one every 10 years	100%, No Deductible	60%
Double Contrast Barium Enema - one every 5 years	100%, No Deductible	60%
Routine Screening, Immunization and Diagnostic Services (guidelines as determined by certain Governmental Agencies) - You may access this information at www.healthcare.gov . You may also contact Customer Service. Their number is located on the back of your ID Card.	100%, No Deductible	No Benefits
Diabetes Education & Control - Copay applies to office visit only. All other services will fall under medical benefits.	\$10 per Office Visit, 100% thereafter, No Deductible	\$10 per Office Visit, 60% thereafter, No Deductible
WELL BABY / CHILD CARE SERVICES		
Well Baby Care - Routine office visits, lab tests and immunizations to age 6.	100%, No Deductible	100%, No Deductible
Well Child Care – Routine office visits and immunizations age 6 through 17.	100%, No Deductible	100%, No Deductible
PHYSICIAN SERVICES		
In-Hospital Medical Visit	80%	60%
Surgery, Assistant to Surgery, Anesthesia	80%	60%
Second Surgical Opinion Services (outpatient)	100%, No Deductible	100%, No Deductible
Maternity Care - dependent daughters are covered.	80%	60%
Newborn Care including circumcision.	80%	60%
Occupational, Physical Therapy and Chiropractic Manipulations Note: Limitations are Physician and Outpatient Facility services combined (per calendar year). Network and Non-Network Coinsurance amounts for these services do not apply to your Coinsurance limits.	80% for the first 20 treatments, 50% thereafter	80% for the first 20 treatments, 50% thereafter
Respiratory, Hyperbaric and Pulmonary Therapy	80%	60%
Speech Therapy when necessary due to a medical condition.	80%	60%
Rehabilitation Services	80%	60%
Temporomandibular Joint Dysfunction / Craniomandibular Disorders	80%	60%
Diagnostic, X-ray, Lab and Testing	80%	60%
Allergy Testing and Treatment	80%	60%
Outpatient Mental Health Services	80%	60%
Outpatient Drug Abuse Services	80%	60%
Outpatient Alcoholism Services	80%	60%

INPATIENT HOSPITAL / FACILITY SERVICES		
	NETWORK	NON-NETWORK
Unlimited Days Semi-Private Room and Board Note: If admission is not Precertified, you pay a \$500 Precertification review penalty.	80%	60%
Ancillaries, Drugs, Therapy Services, X-ray and Lab	80%	60%
General Nursing Care	80%	60%
Surgical Services	80%	60%
Birth Center Care / Maternity Services - dependent daughters are covered.	80%	60%
Inpatient Mental Health Care Services - Note: If admission is not Precertified, you pay a \$500 Precertification review penalty.	80%	60%
Inpatient Drug Abuse Services - Note: If admission is not Precertified, you pay a \$500 Precertification review penalty.	80%	60%
Inpatient Alcoholism Services - Note: If admission is not Precertified, you pay a \$500 Precertification review penalty.	80%	60%
OUTPATIENT HOSPITAL / FACILITY SERVICES		
	NETWORK	NON-NETWORK
Non-Emergency Medical Care provided in the ER	80%	60%
Pre-Admission Testing	80%	60%
Diagnostic, X-ray, Lab and Testing	80%	60%
Surgery, Operating Room	80%	60%
Radiation and Chemotherapy	80%	60%
Occupational and Physical Therapy Note: Limitations are for Physician and Outpatient Facility services combined (per calendar year). Network and Non-Network Coinsurance amounts for these services do not apply to your Coinsurance limits.	80% for the first 20 treatments, 50% thereafter	80% for the first 20 treatments, 50% thereafter
Respiratory, Hyperbaric and Pulmonary Therapy	80%	60%
Speech Therapy when necessary due to a medical condition.	80%	60%
Rehabilitation Services	80%	60%
Outpatient Mental Health Services	80%	60%
Outpatient Drug Abuse Services	80%	60%
Outpatient Alcoholism Services	80%	60%

OTHER COVERED SERVICES		
	NETWORK	NON-NETWORK
Private Duty Nursing - \$5,000 Maximum per calendar year Note: Maximums are Network and Non-Network combined.	80%	60%
Skilled Nursing Facility Note: If admission is not Precertified, you pay a \$500 Precertification review penalty.	80%	60%
Durable Medical Equipment and Oxygen at home	80%	60%
Orthotic Devices and Prosthetic Appliances	80%	60%
Home Health Care - Maximum 100 visits Note: Maximums are Network and Non-Network combined.	80%	60%
Emergency Ambulance	100%, No Deductible	100%, No Deductible
Other Ambulance Services	80%	60%
Hospice Care	80%	60%

HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES		
Human Organ Transplant • \$150 per day to a maximum of \$10,000 for transportation, meals and lodging	80%	60%
Bone Marrow Procedures • \$150 per day to a maximum of \$10,000 for transportation, meals and lodging	80%	60%

Eligible Dependent Age Limitation	Coverage stops at the end of the month of the 26 th birthday for an adult dependent who is an Eligible Dependent.
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Precertification Requirement	Penalty for no Precertification is \$500 reduction of benefits per Inpatient admission.
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Preexisting Condition Limitation (Note: For plan years beginning on or after September 23rd, 2010, preexisting condition limitation does not apply to children under 19 years of age.)	Preexisting Condition Waiting Period: "If you were enrolled in another health insurance policy prior to the hire date of your coverage under this Contract, the length of time you were covered under the previous policy will be applied to the Preexisting Condition Waiting Period. If there is a 63 day lapse in coverage, the 365 day waiting period will apply."
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ALL SERVICES ARE SUBJECT TO A DETERMINATION OF MEDICAL NECESSITY BY HIGHMARK WV BLUE CROSS BLUE SHIELD. PAYMENT IS BASED ON THE ACTUAL CHARGES OR PROVIDER'S REIMBURSEMENT ALLOWANCE. IN ADDITION, YOU WILL BE RESPONSIBLE FOR THE NON-NETWORK LIABILITY.

IV. Eligibility

A. APPLYING FOR COVERAGE

When you apply for coverage, you will choose one of the following:

- Individual coverage.
- Employee and child coverage.
- Employee and spouse coverage.
- Employee and children coverage.
- Family coverage.

An Application must be completed in all instances. In deciding whether or not to approve an Application, we may request more information. Coverage will not begin until your Application has been approved and you have been provided with an Effective Date.

B. ELIGIBLE EMPLOYEES AND PREMIUM COST SHARING

See your Plan Administrator for specific employee eligibility and any employee premium cost sharing requirements.

C. ELIGIBLE DEPENDENTS

An Eligible Dependent is defined as:

1. Spouse

The Certificate Holder's legally recognized spouse.

2. Dependent Children:

- The Certificate Holder or spouse's children and stepchildren;
- Adopted children or children placed for adoption.
- Any dependent children which by court order must be provided health care coverage by the Certificate Holder or the Certificate Holder's spouse.
- Children for whom either the Certificate Holder or the Certificate Holder's Spouse is the legal guardian. We will require court or government approval of guardianship.

3. Age Limits and Disabled Children

The age limits for all eligible children are specified in Section III. Coverage for Eligible Dependents will continue past the age limit for Eligible Dependents who cannot work to support themselves due to a physical or mental disability. This disability must have started before the age limit was attained and must be medically certified by a Physician. After a two-year period following the Eligible Dependent reaching the age limit, we may annually require further proof of the continuance of such incapacity and dependency.

4. Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is legally placed with you for adoption, will be eligible for dependent insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

5. Qualified Medical Child Support Order

Note: This provision will be administered according to the current applicable state and/or federal regulations.

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent insurance. A Qualified Medical Child Support Order is a judgment, decree or order (including

approval of a settlement agreement) issued by a court of competent jurisdiction or state agency, and satisfies all of the following:

- the order specifies your name and last known address, and the child's name and last known address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- the order specifies each plan that it applies to.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy.

6. Custodial Parent Rights

If a child has health coverage through an insurer of a noncustodial parent, the custodial parent may be provided information as may be necessary for the child to obtain benefits. The custodial parent, or the Provider with the approval of the custodial parent, may submit claims for Covered Services without the noncustodial parent's approval and payment for such claims may be sent directly to the custodial parent, the Provider or the state Medicaid agency.

The payment to the custodial parent, the provider or the state Medicaid agency fully satisfies our obligation to the noncustodial parent under this policy with respect to the covered child's claims.

D. ELIGIBILITY CHANGES

It is the Certificate Holder's responsibility to notify the Group of any changes in dependent eligibility.

1. Dependent Additions and Special Enrollment Available for New Dependents

Special Enrollment is available for Dependents if you marry or acquire a child through birth, adoption or placement for adoption. You must notify your Plan Administrator and submit an Application to us within 30 days of the event to add a newly acquired Eligible Dependent. If we receive the Application within 30 days of the event, the Effective Date of the Eligible Dependent's coverage will be the date specified by the Plan Administrator in the Group Contract. If we then accept the Application for Dependent coverage, we will notify you of the Effective Date. If we do not receive the Application within 30 days of the event, acceptance of the Application may be denied.

If you have individual coverage, you can change to two-person or family coverage if you marry or acquire a child through birth or adoption or placement for adoption. You must notify your Plan Administrator, who must then notify us of the change within 30 days of the event.

2. Special Enrollment Rights for Loss of Other Coverage

Special Enrollment is available for individuals, provided:

- a. They remain eligible under the Plan terms;
- b. They originally declined this coverage because of the other coverage;
 - (i) If the other coverage was COBRA, it has since exhausted; or
 - (ii) If the other coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated; and
- c. The employee requests such enrollment not later than 30 days after the date of exhaustion of the other coverage.

Special Enrollment is available to an individual if the individual:

- (i) is no longer eligible for coverage under title XIX of the Social Security Act (Medicaid) or a state children's health plan under title XXI of the Social Security Act (CHIP), provided the individual requests coverage under the Plan within 60 days after the date of termination from this coverage; or
- (ii) becomes eligible for assistance for Plan coverage under title XIX of the Social Security Act (Medicaid) or state children's health plan under title XXI of the Social Security Act, provided the individual requests coverage under the Plan

within 60 days of the date the individual is determined to be eligible for assistance.

Such coverage shall be effective on the first day of the month following the date of enrollment.

3. **Student on a Medical Leave of Absence:** Effective for plan years beginning on or after October 9, 2009 and effective for calendar year plans on January 1, 2010:

Coverage for Eligible Dependents who are enrolled at a post-secondary educational institution and are required to take a medical leave of absence will continue for one year from the first day of the medical leave or until coverage otherwise terminates under the terms of the Plan. The medical leave of absence must:

- Be due to a serious illness or injury;
- Be certified in writing by the treating Physician, and
- Have started after the Dependent is enrolled under the Plan as an Eligible Dependent based on being a student.

4. **Changes in Eligibility**

When you or a Dependent becomes ineligible, you and your Dependents may be eligible for continuation coverage described in this Section IV. COBRA continuation coverage allows individuals 60 days to notify their Group of such ineligibility from the date they become ineligible. It is important to notify the Group as soon as possible to avoid loss of guaranteed availability rights for other coverage.

Coverage other than individual coverage must be changed to individual coverage when only the Certificate Holder is eligible. **You must notify your Group of any changes in eligibility (e.g., divorce) or when a Covered Person under your Certificate becomes eligible for Medicare or becomes covered under another health insurance policy.**

5. **Nondiscrimination**

Subject to all limitations within this Contract, individuals may not be excluded from coverage under the terms of the Contract, or charged more for benefits, based on specified factors related to health status, medical condition (both physical and mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

E. EFFECTIVE DATE

Coverage starts on the Effective Date:

- In accordance with the provisions of the Group Contract;
- Upon acceptance by us of your Application; and
- Only when premiums are fully paid.

No benefits will be provided for Charges Incurred prior to your Effective Date. Coverage will not be delayed or denied due to confinement in a Hospital or other health care institution on your Effective Date. However, a Preexisting Condition Exclusion may apply for Charges Incurred with an Inpatient stay that begins before and continues beyond your Effective Date.

F. IDENTIFICATION CARDS (ID CARDS)

You will receive an ID Card. It contains information you will need when filing a claim or making an inquiry. Your ID Card is the property of Highmark WV. The ID Card must be returned to Highmark WV if your coverage ends for any reason. Further use of the ID Card is not permitted and may subject you to legal action.

G. MEDICARE

Upon becoming eligible for Medicare, coverage may be continued in any of several ways. Your Plan Administrator can tell you if any of the following options are available to you.

1. **Active Employees**

If you are still actively employed, you may be allowed to continue your coverage through your Group on the same basis as prior to your becoming Medicare-eligible.

2. Retirees

If you have retired and coverage is provided to you under your former employer's Group Contract, you may be allowed to participate on the same basis as above. You may be required to pay part of the premium in accordance with your Group Contract. The Group must collect from you your portion of the premium.

If your former Group does not provide retiree benefits, coverage may be available with Highmark WV. To be considered for coverage, you **must** do each of the following.

- Apply for and enroll in, Medicare Part A and Part B, and
- A Highmark WV Medicare supplement policy; or
- Apply for a Medicare Advantage product

Important Note: If you are a Medicare eligible resident of West Virginia, you are not eligible for Traditional Medicare Supplemental coverage if you are presently enrolled in a Group Medicare Advantage product (Freedom Blue).

H. NON-MEDICARE RETIREES

If you have retired and coverage is not continued under your former employer's Group Contract, and you are not eligible for Medicare, you may be eligible for coverage under our individual conversion product. Coverage under the conversion coverage contract may be different. **You must apply in writing no later than 30 days** after your coverage stops.

You must pay for conversion coverage from the date you stop being a Member under this Contract. If you pay from that date, your coverage under the conversion contract will start on the date the coverage under this Contract stops. Further information is provided in this Section IV.

I. HOW AND WHEN YOUR BENEFITS MAY CHANGE

The benefits provided by this Certificate may be changed or revised at any time by amendment to the Group Contract, and if applicable, by approval of the West Virginia Insurance Department. If the benefits are changed or revised, the Plan Administrator will be given notice prior to the changes becoming effective. It is the Plan Administrator's responsibility to notify you of these changes and when they become effective. If you are receiving Covered Services at the time your new benefits become effective, we will only pay for such Services to the extent they continue to be Covered Services under the new benefits.

J. HOW AND WHEN YOUR COVERAGE STOPS

1. When a Covered Person stops being an Eligible Dependent, coverage stops as specified in Section III.
2. When a Covered Person stops being an eligible Certificate Holder, all coverage stops according to the terms of the Group Contract.
3. Termination of the Group Contract by the Plan Administrator automatically ends all of your coverage. It is the responsibility of the Plan Administrator to tell you of such termination.
4. If Highmark WV terminates the Contract, you and the Plan Administrator will be notified 60 days in advance of the coverage termination date. You may be eligible for conversion coverage as indicated in this Section IV.
5. We have the right to void coverage of any Covered Person who engages in the following fraudulent conduct:
 - Deception.
 - Misrepresentation relating to a claim or in obtaining benefits.
 - Misrepresentation in Application for coverage.
 - The misuse of an ID Card.
6. When a Group or Covered Person fails to make a required premium payment, coverage stops at the end of the month of the last fully paid premium payment.

When coverage stops, you will be provided a Certificate of Creditable Coverage free of charge. You may also request a Creditable Coverage Certificate by contacting Customer Service.

To protect your guarantee rights for other coverage after termination of your eligibility for this Plan, be sure to avoid lapses in Creditable Coverage of more than 63 days.

K. CONTINUATION COVERAGE - INVOLUNTARY LAY-OFF

State law requires that insurers offer Group coverage, at the same benefit levels and Group rates (up to 100%) for a period of up to 18 months, in the event a Covered Person loses Group coverage due to involuntary lay-off. In addition, when a Group has more than 20 employees, a Covered Person may choose continuation coverage under COBRA as described below.

L. CONTINUATION COVERAGE – COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended)

Your Group Administrator can tell you if your Group Health Plan is subject to the following COBRA regulations and, if so, how these benefits are administered. **Your employer is required to provide you with notice of your COBRA rights if your Plan is subject to COBRA.**

A federal law (Public Law 99-272, Title X) known as COBRA was enacted requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the Plan would otherwise end. This Section is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your covered spouse, if applicable, should take the time to read this Section and the notice provided by your employer carefully, and refer to them in the event that any action is required on your part.

EMPLOYEE: If you are an employee covered by this Group Health Plan, you may have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

EMPLOYEE’S SPOUSE: If you are the covered spouse of an Eligible Employee, you may have the right to choose continuation coverage for yourself if you lose Group Health Plan coverage for any of the following four (4) reasons:

1. The death of the employee;
2. The termination of the employee’s employment (for reasons other than gross misconduct) or a reduction in the employee’s hours of employment;
3. Divorce or legal separation from the employee; or
4. The employee becomes entitled to Medicare.

EMPLOYEE’S CHILD: In the case of a covered Eligible Dependent child of an employee (including a child of a covered employee born or adopted during the period of COBRA continuation), he / she has the right to continuation coverage if Group Health Plan coverage is lost for any of the following five (5) reasons:

1. Death of the employee;
2. The termination of the employee’s employment (for reasons other than gross misconduct) or reduction in employee’s hours of employment;
3. Parent’s divorce or legal separation;
4. Employee becomes entitled to Medicare; or
5. The Dependent ceases to be an Eligible “Dependent child” under the terms of the Group Health Plan.

You also have a right to elect continuation coverage if you are covered under the Plan as a retiree or spouse or child of a retiree, and lose coverage within one year before or after the employer’s commencement of proceedings under Title 11 (bankruptcy), United States Code.

The eligible employee or family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing Dependent status within 60 days of the date of the qualifying event which would cause a loss of coverage. The notice must be in writing, and should be sent to the employer’s Plan Administrator. When the employer is notified that one of these events has happened, you will in turn be notified that you and your Eligible Dependents have the right to choose continuation coverage. Under the law, you and your Eligible Dependents have 60 days from the later of the date you

would lose coverage or from the date of the notice to elect continuation coverage. If and when you and your Eligible Dependents make this election, coverage will become effective on the day after coverage would otherwise be terminated.

If you do not choose continuation coverage, your coverage under the Plan will end in accordance with the provisions outlined in this Certificate.

If you choose continuation coverage, the Plan Administrator is required to give you coverage, which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or Eligible Dependents. If coverage for similarly situated employees and Eligible Dependents is modified after you elect continuation coverage, your coverage will be modified accordingly.

The required continuation coverage for employee and Eligible Dependents is up to 18 months for employee's termination or reduction in hours of employment. An extension from 18 months up to 29 months is available under certain circumstances to disabled employees (*) who have been determined by the Social Security Administration (SSA) to have a disability onset date either before the COBRA event or within the first 60 days of COBRA continuation coverage. The required continuation coverage is up to 36 months for Eligible Dependents in the following situations: when employee is entitled to Medicare; divorce or legal separation; death of employee; and cessation of dependent child status.

However, the law also provides that your continuation coverage may be terminated for any of the following reasons:

1. The employer no longer provides Group Health Plan coverage to any of its employees;
2. You do not pay the premium for your continuation coverage in a timely manner;
3. You first become covered, after electing COBRA continuation coverage, under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation which would apply to the COBRA covered individual with respect to any Preexisting Condition; or
4. You first become entitled to Medicare, after electing COBRA continuation coverage.

You do not have to show that you are insurable to choose continuation coverage. However, **you will have to pay all of the cost, the Group rate premium plus a 2% administrative fee, for your continuation coverage.** At the end of the 18-month, 29-month, or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under the current group health plan, if the plan provides a conversion privilege. In addition, under the Health Insurance Portability & Accountability Act (HIPAA, 1996), in certain circumstances, such as when you exhaust COBRA coverage, you may have the right to buy individual health coverage with no Pre-Existing Condition exclusion without having to give evidence of good health.

If you have any questions about COBRA, please contact your Plan Administrator. In addition, if you have changed your marital status or you, your spouse, or any eligible covered Dependent have changed address; please notify your Plan Administrator in writing. If any covered child is at a different address, please notify your Plan Administrator in writing so that a separate notice may be sent.

(*) Note: A qualified beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled as of the date of the COBRA event or within 60 days of COBRA coverage, may be eligible to continue coverage for an additional 11 months (29 months total). You must notify the employer within 60 days of the determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. You must provide a copy of the SSA determination of disability. The employer can charge up to 150% of the applicable premium during the 11-month extension. The disabled individual must notify the employer within 30 days of any final determination that he or she is no longer disabled. If the coverage is extended to a total of 29 months, extended coverage will cease upon a final determination that the qualified beneficiary is no longer disabled.

M. MILITARY SERVICE

If you are called up for active military service, commissioned corps of the Public Health Service and certain non-military emergency responders, you may be entitled to military coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA). USERRA may also entitle you reenrollment upon returning from active military service without any Waiting Periods, any Pre-Existing Condition exclusions, or a significant break in coverage.

N. INPATIENT BENEFITS INCURRED BEFORE TERMINATION AND EXCEEDING THE TERM OF CONTRACT

If you are an Inpatient of a Hospital or Skilled Nursing Facility on the day your coverage stops, the benefits listed under the Inpatient Services Section, subsections Bed, Board and General Nursing Services and Ancillary Services only, will continue until the earliest of the following:

1. We pay your maximum benefits.
2. You leave the Hospital or Skilled Nursing Facility.
3. The end of the Benefit Period in which your coverage stopped.
4. You have other group health care coverage for the condition that requires your Inpatient Hospital or Skilled Nursing Facility care.

No other benefits will be provided once your coverage stops.

O. CONVERSION PRIVILEGE

If you or a Dependent, (if the Dependent was covered at the time of termination) stop being a Covered Person, you and your Dependents may be eligible for conversion to a non-group policy offered by Highmark WV if there was continual coverage under this policy for three months immediately prior to the termination of this policy. You are eligible for conversion coverage if the Group coverage is terminated (including discontinuance of the group policy in its entirety), with the exception of the following reasons:

1. You fail to pay any required contribution for your group health care coverage;
2. You obtain other group health insurance coverage within 31 days of termination of coverage under the Group Contract;
3. You become covered under Medicare; or
4. You have similar coverage under any group or non-group health benefits plan, or are provided similar benefits pursuant to, or in accordance with, the requirements of any state or federal law.

The conversion coverage may be different than the coverage provided under this Contract. However, we will not require evidence of insurability for eligibility under the conversion coverage and there will not be any Preexisting Condition exclusions on the conversion coverage beyond those already excluded under the previous Group Contract. You must apply in writing and make the first premium payment to us for such coverage no later than 31 days after your coverage under this Contract ends.

P. GUARANTEED AVAILABILITY OF COVERAGE FOR EMPLOYERS IN THE SMALL GROUP MARKET (This provision applies only to small employers as defined by the laws of the State of West Virginia.)

Health insurance issuers that offer coverage in the small group market are required to offer to any small employer in the state all products that are approved for sale in the small group market and the issuer is actively marketing, and must accept any employer that applied for any of those products. In addition, issuers must accept for enrollment every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan. "Eligible Individual" means an individual who is eligible (1) to enroll in group health insurance coverage offered to a group health plan maintained by a small employer, in accordance with the terms of the group health plan; (2) for coverage under the rules of the health insurance issuer which are uniformly applicable in the state to small employers in the small group market; and (3) for coverage in accordance with all applicable state laws governing the issuer and the small group market. Network plans may limit employers to those with eligible individuals within the network service area and deny coverage where capacity is not adequate.

Q. GUARANTEED RENEWABILITY OF GROUP COVERAGE

A health insurance issuer offering health insurance coverage in the small or large group market is required to renew or continue in force the coverage at the option of the plan sponsor except in situations involving nonpayment of premiums, fraud, violation of participation or contribution rules, termination of the plan, enrollee's movement outside the service area, association membership ceases, or discontinuance of a product or all coverage.

V. Health Care Benefits

This Section describes the Covered Services available to you. Please refer to Section III for specific payment details, benefit maximums and limitations.

Note: For assistance in obtaining more specific benefit information on what procedures or tests are covered, call the Customer Service number on your ID Card. **Certain Covered Services may also require Prior Authorization. For additional information, go to Section VIII, www.highmarkbcbswv.com or contact Customer Service.**

A. MEDICAL NECESSITY REQUIREMENT

All Covered Services must be Medically Necessary unless otherwise specified. Medical Necessity is determined by qualified Highmark WV personnel. Generally, Network and Participating Providers are prohibited from billing you for Services determined by Highmark WV to not be Medically Necessary. However, you could be responsible for such Charges in certain circumstances. Among other things, the Network or Participating Provider must provide you with advance notice, in writing, that the Service or Supply may not be Medically Necessary along with estimated Charges. You must also agree in writing to proceed with such Services and Supplies and to assume the cost thereof. In addition to the preceding requirements, Highmark WV requires some Network and Participating Providers to specifically request a determination in advance that a Service or Supply is not Medically Necessary. For more information, refer to Section VIII. Non-Network and Non-Participating Providers may bill you for Services deemed by us as not Medically Necessary.

B. PRIOR AUTHORIZATION

Certain Covered Services require Prior Authorization. For more information, go to Section VIII, call Customer Service or visit Highmark WV's website at www.highmarkbcbswv.com. The authorization list is located under the Provider drop-down tab.

C. INPATIENT SERVICES

1. Bed, Board and General Nursing Services

- A semiprivate room.
- A private room (a room with one bed). We will pay only the Hospital's average semiprivate room rate.
- A bed in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for the intensive care of critically ill patients.

2. Ancillary Services, including:

- Operating, delivery, treatment rooms, and equipment.
- Prescription Drugs.
- Whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing.
- Anesthesia, anesthesia supplies and services given by an employee of Hospital or Facility Other Provider.
- Oxygen and other gasses.
- Medical and surgical dressing, supplies, casts, and splints.
- Diagnostic Services.
- Therapy Services.

3. **Medical Care Visits.** The personal examination given to you by your Physician or Professional Other Provider. Consultations are not a part of this benefit. Benefits are provided for one Visit for each day you are an Inpatient.

4. **Intensive Medical Care.** Constant attendance and treatment when your condition requires it.

5. **Concurrent Care.** Care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Concurrent Care is also care by two or more Physicians during one Hospital stay for two or more unrelated conditions.

6. **Diagnostic Surgical Procedures.** Surgical procedures to diagnose your condition while you are in the Hospital.
7. **Inpatient Consultation.** A personal bedside examination by another Physician or Professional Other Provider, performing within the scope of their license, when requested by your Physician. The Physician or Professional Other Provider rendering the consulting service must be board-eligible, if applicable, and possess the knowledge, training, and skill needed to provide this service. Consultation services are not covered if the consultant subsequently takes charge of the patient. At that point, we will consider him the treating Physician. We will not provide coverage for both the treating Physician and initial treating Physician for services rendered during the same time period. Staff consultations required by Hospital rules are not covered.
8. **Newborns**
 - **Inpatient Newborn Care.** Routine care of a newborn, including circumcision while the mother remains an Inpatient for the maternity admission or if the newborn is added to your Contract within the time limit specified in Section IV. Coverage must be in effect for the newborn care to be a Covered Service. **Each new dependent must be added to your contract within 30 days of acquiring the new dependent, regardless of the type of coverage in effect at the time you acquire the new dependent.** Refer to the Section IV for information on how to apply for the necessary coverage.
 - **Newborn Hearing Impairment Testing.** In West Virginia, health care providers present at or immediately after childbirth are required to perform a test for hearing loss on the infant unless the infant's parents refuse. If delivery takes place in a non-covered facility including home birth, a West Virginia health care provider shall inform the parents of the need to obtain this service within the first month of life. The newborn testing shall be a covered benefit.
 - **Detection and Control of Diseases in Newborns.** West Virginia law requires the hospital or birthing center in which the infant is born, the parents or legal guardians, the Physician attending the newborn child, or any person attending the newborn child not under the care of a Physician, to ensure that the newborn be tested for phenylketonuria, galactosemia, hypothyroidism, sickle-cell anemia, congenital adrenal hyperplasia, cystic fibrosis, biotinidase deficiency, isovaleric acidemia, glutaric acidemia type I, 3-Hydroxy-3-methylglutaric aciduria, multiple carobxylase deficiency, methylmalonic acidemia-mutase deficiency form, 3-methylcrotonyl-CoA carboxylase deficiency, methylmalonic acidemia, Cbl A and Cbl B forms, propionic acidemia, beta-ketothiolase deficiency, medium-chain acyl-CpA, dehydrogenase deficiency, very long-chain acyl-CpA dehydrogenase deficiency, long-chain hydrocyacyl-CpA dehydrogenase deficiency, trifunctional protein deficiency, carnitine uptake defeat, maple syrup urine deficiency, homocystinuria, citrullinemia type I, argininosuccinate acidemia, tyrosinemia type I, hemoglobin S/Beta-thalassemis, sickle C disease and hearing deficiency and certain other disease specified by the Bureau of Public Health.

D. PREVENTIVE CARE SERVICES

Note: In addition to the Covered Services listed below, there are other routine screening, immunization and diagnostic services covered as afforded by the Patient Protection and Affordability Care Act (PPACA). For additional information, go to www.healthcare.gov or contact Customer Service. Their phone number is on the back of your ID Card.

1. Routine Gynecological Services

- Pap smears (including related office visits) - annually or more often if recommended by a Physician.
- Human Papilloma Virus (HPV) Testing - one every 3 years age 30 and older.
- Mammograms according to the following schedule:
 - Age 35 through 39 years of age - one baseline mammogram
 - Age 40 through 49 years of age - every two years or more often if recommended by physician

50 and over – one per calendar year

Note: As required by West Virginia law, female enrollees have direct access to a women's health care provider of their choice.

2. Diabetic Services - Services provided or performed for the treatment of both insulin dependent and non-insulin dependent diabetes includes:

- Blood glucose monitors and monitor supplies; (paid under your durable medical equipment (DME) benefits)
- Insulin infusion devices; (paid under your DME benefits)
- Insulin, syringes (paid under your prescription drug benefits), and insulin injection aids or devices;
- Pharmacological agents for controlling blood sugar (paid under your prescription drug benefits);
- Urine ketone testing strips;
- Urine micro albumin test;
- Blood pressure monitoring device;
- Podiatric appliances and therapeutic footwear;
- Foot Orthotics; and
- Orthopedic appliances including canes, crutches and walkers, and other items as may be medically necessary.

You may directly access any Network Provider for one annual diabetic retinal exam.

Diabetes self-management education to ensure the proper self-management and treatment, including diet education, is a Covered Service. However, this education is limited to only those services considered medically necessary, and

- Visits medically necessary upon diagnosis of diabetes;
- Visits necessitated by a significant change in the patient's symptoms or conditions resulting in a change in the patient's self-management; and
- When a new medicine or therapeutic process relating to treatment or management of the patient's condition has been identified as medically necessary.

Education services may be provided by:

- A licensed pharmacist when providing instruction on the proper use of equipment covered by this contract or supplies and medication prescribed by a licensed Physician;
- A diabetes educator certified by a national diabetes educator certification program;
- A registered dietitian registered by a nationally recognized professional association of dietitians.

National diabetes education certification or any professional association of dietitians must be certified to the Insurance Commissioner by the West Virginia Health Department.

3. Prostate screening exam and prostate specific antigen (PSA) test for males over age 50 - one per calendar year.

4. Colorectal Cancer Screening for individuals age 50 and older, symptomatic person under age 50 or a person under age 50 with high risk factors (e.g. family history).

- Exam - one per calendar year.
- Fecal Occult Test - one per calendar year.
- Flexible Sigmoidoscopy - one every 5 years.
- Colonoscopy - one every 10 years.
- Double Contrast Barium Enema - one every 5 years.

5. Annual Kidney disease screening and laboratory testing; including any combination of blood pressure testing, urine albumin or urine protein testing, and serum creatinine testing.

E. SPECIAL SERVICES

1. **Pre-Admission Testing.** Outpatient tests and studies required for your scheduled Hospital admission as an Inpatient, which would have been covered as an Inpatient.
2. **Mastectomy Benefits.**
 - Reconstruction of breast on which the mastectomy was performed;
 - Reconstructive surgery of the other breast to present symmetrical appearance;
 - Prostheses and coverage for physical complications at all stages of the mastectomy procedure, including lymphedemas in a manner determined in consultation with the attending physician and the patient.
 - Minimum stay of 24 hours of Inpatient care following a total mastectomy or partial with lymph node dissection for treatment of breast cancer.
 - Minimum stay of 48 hours of Inpatient care for a radical or modified mastectomy.

F. SURGICAL SERVICES

1. **Surgery.** This must be done by a Physician or Professional Other Provider performing within the scope of their license. Benefits include Medical Care visits before and after Surgery.
2. **Special Surgery**
 - Sterilization, regardless of Medical Necessity.
 - Removal of impacted teeth. Partial and Full-boney impacted teeth are covered under your medical benefits; all soft tissue impactions would be covered under your Dental benefits, if applicable.
 - Mandibular staple implant due to trauma and/or accidental injury.
 - Maxillary or mandibular frenectomy.
 - Kidney transplants
3. **Multiple Surgical Procedures.** When more than one surgical procedure is performed through the same body opening during one operation, you are covered for the most complex procedure. When more than one surgical procedure is performed through more than one body opening during one operation, you are covered for the most complex procedure and for one-half of the benefit for additional procedures, if Medically Necessary.
4. **Assistant at Surgery.** A Physician's help to your surgeon in performing covered Surgery when no qualified house staff member, intern, or resident exists.
5. **Anesthesia.** Administration of anesthesia, done in connection with a Covered Service, by a Physician or certified registered nurse anesthetist who is not the surgeon or the assistant at Surgery. This benefit includes care before and after the administration. The services of a standby anesthesiologist are covered during coronary angioplasty Surgery.
6. **Second Surgical Opinion.** A second Physician's opinion and related Diagnostic Services to help determine the need for elective covered Surgery services recommended by your first Physician is a Covered Service. The second opinion must be provided by someone other than the first Physician who recommended the Surgery. This benefit is not payable while you are an Inpatient of a Hospital. We cover a third opinion if the first two opinions conflict. The Surgery is a Covered Service even if the Physicians' opinions conflict.

G. EMERGENCY SERVICES

Coverage shall be provided for Emergency Medical Services to the extent necessary to screen and Stabilize an Emergency Medical Condition. Emergency Services are those provided to evaluate and treat an Emergency Medical Condition, a condition manifesting itself by the sudden, and unexpected onset of acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairments to bodily functions or serious dysfunction of any bodily part or organ based on a Prudent Layperson standard. Emergency

Medical Conditions include, but are not limited to, heart attacks, strokes, loss of consciousness or respiration, convulsions and other acute conditions, which we determine to be a Medical Emergency only if:

- Severe symptoms occur suddenly and unexpectedly;
- Immediate care is secured; and
- The illness or condition, as finally diagnosed or as indicated by its symptoms, is one, which would normally require immediate Medical Care.

Prior Authorization is not required for treatment of Emergency Medical Conditions.

If a member seeks treatment at a Hospital emergency room and receives services that are not Medically Necessary, this Certificate will not reimburse the cost of such services, other than a Medical Screening Exam to determine if an Emergency Medical Condition exists or, if based on retrospective review, a Prudent Layperson would have believed an Emergency Medical Condition exists (in any case, less any applicable Coinsurances and Deductibles).

Note. Emergency Care received in a Physician's office will be paid as any other Office Visit.

Emergency Care

Covered emergency services for the treatment of Emergency Medical Conditions include pre-hospital services to the extent necessary to screen and stabilize your condition, such as:

- Outpatient Hospital services;
- Medical, surgical and anesthesia services;
- Diagnostic Services;
- Tetanus toxoid immunizations; and.
- Rabies vaccine.

H. HOME, OFFICE AND OTHER OUTPATIENT VISIT

Medical Care, not falling within the Emergency Services Benefit, to examine, diagnose and treat an injury, condition, disease, or illness.

I. HOSPITAL-BASED CLINICS

A non-emergency Outpatient Visit in a Hospital-based clinic setting may apply to your Outpatient facility benefit and not to your Office Visit benefits.

J. INJECTABLE DRUGS

Certain injectable drugs may require pre-authorization. Contact Medical Management for additional information. Their phone number is located on the back of your ID Card.

K. DIAGNOSTIC SERVICES

Diagnostic Services include:

- Radiology, ultrasound and nuclear medicine,
- Laboratory and pathology services,
- EKG, EEG, and other electronic diagnostic medical procedures.

L. ALLERGY TESTS AND TREATMENT

Allergy tests that are performed and related to a specific diagnosis are Covered Services. Desensitization treatments are also Covered Services.

M. THERAPY SERVICES

Services or supplies used to promote the recovery from an illness or injury include:

1. **Radiation Therapy.** The treatment of disease by X-ray, radium, or radioactive isotopes.

2. **Chemotherapy.** The treatment of malignant disease by chemical or biological antineoplastic agents.
3. **Dialysis Treatments.** The treatment by dialysis methods of an acute or chronic kidney ailment, including chronic ambulatory peritoneal dialysis, which may include the supportive use of an artificial kidney machine.
4. **Physical Therapy.** The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury, or loss of a body part. Such services include physical treatments, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and may include devices if we determine that they are Medically Necessary.
 - Benefits are also provided for chiropractic (spinal) manipulations.
 - Benefits are also available for aquatic therapy.
5. **Respiratory Therapy.** Introduction of dry or moist gasses into the lungs for treatment purposes.
6. **Hyperbaric and Pulmonary Therapy.** The administration of oxygen in a pressurized chamber. Under pressurization, oxygen levels are increased. Certain conditions should be reviewed for Medical Necessity.
7. **Outpatient Speech Therapy.** In order to be considered a Covered Service, this therapy must be performed by a certified/licensed therapist and be Medically Necessary due to a medical condition such as:
 - A stroke.
 - Aphasia.
 - Dysphasia.
 - Post-laryngectomy.
8. **Outpatient Occupational Therapy.** In order to be considered a Covered Service, this therapy must be Medically Necessary and must be expected to improve the level of functioning within a reasonable period of time.

N. REHABILITATION SERVICES

1. For Services provided at a:
 - A hospital duly licensed by the state of West Virginia that meets the requirements for rehabilitation
Hospitals as described in the Medicare Provider Reimbursement Manual, Part 1;
 - A distinct part rehabilitation unit in a Hospital duly licensed by the state of West Virginia; or
 - A hospital duly licensed by the state of West Virginia that meets the requirements for cardiac rehabilitation; or
 - Similar facilities located outside of the state.
2. Benefits will be provided for Rehabilitation Services for the following conditions:
 - Stroke;
 - Spinal cord injury;
 - Congenital deformity;
 - Amputation;
 - Major multiple traumas;
 - Fracture of femur;
 - Brain injury;
 - Polyarthritis, including rheumatoid arthritis;
 - Neurological disorders;
 - Cardiac disorders; and
 - Burns.

Rehabilitation services do not include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

Your Physician must certify that there is reasonable likelihood that Rehabilitation Services will correct or restore you to your optimal physical, medical, psychological, social, emotional, vocational and economic status. Your Physician's certification and recommended course of treatment are subject to review for Medical Necessity.

O. MATERNITY SERVICES

Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy, miscarriage, and therapeutic and elective abortions are Covered Services. These are Covered Services for the Certificate Holder and all Eligible Dependents.

If this group health plan provides for maternity or newborn infant coverage, under Federal Law, it may not restrict such benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or the issuer for prescribing lengths of stay not in excess of the above periods. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable. Precertification is required **only** when the Inpatient stay exceeds 48 hours and 96 hours respectively.

P. MENTAL HEALTH CARE AND SUBSTANCE ABUSE (DRUG AND ALCOHOL) COVERAGE

1. Mental Health Care

In addition to other Covered Services, the following services are payable for the treatment of Mental Illness:

- Individual psychotherapy.
- Group psychotherapy.
- Family counseling; counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Contract. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient.
- Electroshock therapy or convulsive drug therapy and related anesthesia only if given in a Hospital or Psychiatric Hospital.
- Psychological testing.
- Intensive Outpatient Services (IOP).
- Partial Hospital (PH).
- Psychiatric Inpatient hospitalization.

In addition to other Covered Services, West Virginia law requires coverage of Serious Mental Illness which is defined as an illness that is included in the sub classification of:

- Schizophrenia and other psychotic disorders;
- Bipolar disorders.
- Depressive disorders.
- Substance-related disorders with the exception of caffeine, nicotine related disorders.
- Anxiety related disorders.
- Anorexia and bulimia

2. Drug Abuse and Alcoholism Service

Covered Services for Drug Abuse and Alcoholism rehabilitation include:

- Individual psychotherapy Schizophrenia and other psychotic disorders;
- Group psychotherapy

- Family counseling; counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Contract. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient.
- Covered Services also include Inpatient detoxification services.

Services beyond the evaluation or to diagnose conditions related to mental deficiency, retardation, an autistic disease of childhood, learning disabilities or mental retardation are not covered.

We do not pay benefits for Mental Illness that cannot be treated. We will, however, pay benefits to determine if the disorder or illness can be treated. Your Physician must certify that there is a reasonable likelihood that your treatment will be of substantial benefit and substantial improvement is likely.

Q. WELL BABY AND WELL CHILD CARE SERVICES

1. Well Baby Care Services.

Routine office visits and immunizations for ages one month to six years are Covered Services. Allowable office visits, lab tests and immunizations will follow the schedule recommended by the American Academy of Pediatrics (AAP). You may access this information at www.aap.org or contact Customer Service. Their phone number is located on the back of your ID Card.

2. Well Child Care Service.

Routine office visits and immunizations for ages six through seventeen years are Covered Services. Allowable office visits and immunizations will follow the schedule recommended by the American Academy of Pediatrics (AAP). You may access this information at www.aap.org or contact Customer Service. Their phone number is located on the back of your ID Card.

R. DENTAL SERVICES FOR AN ACCIDENTAL INJURY

Dental services will be covered only when due to an accidental injury to the jaws, sound natural teeth, mouth or face. Such services must be Incurred within one year from the date of the accident. Injury as a result of chewing or biting shall not be considered an accidental injury.

S. AMBULANCE SERVICES

Ambulance services include local ground transportation by a vehicle designed, equipped, and used only to transport the sick and injured:

- From your home, scene of an accident or Medical Emergency to a Hospital. (See also, Emergency Care services Section.)
- Between Hospitals.
- Between a Hospital and a Skilled Nursing Facility.
- From a Hospital or Skilled Nursing Facility to your home.

Trips must be to the closest facility that can give Covered Services appropriate for your condition. Transportation will also be covered when provided by a professional ambulance service for other than local ground transportation. Special treatment must be required and the transportation must be to the nearest Hospital qualified to provide the special treatment.

T. PRIVATE DUTY NURSING SERVICES

Skilled Care rendered by a registered, licensed vocational or licensed practical nurse when ordered by a Physician. Care that is primarily non-medical or Custodial Care is not covered. Such services must be certified initially and every 30 days by your Physician for Medical Necessity. Inpatient Services are Services that we decide are of such a nature or degree of complexity that the Provider's regular nursing staff cannot give them.

U. SKILLED NURSING FACILITY SERVICES

Benefits for the same services available to an Inpatient of a Hospital are also covered for an Inpatient of a Skilled Nursing Facility. Such services must be Skilled Care and authorized and provided pursuant to your Physician's Plan of Treatment. Your Physician must certify initially and every two weeks that you are receiving Skilled Care and not merely Custodial Care.

No benefits are payable:

- Once a patient can no longer significantly improve from treatment for the current condition as determined by us.
- For Custodial Care.
- Solely for the treatment of pulmonary tuberculosis.

V. HOME HEALTH CARE SERVICES

The following are Covered Services when you are Homebound and receive them from a Hospital or a Home Health Care Agency:

- Intermittent Skilled Care rendered by a registered or licensed practical nurse or nurse-midwife.
- Physical therapy, occupational therapy or speech therapy.
- Medical and surgical supplies.
- Prescription Drugs.
- Oxygen and its administration.
- Medical social services.
- Home health aide visits when you are also receiving Skilled Care or Therapy Services.
- Laboratory tests.
- Home infusion therapy.

We do not pay Home Health Care benefits for any services or supplies not specifically listed above. Non-covered examples include, but are not limited to:

- Dietician services.
- Homemaker services.
- Food or home delivered meals.
- Custodial Care.
- Maintenance therapy.
- Routine prenatal care.
- Private duty nursing.
- Personal comfort items.

W. HOSPICE SERVICES

Hospice care consists of health care benefits provided to a terminally ill Covered Person. Benefits will begin when the prognosis of life expectancy is estimated to be six months or less.

A Treatment Plan must be developed and submitted to us for our approval by the Covered Person's Physician and the Hospice Provider.

A licensed Hospice organization or a Hospice program sponsored by a Hospital or Home Health Care Agency and approved by us must provide all Covered Services. The Covered Services listed in the Home Health Care Services Section are also considered Hospice services. In addition, your coverage includes:

- Acute Inpatient hospice care.
- Respite care.
- Dietary guidance.
- Durable medical equipment.
- Home Health aide visits.

Approved Prescription Drugs will be limited to a two-week supply per Prescription Order or Refill. These Prescription Drugs must be required for palliative or supportive care.

In addition to the excluded services listed in the Home Health Care Services Section, no Hospice services will be provided for:

- Physician Visits.
- Volunteer services.
- Spiritual counseling.
- Bereavement counseling for family members.
- Chemotherapy or radiation therapy if other than palliative.

X. TEMPOROMANDIBULAR DISORDERS (TMD) / CRANIOMANDIBULAR DISORDERS (CMD)

Benefits will be provided for the following procedures for the treatment of TMD or CMD:

- Health history.
- Clinical examination.
- Diagnostic imaging procedures.
- Conventional diagnostic and therapeutic injections.
- Limited orthotics; splints or appliances are limited to one every three years. All adjustments to the appliance performed during the first six months of installation are considered part of the total appliance fee.
- Physical medicine and physiotherapy; which shall include:
 - ♣ Ultrasound
 - ♣ Diathermy
 - ♣ High Voltage Galvanic Stimulation
 - ♣ Transcutaneous Nerve Stimulation
- Surgery, including arthrotomy and diagnostic arthroscopy.

Y. MEDICAL SUPPLIES AND EQUIPMENT

1. **Medical and Surgical Supplies.** These supplies include syringes, needles, oxygen, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use such as elastic bandages or thermometers.
2. **Durable Medical Equipment.** Durable medical equipment must be prescribed by a Physician or Professional Other Provider acting within the scope of their license. It must serve only a medical purpose and must be able to withstand repeated use. You may rent or purchase the equipment; however, we will not pay more in total rental costs than the customary purchase price, as determined by us.
3. **Orthotic Devices.** Rigid or semi-rigid supportive devices that limit or stop the motion of a weak or diseased body part.
4. **Prosthetic Appliances.** The purchase, fitting, adjustments, repairs and replacements of prosthetic devices that are artificial substitutes and necessary supplies that:
 - replace all or part of a missing body organ and its adjoining tissues.
 - replace all or part of the function of a permanently useless or malfunctioning body organ.

Excluded are:

- Dental appliances.
- Replacement of cataract lenses unless needed because of a lens prescription change.
- Elastic bandages.
- Garter belts or similar devices.
- Orthopedic shoes that are not attached to braces.

Z. PRESCRIPTION DRUG CLAIMS

If your Group Health Plan includes a Prescription Drug benefit offered by Highmark WV, you may be able to fill a prescription through a Network of Participating Pharmacies, Non-Participating Pharmacies, or a Mail Order Pharmacy service. Please refer to Section X for details of your Preferred Prescription Drug Benefits.

AA. ORGAN TRANSPLANT SERVICES

The following human organ transplants are Covered Services:

- Heart.
- Heart/lung.
- Lung (single or double).
- Liver.
- Pancreas.

Note: Kidney transplants are covered under Surgical Services, Special Surgery.

Benefits will be provided for:

- Expenses of the recipient directly related to the transplant procedure. This includes pre-operative and post-operative care, and immunosuppressant drugs.
- Expenses for the acquisition, transportation, and storage costs directly related to the donation of a human organ to be used in a covered organ transplant procedure.
- Retransplantation. Benefits for retransplantation are included in the maximum lifetime benefits payable per type of transplant, as indicated in Section III.
- Expenses for transportation to and from the site of the transplant Surgery. Benefits will also be provided for meals, and lodging, for the covered recipient and one additional adult. If the patient is a minor, expenses for transportation, meals and lodging are provided for the patient and two accompanying adults. Contact Medical Management to receive further details regarding travel and lodging.

The policy providing coverage for the recipient in a transplant operation shall also provide for the reimbursement of any medical expenses of a live donor to the extent benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid. Such benefits may be limited to those expenses directly relating to the organ donation.

BB. BONE MARROW PROCEDURES

Benefits are provided for the following types of bone marrow transplants.

- Allogeneic.
- Autologous.
- Syngeneic.
- Peripheral stem cell transplants.

Covered diseases:

- Leukemia.
- Lymphoma.
- Blood diseases.
- Genetic diseases.
- Solid tumors, including breast cancer.

Benefits will not be provided for bone marrow transplants for the treatment of diseases or conditions resulting from a human T-cell leukemia virus, including Acquired Immune Deficiency Syndrome (AIDS).

Covered Services will be limited to the following.

- Bone marrow donation and storage.

- Pre-transplant chemotherapy and/or radiation treatment.
- Bone marrow or peripheral stem cell transplant.
- Post-transplant Outpatient care directly related to the transplant.
- Expenses for transportation to and from the site of the transplant operation. Benefits will also be provided for meals and lodging for the covered recipient and one additional adult. If the patient is a minor, expenses for transportation, meals, and lodging will be provided for the patient and two accompanying adults (Contact Medical Management to receive further details regarding travel and lodging), and
- Retransplantation; Benefits for retransplantation are included in the lifetime maximum benefits payable per cause of bone marrow transplant as indicated in Section III.

CC. CLINICAL TRIALS COVERAGE

Clinical trials of new, untested or non-standard treatment may be a covered benefit provided:

1. the treatment is conducted for a Phase II or above stage for a life-threatening medical condition or prevention, early detection, or treatment of cancer;
2. the treatment has therapeutic intent;
3. the treatment is approved by one of the appropriate federal agencies;
4. the treatment is in accordance with all state and federal laws and Highmark WV's internal policies and procedures, including, but not limited to, Prior Authorization, clinical trials, Medical Necessity review and case management. Coverage for these Services must be approved in advance and in writing by Highmark WV;
5. the treatment is provided in West Virginia unless approved in advance by Highmark WV;
6. the facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise;
7. there is no clearly superior, non-Investigational treatment alternative; and
8. available data that the treatment will be more effective than the non-Investigational alternative.

DD. COST EFFECTIVE NON-COVERED SERVICES

We may approve benefits that are not expressly covered in this Certificate in limited circumstances if we determine that a more cost-effective means of Treatment is appropriate. Coverage for these Services must be approved in advance and in writing by Highmark WV.

VI. Exclusions

We do not provide benefits for the following Services, Supplies, or Charges and as a result, you may be responsible for the related Charges.

1. Not prescribed by or performed by or under the direction of a Physician or Professional Other Provider.
2. Not performed within the scope of the Provider's license.
3. Received from other than a Provider.
4. Experimental or Investigational.
5. Not Medically Necessary. (See section V. A for information on your liability for not Medically Necessary Services.)
6. Services outside generally accepted medical standards and practices.
7. To the extent governmental units or their agencies provide benefits, except that benefits are provided for Covered Services received from a Veterans Administration Hospital unless the injury, ailment, condition, disease, disorder, or illness is related to military service for which Governmental benefits are available
8. Injuries, conditions, diseases, disorder, or illnesses that occurs as a result of any act of war.
9. Where you have no legal obligation to pay in the absence of this or like coverage.
10. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
11. Received from a member of your Immediate Family.
12. Incurred before your Effective Date.
13. Incurred after you stop being a Covered Person, except as specified in Section VIII.
14. The following physical examinations or services:
 - Solely required by an insurance company to obtain insurance.
 - Solely required by a governmental agency such as the FAA, DOT, etc.
 - Solely required by an employer in order to begin or to continue working.
 - Premarital examinations.
 - Screening examinations, except as specified.
 - X-ray examinations made without film.
 - Routine or annual physical examinations, except as specified.
15. Where payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This does not apply if this coverage is primary and Medicare is the secondary payer.
16. Received in a military facility for a military service related injury, ailment, condition, disease, disorder, or illness for which Governmental benefits are available.
17. Surgery and other services or devices primarily to improve appearance and any complications incident to such services. Exceptions include: (a) only those that restore a body function or which were caused by disease, trauma, birth defects, growth defects, prior therapeutic processes; (b) reconstructive surgery following Covered Services for a mastectomy, including reconstruction of the other breast for the purpose of restoring symmetry; or (c) reconstructive or cosmetic surgery necessary as a result of an act of family violence. There are no benefits for wigs and hair prostheses.
18. Inpatient admissions primarily for Diagnostic Services, physical therapy or occupational therapy, when these services could have been performed on an Outpatient basis and it was not Medically Necessary that you be an Inpatient to receive them.
19. Custodial Care
20. Primarily for educational, vocational or training purposes, including speech therapy for language and/or developmental delay, stuttering and articulation errors, except as specified.
21. Conditions related to an autistic disease of childhood, learning disabilities or mental retardation which extends beyond traditional medical management or for inpatient confinement for environmental change.
22. Topical anesthetics or stand-by anesthesia, except as specified.
23. Arch supports, molded removable foot orthotics, and other foot care or foot support devices only to improve comfort or appearance such as care for flat feet, subluxations, corns, bunions (except capsular and bone

- Surgery), calluses, ingrown toenails and similar foot conditions, including Visits Incurred specifically to prepare or fit for such devices.
24. The treatment of obesity, including dietary supplements, vitamins and any care that is primarily dieting or exercise for weight loss. The only exception to this exclusion would be if Surgery were Medically Necessary.
 25. Marital counseling or any service for marital maladjustments. Specific non-covered therapies are: marital therapy, sexual therapy, or any therapy which is not specifically listed as a Covered Service.
 26. Massage therapy, pet therapy, dance therapy, art therapy, nature therapy or any therapy which is not specifically listed as a Covered Service.
 27. The treatment of sexual problems not caused by organic disease or physical trauma.
 28. Transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
 29. Reversal of sterilization.
 30. In-vitro fertilization, gamete intra-fallopian transfer and other ova transfer procedures.
 31. The treatment of cysts or abscesses associated with the teeth, dental X-rays, dentistry or any other dental processes, except as specified.
 32. Appliances designed for orthodontic purposes such as braces, bionators, functional regulators, Frankel, and similar devices.
 33. Personal hygiene and convenience items. Examples include diapers, cervical pillows, lift chairs, Jacuzzi's, exercise equipment and special linens, pillows, and air filters for allergy conditions.
 34. Eyeglasses, contact lenses, or examinations for prescribing or the fitting of them, excluding those for aphakic patients and soft lenses or sclera sheets for use as corneal bandages.
 35. Hearing aids or examinations for prescribing or fitting them.
 36. Hypnosis, acupuncture and massage therapy.
 37. Telephone consultations, missed appointments, or completion of a claim form.
 38. Human organ transplant services, other than as listed in this Certificate.
 39. Services rendered for a Preexisting Condition in the number of months, following the earlier of the first day of any waiting period or the Effective Date, as specified in this Certificate.
 40. Fraudulent or misrepresented claims.
 41. Rehabilitation Services for Vocational Rehabilitation, long-term maintenance, or Custodial Care.
 42. Amounts you must pay as a Fee, Deductible, Coinsurance, Non-Network Liability or other Covered Person liability.
 43. Illness or injury arising in the course of employment when care is received without cost under the laws of the federal or any state government or any political subdivision thereof, including any Workers' Compensation program or any employer self-funded Workers' Compensation plan. (also see Chapter VII, Section D)
 44. Prescription Drugs, except as specified. Prescription Drugs purchased from a Pharmacy on an Outpatient basis are payable under Prescription Drug Benefits if your Plan provides such benefits.
 45. The treatment of temporomandibular joint syndrome with intraoral prosthetic devices or by any other method to alter vertical dimension; for the treatment of temporomandibular joint dysfunction not caused by documented organic disease or physical trauma.
 46. Services excluded elsewhere in this Certificate.
 47. Routine immunizations, except as specified.
 48. Any service or supply that can be purchased without a Prescription Order, Examples include nutritional supplements, Ensure, Pediasure or baby formula, batteries, earplugs and any over the counter item.
 49. Any service for or related to surrogate motherhood.
 50. Residential Treatment Facilities.
 51. Partial birth abortion.
 52. Injuries sustained while committing an illegal act.
 53. Cloning or any services related to cloning.
 54. Cleft Palate Orthodontic Treatment.
 55. Defective Services or Supplies.
 56. Services or Supplies in excess of any maximum limits or benefits.

VII. Coordination of Benefits, Right of Recovery, and Right of Reimbursement/Subrogation

A. COORDINATION OF BENEFITS

All benefits provided by this Certificate are subject to this coordination of benefits provision. The purpose is not to deny you benefits but to ensure that duplicate payments are not made when you are covered by this Certificate and any Other Contract. If you are covered by more than one health benefit plan, you should file all claims with each plan.

1. In addition to the definitions of the Contract and this Certificate, the following definitions apply to this Section VII, A.:

Other Contract is defined as any arrangement providing health care benefits or services through:

- Group, franchise, or blanket insurance coverage.
- Blue Cross plans, Blue Shield plans, health maintenance organizations, preferred provider organizations, group practices, individual practices or any other prepayment coverages.
- Coverage under labor-management trustee plans, union welfare plans, single or multi-employer organization plans or employee benefit organization plans.

Other Contracts do **not** include individual health care benefits policies or contracts that are not issued through or by a group.

2. **Effect on Benefits**

When we are primary, we will pay for Covered Services without regard to your coverage under any Other Contract. When we are secondary, the benefits we normally pay for Covered Services may be reduced by the Other Contract's payment and any applicable Copays, Coinsurances and Deductible. Coordinated Benefits will never be less than those normally provided under this Contract. Generally, we will pay what is left of our Reimbursement Allowance after the primary plan pays and not more than our Reimbursement Allowance.

3. **Order of Benefit Determination**

We are secondary when:

- We cover you as an Eligible Dependent and the Other Contract covers you as other than a Dependent.
- We cover a child as the Eligible Dependent of an Eligible Employee whose birthday falls later in the year and the Other Contract covers the child as the Dependent of a parent whose birthday falls earlier in the year, except for a Dependent child whose parents are legally separated or divorced, or have the same birthday. If both parents have the same birthday, we are secondary if the Other Contract has provided coverage longer for the parent who is not the Eligible Employee.
- The Other Contract does not contain a coordination of benefits provision or specifically takes the position as primary.

In the case of legal separation or divorce:

- If the parent with custody has not remarried, the coverage of the parent with custody is primary.
- If the parent with custody has remarried, the coverage of the parent with custody is primary. The spouse of the custodial parent's coverage is secondary and the coverage of the parent without custody pays last.
- **Divorce decree exception:** Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent is primary. If the parents have joint *equal* custody and a court decree does not specify which parent is financially responsible for the child's health care expenses, then we determine the order of benefits as if the parents are married.

For a Dependent child coverage under more than one plan of individuals who are not the parents of the child, the above provisions shall determine the order of benefits as if those individuals were the parents of the child.

When these rules do not apply and the Other Contract has covered you longer, that Other Contract is primary. Even if we have covered you longer than an Other Contract, we are secondary if we cover you as retired or laid off and the Other Contract covers you as other than retired or laid off.

We are also secondary when the Other Contract does not have a coordination of benefits provision, or does not have a coordination of benefits provision with the same order of benefit determination as this one, unless the Other Contract has an order of benefit determination based on gender, which we acknowledge.

These rules do not apply if the Other Contract:

- Is an individual or family insurance contract (except in automobile “no fault” and traditional “fault” type insurance contracts) unless otherwise permitted under state law;
- Provides only Hospital indemnity benefits of not more than \$100 per day for an Inpatient Hospital stay;
- Is school accident coverage for students who sustain accidental injury;
- Is a state plan under Medicaid; or
- TRICARE.

In addition to the coordination rules outlined above, other governmental parties may occasionally pay as primary. In those situations, our payments as secondary will comply with the applicable Federal or State law (e.g. Medicare).

You will be asked to complete questionnaires from time to time asking about other health care coverage. To avoid possible claims denials:

- Complete and return the questionnaire quickly.
- Notify us promptly with changes to the Other Contract.

4. Provision Enforcement

We will coordinate benefits to the extent that we are informed by you or some other party of your coverage under any Other Contract. We are not required to determine if and to what extent you are covered under any Other Contract.

In order to apply and enforce this provision or any provision of similar purpose of any Other Contract, a Covered Person claiming benefits must furnish us with any needed information.

5. Source of Payment

If payment is made under any Other Contract where we should have made payment under this provision, then we have the right to pay whoever paid under the Other Contract. We will determine the necessary amount under this provision. Amounts so paid are benefits under this Contract. We are then discharged from liability for such amounts paid for Covered Services.

6. Medicare

Health benefits for a Covered Person who has Medicare will be modified as follows:

The amount payable under this Plan for expenses Incurred for which benefits are payable under both this Plan and Medicare will be reduced by the amount payable for those expenses under Medicare. This provision will not apply to a person while Medicare is assuming the role of secondary payer to this Plan for that Covered Person.

7. Medicaid

When you have this Plan and Medicaid, we pay first.

B. RIGHT OF RECOVERY

If we pay more for services than any provision under this Contract requires, we have the right to recover the excess from anyone to or for whom the payment was made. Such right includes recovery through deductions and offsets from any pending and subsequent claims for payments under this policy which includes recover of any payments made during a period in which premiums were delinquent or the

individual was otherwise ineligible. You agree to do whatever is necessary to secure our right to recover the excess payment.

C. RIGHT OF REIMBURSEMENT AND SUBROGATION

To the extent we pay any medical or other expenses for a Covered Person, we shall have the right to be reimbursed for those expenses from any recovery that the Covered Person may obtain from any Responsible Party. This is known as our Right of Reimbursement.

If the Covered Person fails or refuses to make or pursue a claim against any Responsible Party, then we shall have the right to make and/or pursue such claim against any Responsible Party. This right exists to the extent that we have paid any medical or other expenses for that Covered Person under this Plan. This is known as our Right of Subrogation.

Under our Right of Subrogation, we may, at our discretion:

- (1) Assert a claim on behalf of the Covered Person against any Responsible Party (including bringing suit in the Covered Person's name); or
- (2) Intervene in any lawsuit or claim that the Covered Person has filed or made against any Responsible Party.

Our Right of Reimbursement, as well as our Right of Subrogation, is hereinafter referred to as Right of Reimbursement.

Our Right of Reimbursement shall constitute a lien against the proceeds of any:

- (1) Settlement or compromise between a Covered Person and any Responsible Party; or
- (2) Judgment or award obtained by a Covered Person against a Responsible Party; or
- (3) Third party reimbursement or proceeds

The types of proceeds described in (1), (2), and (3) immediately above are hereinafter referred to as Subrogated Recovery. Our Right of Reimbursement shall exist notwithstanding any allocation or apportionment of any Subrogated Recovery that purports to limit or eliminate our Right of Reimbursement. All recoveries the Covered Person or the Covered Person's representative obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Any Subrogated Recovery that excludes or limits, or attempts to exclude or limit, the cost of medical Services or care shall not preclude us from enforcing our Right of Reimbursement. Our Right of Reimbursement shall not be eliminated or limited in any way because the Subrogated Recovery fails to fully compensate or "make whole" the Covered Person on his or her total claim against any Responsible Party. Similarly, our Right of Recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.

A Covered Person agrees to do nothing to prejudice our rights and to cooperate fully with us. The Covered Person must notify our Third Party Recoveries Department, in writing, of the existence of any Responsible Party. If a Covered Person retains legal counsel to recover from any Responsible Party, the Covered Person must immediately notify legal counsel of our Right of Reimbursement. In addition, the Covered Person must immediately notify our Third Party Recoveries Department, in writing, that legal counsel has been retained. The Covered Person must also provide us with prompt notice of any Subrogated Recovery.

A Covered Person further agrees to notify us of any facts that may impact our Right of Reimbursement, including but not limited to:

- (1) Filing of a lawsuit;
- (2) Making a claim against any third party, for Worker's Compensation benefits, or against any other potential source of recovery;
- (3) Timely advance notification of settlement negotiations; and
- (4) Timely advance notification of the intent of a third party to make payment of any kind for the benefit of or on behalf of the Covered Person that is in any manner related to the condition giving rise to our Right of Reimbursement.

A Covered Person and / or his or her legal counsel may be required to execute and deliver to us written confirmation of our Right of Reimbursement. In addition, a Covered Person may be required to execute and deliver to us other documents that may be necessary to secure and protect our Right of Reimbursement. Our failure to request such written confirmation or other documents shall not be considered to be a waiver by us of our Right of Reimbursement. Failure to provide such written confirmation or other documents upon request, or failure to cooperate with us in the protection of our Right of Reimbursement, may result in:

- (1) Cancellation of benefits; and / or
- (2) Denial of the claim upon which our Right of Reimbursement is based.

Any such cancellation or denial shall not affect our Right of Reimbursement to the extent of any medical expenses actually paid by us.

A Covered Person agrees to keep in a segregated account that portion of any Subrogated Recovery that is equal to any benefits we have paid for the Covered Person's injuries, until our Right of Reimbursement has been satisfied. A Covered Person and / or his or her legal counsel shall promptly pay us all amounts recovered as a result of any Subrogated Recovery to the extent we have paid any medical or other expenses for that Covered Person. We have no duty or obligation to pay any legal fees or expenses incurred by such Covered Person in obtaining a Subrogated Recovery.

Should we be required to take any action to enforce our Right of Reimbursement, including, but not limited to, the filing of a civil action, we shall be entitled to recover all costs associated with such enforcement efforts. These costs include, but are not limited to, all attorney's fees and expenses incurred by us.

If necessary, we shall have the right to seek appropriate equitable relief to redress any violation of this provision by a Covered Person. Recoveries under this provision will be applied to your claim history, less any charges or fees incurred in obtaining the recoveries.

If we are unable to recover our benefits notwithstanding a Covered Person's recovery from a Responsible Party, and if the Covered Person thereafter incurs health care expenses for any reason, we may exclude benefits for otherwise covered expenses until the total amount of those health care expenses exceeds the recovery from the Responsible Party.

You may contact Highmark WV's Third Party Recoveries Department at 1-800-989-9675.

***Responsible Party.** Any individual, partnership, society, association, firm, institution, company, public or private corporation, trust, estate, syndicate, or any federal, state, county, municipal or other governmental entity or any agency thereof or any other entity or individual that may be liable for payment to a Covered Person as a result of negligence, contract or otherwise, including, but not limited to, that Covered Person's own insurance company (for example, that Covered Person's own uninsured or underinsured motorist coverage for automobile insurance, medical payments provisions or homeowners coverage).

D. WORK RELATED INJURY AND ILLNESS

This Plan does not provide benefits for a work-related injury or illness when covered under a Workers' Compensation Program. **It is your responsibility to inform the Provider of the work-related nature of the injury or illness and where appropriate, to seek benefits under any applicable Workers' Compensation Program.** If the Provider was not properly informed, or if Highmark WV paid claims more appropriately paid by Workers' Compensation, you must notify Highmark WV's Third Party Recoveries Department at the number provided above.

Highmark WV reserves the right to conduct an investigation of *any* illness or injury it has *any* reason to believe may be work-related, and to do so *before or after* claims are paid. In these situations, failure to respond to a Highmark WV inquiry or failure to otherwise cooperate with Highmark WV's investigation may result in the denial or adjustment of all affiliated claims. Highmark WV may, in its sole discretion, withhold payment unless or until the member produces a written denial of workers' compensation coverage.

VIII. General Provisions

A. HOW TO APPLY FOR BENEFITS; CLAIM FORMS

A claim must be filed for you to receive benefits. Many Providers will submit a claim for you. A claim for benefits includes any Pre-Service claims and Post-Service claims. A Pre-Service claim is any claim for benefits under your Group health plan, which requires you to contact us in advance of obtaining Provider Services. In order to qualify as a claim for benefits, it must contain certain minimum information. If certain minimum information is not included, it will be returned to the person who submitted it.

This policy does not cover claims that may be fraudulently filed, whether filed by you or a Provider. This policy will also not cover claims when premiums payable by the Group are not timely paid. Claims filed in the event of fraud or non-payment of premiums are not considered claims for benefits since there are no benefits payable under this Certificate in such circumstances.

If you need a claim form, you can obtain it from your Group or Provider. Note that Non-Participating Providers are not obligated to bill Highmark WV directly. As a result, it will be your responsibility to submit to us the claim form. If the Provider does not have the forms, we will send you one. We are not liable unless we receive written proof that Covered Services have been given to you. Proof must be given to us within one year of your receiving Covered Services or the date another payor, primary to Highmark WV, processes the claim (pays or denies). We may require medical records or other supporting documents before proof of loss is considered sufficient to determine benefits.

An Explanation of Benefits (EOB) is created for all processed claims. You will receive a paper EOB for claims for which you owe additional money, other than a copayment, and claims you file yourself. In most cases, the EOB or other notice will be mailed directly to the Certificate Holder. Certificate Holders may view EOB's at: www.mybenefitshome.com. You may also request a copy of a particular EOB or you may request to continue to receive paper EOBs through Member Services by calling the number on the back of your Highmark WV ID card.

In some limited circumstances, Highmark WV may permit an alternative recipient for the EOB if specifically requested. EOB's are available for both Custodial and Non-Custodial parents / guardians of Eligible Dependents.

B. PRE-SERVICE CLAIM CONDITIONS

1. Pre-Certification Review

Pre-Certification Review (also called Prior Authorization) is part of the determination of Medical Necessity. It is not a guarantee of coverage or payment. Payment will be dependent upon all provisions, limitations, and conditions of this Contract. A second surgical opinion may be required for the Pre-Certification process. Failure to obtain Pre-Certification for Medical Necessity may result in a complete denial or a reduction in benefits. Most Providers will call our Medical Management staff on your behalf to obtain Pre-Certification. In order to maximize your benefits, please follow up with your Provider to ensure the Pre-Certification process (Prior Authorization) has been completed.

2. Inpatient Admissions:

Prior to each admission which is not an Emergency Admission or an Admission related to childbirth, you or your Physician must contact us at least two weeks prior to the date of admission, when possible. Otherwise, you or your Physician must contact us as soon as your intended admission is known. For an Emergency Admission or an admission related to childbirth services, you or your Physician must contact us within 48 hours of the emergency admission or for lengths of stay beyond 48 hours for vaginal delivery or 96 hours for Cesarean delivery.

If you fail to contact us as required, you may be required to pay a Pre-Certification Review Penalty. The amount of the penalty is specified in Section III. This Pre-Certification Review Penalty is in addition to any other Deductibles or Copays. It is also not applied to the Network or Non-Network Coinsurance Limits.

3. **Other services that require Pre-Certification for Medical Necessity:**

- Skilled Nursing Facility Admissions.
- Post-Hospital/ other Inpatient Level of Care.
- Home Health Agency Services.
- Durable Medical Equipment.
- Rehabilitation Services.
- Clinical Trials
- Behavioral health.
- Long term acute care.
- Potentially Experimental, Investigational or cosmetic Services.
- Outpatient therapies.
- Pain Management.
- Hospice.
- Injectable drugs.
- Transplant Services.
- Out-of-Network Services.

This is not an all-inclusive list. For additional information call Customer Service or visit Highmark WV's website at www.highmarkbcbswv.com. The authorization list is located under the Provider drop-down tab.

4. **Non-Network Prior Authorization for Non-Emergency Care:**

A Network Provider can provide most Medically Necessary Covered Services. In some cases, we may determine that a Non-Network Provider can only provide certain Covered Services. The Prior Authorization of Non-Network benefits process is described below. Non-Network Prior Authorization must be completed in order for us to provide you with the higher level of benefits available for Network Providers.

After your Physician has examined you, he or she must provide us with each of the following:

- The proposed Treatment Plan.
- The name and location of the proposed Non-Network Provider.
- Copies of your medical records, including diagnostic reports.
- An explanation of why the Covered Services cannot be provided by a Network Provider.

Our determination of whether the Covered Services are available at a Network Provider will be made in accordance with uniform medical criteria. We will then notify you and your Physician if the benefits sought for Covered Services from a Non-Network Provider will be paid as if they had been provided at a Network Provider. You will be responsible for any Non-Network Liability for services received from a Non-Network Provider.

5. **Other Pre-Service**

Any other terms of this Plan that require you to notify us prior to receiving Services.

C. INITIAL CLAIMS FOR BENEFITS

1. **Pre-Service Claims**

A Pre-Service Claim is a claim for Services that has not yet been rendered and for which you are required under the Plan to contact us in advance. If your Pre-Service Claim is improperly filed, you and / or your Provider will be notified within five days of receipt of your claim. If your Pre-Service Claim is properly filed, we will notify you and / or your Provider of our decision within a reasonable time appropriate to the medical circumstances, but no later than 15 days from the receipt of the claim. We may extend this period for another 15 days if we determine it to be necessary because of matters beyond our control. In the event that this extension is necessary, you and / or your Provider will be notified prior to the expiration of the initial 15-day period as to the reasons for the extension. If additional information is needed to perfect or process the claim, we will provide you and / or your Provider with at least 45 days from receipt of the notice to provide the specified information. If we are not provided the additional requested information within the

designated time, we will complete our review based on the information we have been provided. Once we have made a decision on Services requiring prior contact, you and / or your Provider will receive notification of the decision.

2. Urgent Care Claims

An Urgent Care claim is any claim for Medical Care or Treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or Treatment that is the subject of the claim.

For Urgent Care claims, we will notify you and / or your provider of our decision as soon as possible but not later than 24 hours after the receipt of the claim by us. If we have not been provided with sufficient information to determine if the benefits are covered or payable, we will notify you and / or your Provider as soon as possible, but not later than 24 hours after receipt of the claim of the specific information necessary to complete the claim. You and / or your Provider shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours to provide the specified information.

3. Concurrent Care Claims

If we have approved an ongoing course of Treatment to be provided over a period of time or number of Treatments and then determine a reduction or termination of such course of Treatment is appropriate, we shall notify you and / or your Provider before the end of such period of time or number of Treatments that this is an Adverse Benefit Determination. Our notification will allow you and / or your Provider to request an appeal of the Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a claimant to extend the course of Treatment beyond the period of time or number of Treatments that is a claim involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies, and we shall notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim provided that any such claim is made to us at least 24 hours prior to the expiration of the prescribed period of time or number of Treatments.

4. Post-Service Claims

A Post-Service Claim is a claim for Services that already have been rendered, or where the Plan does not require prior contact with us. Claims filed as described in this Section VIII will be processed within a reasonable time, but no later than 30 days of receipt of the claim. We may extend the initial period for 15 days if we determine it to be necessary because of matters beyond our control. In the event that we utilize this extension, you and / or your Provider will be notified prior to the expiration of the initial 30-day period as to the reasons for the extension. If additional information is needed to perfect or process the claim, we will provide you and / or your Provider with at least 45 days from receipt of the notice to provide the specified information. If we are not provided the additional requested information within the designated time, we will complete our review based on the information we have been provided.

We may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. You or your Provider furnishing the specified additional information may appeal the claim.

D. APPEAL PROCEDURES FOR “ADVERSE BENEFIT DETERMINATIONS”

At any time during the appeal process, a Member may choose to designate an authorized representative to participate in the appeal process on his/her behalf. The Member or the Member’s authorized representative shall notify us, in writing, of the designation. For purposes of the appeal process, Member includes designees, legal representatives and, in the case of a minor, parents of a Member entitled or authorized to act on the Member’s behalf. We reserve the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member. Such procedures as adopted by us shall, in the case of an Urgent Care

Claim, permit a Professional Provider or Professional Other Provider with knowledge of the Member's medical condition to act as the Member's authorized representative.

At any time during the appeal process, a Member may contact the Customer Service Department at the toll-free telephone number listed on his / her Identification Card to inquire about the filing or status of an appeal.

1. Expedited Review Process for Urgent Care Claims

There is a process for an Expedited Review, which is reserved for Urgent Care claims. In such cases, you or your authorized representative (your family, your Provider or other designee) can request an Expedited Review by calling Health Care Services at the number on the back of your Identification Card. We will arrange to have the Adverse Benefit Determination reviewed by the clinical peer reviewer as soon as possible, but no later than 24 hours after we receive your request for review.

We will notify you of our coverage decision by phone and then follow in writing regardless of outcome. If the decision is adverse, you may appeal the decision via the standard appeal process as set forth below.

2. Standard Internal Appeal Process

Highmark WV maintains an appeal process involving one (1) level of review.

If a Member has received notification that a Claim has been denied, in whole or in part, the Member may appeal the decision. For purposes of this Subsection, determinations made to rescind a Member's coverage or to deny the enrollment request of an individual determined ineligible for coverage under this Agreement, can also be appealed in accordance with the procedures set forth in this Subsection. The Member's appeal must be submitted within one hundred eighty (180) days from the date of the Member's receipt of notification of the adverse decision.

The Member, upon request, may review all documents, records and other information relevant to the appeal and shall have the right to submit or present additional evidence or testimony which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of the appeal.

In reviewing your appeal, we will take into account all the information you submit, regardless of whether the information was considered at the time the initial decision was made. A new review will be completed and we will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original decision, and will not be a subordinate of the individual who made the original determination. For appeals of Adverse Benefit Determinations which were based on medical judgment, including Medical Necessity or Experimental Treatment, we will consult with a Physician or other health professional that holds an unrestricted license and has appropriate training and experience in the field of medicine involved in the medical judgment, medical condition, procedures, or Treatment under review.

If additional information is needed to perfect or process the claim, we will request the specific information from you and / or your Provider. If we are not provided the additional requested information we will complete our review based on the information we have on our files.

We will notify you and / or your Provider of our decision in writing, regardless of outcome. For Pre-Service claims, you will be notified within a reasonable time taking into account the medical circumstances, but no later than 30 days from receipt of your request for appeal. For Post-Service claims, you will be notified within a reasonable period of time, but no later than 60 days from receipt of your appeal request.

If the Plan fails to provide notice of its decision within the above-stated time frames or otherwise fails to strictly adhere to these appeal procedures, the Member shall be permitted to request an external review and/or pursue any applicable legal action.

In the event an adverse decision is rendered on the appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding the right of the Member to request an external review and / or pursue any applicable legal action.

3. External Review Process

Where the Claim that has been denied or the matter involved in the internal appeal process relates to determinations made to rescind a Member's coverage or to deny the enrollment request of an individual determined ineligible for coverage under this Agreement; or requirements as to medical necessity, appropriateness, health care setting, level of care or effectiveness of the service, a Member or a health care Provider, with the written consent of the Member, may within four (4) months from the receipt of the notification of the final decision, appeal the denial resulting from the internal appeal process. This can be done by filing a request for an external review with us. The Member should include any material justification and all reasonably necessary supporting information as part of the external review filing.

Requests for an external review may be filed at the following addresses:

For medical judgment including Medical Necessity or Experimental Treatment:

Highmark WV Blue Cross Blue Shield
ATTN: Clinical Appeals Coordinator
P.O. Box 1353
Charleston, WV 25325

For other types of appeals:

Highmark WV Blue Cross Blue Shield
ATTN: Customer Service Appeals
P.O. Box 7026
Wheeling, WV 26003

All records from the initial review shall be forwarded to an external Independent Review Organization (IRO). Additional material related to the issue which is the subject of the external review may be submitted by the Member, the health care Provider or us. Each shall provide to the other copies of additional documents provided.

Within five (5) business days of the filing of the request for an external review, we will notify the Member or the health care Provider, as appropriate, that an external review request has been filed. We shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision to the IRO conducting the external review within five (5) days of the receipt of notice that the external review request was filed. The Member or the health care Provider may supply additional written information, with copies to us, to the IRO for consideration on the external review within ten (10) days of receipt of notice that the external review request was filed.

The external review will be conducted by an IRO selected by us or as otherwise required by law. We will notify the Member or the health care Provider of the name, address and telephone number of the IRO assigned within two (2) business days following receipt of the request for assignment.

The IRO conducting the external review shall review all the information considered in reaching any prior decisions to deny payment for the health care service and any other written submission by the Member or the health care Provider.

Within forty-five (45) days of the filing of the external review, the IRO conducting the external review shall issue a written notification of the decision to us, the Member or the health care Provider, including the basis and clinical rationale for the decision.

We shall authorize any health care service or pay a Claim determined to be Medically Necessary and Appropriate based on the decision of the IRO.

Expedited External Review. If your situation meets the definition of an Urgent Care Claim, your external review will be completed as expeditiously as possible.

E. NOTICE OF ADVERSE CLAIM/APEAL DECISIONS

If a claim is denied, in whole or in part, you will receive written notice with the following information:

- The specific reason or reasons for the decision,
- Diagnosis code and procedure code (as well as descriptions of each)
- Reference to the plan provision that supports the decision,
- Descriptions of any further information required to complete the claim, and an explanation of why further information needs to be submitted,
- A description of appeal procedures and relevant time limits,
- A statement of ERISA rights (to bring a civil action), if ERISA applicable, should the claim be denied on appeal,
- A statement that Highmark WV will provide, free of charge upon request, a copy of any internal rule, guideline or protocol used to make the decision, and
- A declaration that any scientific or clinical judgment involved in the decision and applied in the circumstances, if applicable (i.e. Medical Necessity, experimental treatment, etc.), will be provided free of charge upon request.

If services are approved after appeal, payment of claims will be dependent upon all provisions, limitations, and conditions of this Contract. For instance, all Deductibles, Co-Insurance, Co-Pays and other limitations still apply.

F. PRESCRIPTION DRUG CLAIM APPEALS

You may dispute a prescription drug benefit decision by filing a claim for benefits with Highmark WV (or its designee). Such claims are subject to the procedures for initial claims for benefits and appeals described previously.

G. DESIGNATING AN AUTHORIZED REPRESENTATIVE

You have the right to designate an authorized representative to act on your or the patient's behalf in pursuing a claim or an appeal of an Adverse Benefit Determination. This authorization may be granted for a particular event or date of service after which time the authorization approval is revoked, or may be granted for any present or future claim for health care benefits you may have. You are free to designate any person to act as your authorized representative. However, in general, designations of authorized representative status for any present or future claims for health care benefits are more appropriately made to family members and other trusted persons whom you may wish to authorize to assist you in the future with health care claims matters. To initiate the designation process, contact a Customer Service Representative at the telephone number located on the back of your ID Card.

H. TREATMENT PLANS

Certain Covered Services provide benefits only when you receive care as part of a Treatment Plan approved by us. In order to maximize your benefits, your Provider must submit a Treatment Plan to us as specified in Section III. When we approve this, we will give your Provider authorization for additional Treatments or Services. The Services or number of additional Treatments authorized will depend upon the Treatment Plan. We may need to request updated Treatment Plans as your treatment progresses. If a Treatment Plan is not submitted or approved, services will be denied as not Medically Necessary. If you change Providers, a new Treatment Plan must be submitted. We will be flexible in allowing additional visits while your Treatment Plan is being prepared or under review. A Treatment Plan typically involves a written course of services and information to evaluate Medical Necessity of proposed treatment(s).

I. PREEXISTING CONDITION LIMITATIONS AND EXCLUSION PERIOD

Please refer to Section III to see if this section applies to you.

A Preexisting Condition exclusion is applied for 12 months after the earlier of the Effective Date of coverage or the 1st day of a Waiting Period, if applicable. The Preexisting Condition exclusion is applicable for conditions, regardless of the cause, for which medical advice, diagnosis, care or treatment

was recommended or received during the 6-month period ending on the earlier of the first day of coverage or the first day of any Waiting Period. This Preexisting Condition limitation exclusion period does not apply to pregnancy, if covered by this Contract. Newborn, adopted children under age 18, or children placed for adoption under age 18, are exempted from this Preexisting Condition limitation exclusion period if they are covered under this Contract within 30 days of their date of birth, adoption, or placement for adoption. These exemptions do not apply after the child has a break in coverage of 63 or more days. If you were enrolled under other Creditable Coverage prior to the earlier of the first day of coverage or the first day of any Waiting Period under this Contract, the length of time you were enrolled under the Creditable Coverage will be applied to reduce the Preexisting Condition waiting period. To qualify for this reduction in waiting period, your previous Coverage must have terminated no more than 63 days prior to the earlier of the first day of coverage or the first day of any Waiting Period under this Contract. To limit the extent of this exclusion, you should submit evidence of Creditable Coverage to us at the earliest possible time. Days of Creditable Coverage that occur before a "Significant Break in Coverage," defined as a period of 63 consecutive days during all of which the individual does not have any Creditable Coverage, will not be applied to reduce the limitation exclusion period.

J. OUR RIGHT TO REVIEW CLAIMS

When a claim is submitted, we may review it to ensure the service was Medically Necessary and all other conditions for coverage are satisfied. We will determine Medical Necessity. Highmark WV determines Medical Necessity through qualified individuals.

K. PAYMENT OF BENEFITS

1. Non-Assignability

You authorize us to make payments directly to Providers who have performed Covered Services for you.

You may not assign your right to receive payment for benefits to anyone. We reserve the right to make payment of any claim directly to you regardless of whether you assign your right to receive payment for benefits to a Provider. We are discharged from liability to the extent of such amounts paid to you for Covered Services. It is then your responsibility to pay the Provider.

2. Choice of Provider

The choice of a Provider is solely yours. Once a Provider performs a Covered Service, we will not honor your request for us to withhold payment .

3. Provider Status (Network or Non-Network; Participating or Non-Participating)

Providers are designated as Network or Non-Network. The amount of benefits that you will receive for Covered Services may vary depending on whether the Provider is in the Network. You will receive maximum benefits by seeking Covered Services from a Network Provider. Typically, you will incur higher cost sharing for Services provided by a Non-Network Provider (Non-Network Coinsurance and Non-Network Liability).

Some Providers are only designated as Participating or Non-Participating. A Participating Provider is a Provider that simply has an agreement with us regarding reimbursement for Covered Services. However, a Participating Provider may not be in the Network. Though Participating Providers have agreed to accept a Reimbursement Allowance from us as payment in full, the Participating Reimbursement Allowance may differ from the Network Reimbursement Allowance.

You will typically incur a higher Coinsurance percentage for Non-Network services (Non-Network Coinsurance). Also, you may incur an additional amount for Non-Network Liability. See the How Claims are Paid Section below and Section III for more specific details.

We have agreed to make payment directly to Participating and Network Providers for Covered Services. Therefore, you should not be required to pay for Covered Services at the time they are rendered by Participating or Network Providers other than any Deductibles, Coinsurances or Fees. Participating and Network Providers have the right to request proof that any required Deductible or other Covered Person cost sharing has been met before filing your claim with Highmark WV.

In the event these amounts have not been met, the Provider may request that you pay for the Covered Services (up to the amount of your Deductible or any required Fee) at the time Covered Services are rendered. The Participating Provider will still file a claim on your behalf to ensure the amount you paid is credited toward your Deductible and other limits.

See Section III.B for how to verify a Provider's status.

L. HOW CLAIMS ARE PAID

You are responsible for payment of any Deductibles, Fees, Coinsurances and Non-Network Liabilities required under this Contract for Covered Services received from a Provider.

1. Provider Payment and Covered Person Cost-Sharing

This coverage shares the cost of your medical expenses with you. Each Benefit Period before we start to pay, you must pay a certain dollar amount of Covered Services at a Network or Non-Network Provider, as specified in Section III. This front-end payment is your Deductible. Our records must show that you have met this Deductible. Submit copies of all your bills, even those that you must pay to meet the Deductible.

Your Deductible may be reduced by the amount applied toward your Deductible in the last three months of the previous Benefit Period. After the amount of Covered Services exceeds your Deductible, we pay a portion of the remaining balance of Covered Services during that Benefit Period. The amount that you pay is called the Coinsurance. When you receive Covered Services from a Non-Network Provider not otherwise approved by us, the amount that you pay is called the Non-Network Coinsurance. There are limits to the amount of Network and Non-Network Coinsurance for which you are responsible, unless otherwise specified in Section III. The Deductible, Network and Non-Network Coinsurance amounts are specified in Section III and will renew each Benefit Period. Some of the benefits of this Certificate have a maximum amount payable each Benefit Period. These amounts will also be included in Section III. In addition to any Deductibles and Coinsurances, you may also be responsible for a Non-Network Liability. The Non-Network Liability is not applied towards any Network or Non-Network Coinsurance limits.

Providers must bill you for all Network and Non-Network Coinsurances specified in this Contract. If a Provider does not bill you for, or waives a Network or Non-Network Coinsurance, the claim for Covered Services will be reduced by the amount that was not billed or was waived. Benefits will also be reduced by the amount that was not billed or was waived, minus the Coinsurance. Many times, claims for Covered Services are not received in the same order you received the Covered Services. The Deductible, Network and Non-Network Coinsurances will be applied in the sequence that claims are received and processed by us.

2. Non-Network Liability

In addition to those Deductibles and Coinsurances described above, you are responsible for some or all of the amounts in excess of the Reimbursement Allowance for Covered Services received from a Non-Network Provider, unless otherwise specified or approved. Your Non-Network Liability is not capped by any Deductible or Coinsurance Limits or Maximum Out-of-Pocket.

For Covered Services received from Non-Network Providers who are otherwise Participating Providers with us.

You will be responsible for the difference between the Network Provider Reimbursement Allowance and the Reimbursement Allowance with the Participating Non-Network Provider.

For Covered Services received from Non-Participating Providers

You will be responsible for the difference between the Network Reimbursement Allowance and the Non-Participating Provider's Actual Charge.

3. Out-of-Area Services

Highmark WV has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Highmark WV's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated

National Account arrangements available between Highmark WV and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Highmark WV's service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. Highmark WV's payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Highmark WV will remain responsible for fulfilling Highmark WV's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Highmark WV's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Highmark WV.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Highmark WV uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

B. Non-Participating Healthcare Providers Outside Highmark WV's Service Area

1. Member Liability Calculation

When covered healthcare services are provided outside of Highmark WV's service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Highmark WV will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, Highmark WV may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Highmark WV will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Highmark WV will make for the covered services as set forth in this paragraph.

4. Common Accident Deductible

Only one Covered Person's Deductible is required when two or more Covered Persons in a Certificate Holder's family are injured in the same accident. Covered Services must be Incurred within 90 days of the accident during the same Benefit Period.

M. HOW TO REPORT FRAUD

Fraud increases the cost of health care for everyone and increases your Group's premium. Highmark WV's Special Investigation Unit investigates allegations of fraud, waste, and abuse. Here are some things you can do to prevent fraud:

- Don't give your Plan identification number over the telephone or to people you do not know, except for your health care provider or us.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using Providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review EOBs that you receive from us.
- Do not ask your Provider to make false entries on certificates, bills, or records in order to get us to pay for an item or Service.
- If you suspect that a Provider has charged you for Services that you did not receive, billed you twice for the same Service, or misrepresented any information, do the following:
 - ❖ Call the Provider and ask for an explanation. There may be an error.
 - ❖ If the Provider does not resolve the matter, call us at 800-788-5661 and explain the situation. All reports to this number are confidential and you can remain anonymous.
- Do not maintain as a family member on your policy:
 - ❖ Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - ❖ Your child over the age specified in Section III (unless he / she is disabled and incapable of self support).
- If you have questions about the eligibility of a dependent, check with your Plan Administrator or call Customer Service.
- **You can be prosecuted for fraud and your Group may take action against you if you falsify a claim to obtain benefits or try to obtain services for someone who is not eligible or is not longer enrolled in the Plan.**

N. LIMITATION OF ACTIONS AND VENUE

No legal action may be taken to recover benefits within 90 days after a claim has been submitted. No legal action related to this Contract may be taken before the appeals process has been exhausted. In no event can legal action be brought against Highmark WV later than two (2) years after the time within which a claim is required to be submitted. Exclusive venue for any action shall be before the courts of Wood County, West Virginia.

O. NON-WAIVER PROVISION

Any failure of Highmark WV to enforce any term or condition of this Contract shall not constitute a waiver in the future of any term or condition of this Contract. Highmark WV may choose not to enforce any term or condition of this Contract. Such choice shall not constitute a waiver in the future of any such term or condition.

P. SEVERABILITY

If any portion of this Certificate shall be held invalid, illegal, or unenforceable for any reason, the remainder shall continue to be effective.

Q. GOVERNING LAW

This Certificate shall be governed and construed in accordance with the laws of the State of West Virginia, unless preempted by federal law.

IX. Definitions

Actual Charge. The amount ordinarily charged by a Provider for services. Actual Charges do not include the application of any discount, allowance, incentive, adjustment, settlement, or Provider's Reasonable Charge.

Adverse Benefit Determination. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a member's, or eligible dependent's, eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Alcoholism. A condition classified as a mental disorder and described in the International Classification of Diseases of the U.S. Department of Health and Human Services (ICD-9-CM), as alcohol dependence, abuse, or alcoholic psychosis.

Alcoholism Treatment Facility. A Facility Other Provider that provides detoxification and rehabilitation treatment for Alcoholism.

Ambulatory Medical Facility. A Facility Other Provider with an organized staff of Physicians that:

- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations;
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or Professional Other Provider; and
- Has met all state health planning and licensure requirements.

Ambulatory Surgical Facility. A Facility Other Provider with an organized staff of Physicians that:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations;
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or Professional Other Provider; and
- Has met all state health planning requirements.

Application. All questionnaires and forms required by us to determine your eligibility and insurability.

Benefit Period. The period of time specified in Section III that Deductible, Fees and Coinsurances apply for which benefits will be paid for Covered Services.

Birthing Center. A Facility Other Provider that meets the specifications and is licensed in accordance with Article 2E, Chapter 16 of the West Virginia Code. Outside of West Virginia, it is a Facility Other Provider that we recognize as a Birthing Center which:

- Has an organized staff of Physicians or nurse-midwives;
- Has permanent facilities and equipment for the primary purpose of providing prenatal, postpartum, labor, vaginal delivery, and newborn care for uncomplicated pregnancies;
- Provides treatment by or under the supervision of Physicians or nurse-midwives and nursing services when the patient is in the facility;
- Does not provide primarily Inpatient accommodations.
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or Professional Other Provider; and
- Has met all state licensure and health planning requirements.

Carry-Over Deductible Period. The period of time that any covered expense Incurred during the three months prior to the start of the Benefit Period, which we apply toward your Deductible for the next Benefit Period. This applies to individual and/or family Deductibles.

Certificate. This document, including all Riders.

Certificate Holder. An eligible employee of the Group who has been approved for coverage under the terms and conditions of the Group Contract.

Certification of Creditable Coverage. Written certification of prior health insurance coverage provided by a health insurer or employer to individuals.

Charges. See Actual Charge.

Coinsurance -a percentage of the expenses for Covered Services for which you are responsible, after the Deductible has been met and benefits for Covered Services have been paid by us as indicated in Section III.

Concurrent Care. An ongoing course of treatment to be provided over a period of time or number of treatments.

Contract (or Group Contract). The agreement (including the Group Application, individual Applications of the Certificate Holders, this Certificate, Summary of Benefits and any Riders) between your Group and us, referred to as the Group Contract or Master Group Contract.

Co-Pay. An upfront set amount that is the responsibility of the Covered Person for Office Visits and other Services as specified in Section III or on your ID Card.

Covered Service. A Provider's Service or Supply, for which we will pay as described in this Certificate, and is Medically Necessary and within generally accepted medical Standards.

Craniomandibular Disorders (CMD). Problems of the stomatognathic system, including disorders of the temporomandibular joint, muscles of mastication and the related occlusion.

Creditable Coverage. Previous health benefits provided to the Covered Person prior to application for the Contract, including: church or government plans; individual or group plans; Medicare and Medicaid; qualified health risk pools; military benefits; public health benefits; Federal Employee Health Benefits Plan; Indian Health Services; and Peace Corps.

Custodial Care. Care which is not Skilled Care or which does not require the constant supervision of skilled medical personnel including, but not limited to:

- Administration of medication, which can be self-administered or administered by a layperson with training;
- Help in walking, bathing, dressing, feeding, or the preparation of special diets;
- Assisting the patient in meeting activities of daily living;
- Care that can be taught or administered by a layperson;
- Rest care; or
- Care for someone's convenience.

Custodial Care does not include care provided for its therapeutic value in the treatment of injury, ailment, condition, disease, disorder or illness.

Day/Night Psychiatric Facility. A Facility Other Provider which is primarily engaged in providing Diagnostic Services and therapeutic services for the treatment of Mental Illness only during the day or during the night.

Deductible. The amount of Actual Charges or the Professional Allowance for Covered Services, usually stated in dollars, for which you are responsible, before we start to pay.

Diagnostic Service. A test or procedure performed when you have specific symptoms to detect or monitor your injury, ailment, condition, disease, disorder, or illness. It must be ordered by a Physician or Professional Other Provider performing within the scope of their license. These services are limited to the Diagnostic Services listed in this Certificate.

Dialysis Facility. A Facility Other Provider that mainly provides dialysis treatment, maintenance, or training to patients on an Outpatient or home care basis.

Drug Abuse. A condition classified as a mental disorder and described in the International Classification of Diseases of the U.S. Department of Health and Human Services (ICD-9-CM), as drug dependence, abuse or drug psychosis.

Drug Abuse Treatment Facility. A Facility Other Provider which provides detoxification and rehabilitation treatment for Drug Abuse.

Effective Date. 12:01 a.m. on the date when your coverage begins as indicated in the Eligibility Section of this Certificate.

Eligible Dependent (also noted as Dependent) A Covered Person other than the Certificate Holder, as shown in the Eligibility Section of this Certificate.

Emergency Admission. An admission as an Inpatient in a Hospital from a Hospital emergency room as a result of an Emergency Medical Condition such that the Covered Person is unstable and unable to be transferred to another Hospital and which, in the absence of immediate and ongoing medical attention as an Inpatient, would reasonably result in:

- Permanently placing the Covered Person's health in jeopardy;
- Serious impairment to bodily functions;
- Serious and permanent dysfunction of any body organ or part; or
- Other serious medical consequences.

Emergency Medical Condition. A condition that manifests itself by the sudden and unexpected onset of acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of any bodily part or organ. Emergency Medical Conditions include heart attacks, strokes, loss of consciousness or respiration, convulsions and other acute conditions which we determine to be a Medical Emergency only if:

- Severe symptoms occur suddenly and unexpectedly;
- Immediate care is secured; and
- The illness or condition, as finally diagnosed or as indicated by its symptoms, is one, which would normally require immediate Medical Care.

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

Enrollment Date. The date when you enroll for benefits which may precede your Effective Date in the event there is a Waiting Period but in no event it may precede the Group's Effective Date.

Experimental and Investigational - a treatment, service, procedure, facility, equipment, drug, service or supply ("intervention") that has been determined not to be medically effective for the condition being treated and therefore is considered experimental/investigative in nature. An intervention is considered to be experimental/investigative if:

1. the intervention does not have FDA approval to be marketed for the specific relevant indication(s); or
2. available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or
3. the intervention is not proven to be as safe or effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or
4. the intervention does not improve health outcomes; or
5. the intervention is not proven to be applicable outside the research setting

These criteria apply even if there is no available alternative to treat an injury, ailment, condition, disease, disorder, or illness. This determination will be made by Highmark WV, in its sole discretion, and will be conclusive.

Facility Other Provider. The following entities that are licensed, where required, and which for compensation from their patients render Covered Services. Only the following facilities are included in this definition:

- Alcoholism Treatment Center
- Ambulatory Medical Facility
- Ambulatory Surgical Facility
- Birthing Center
- Day/Night Psychiatric Facility
- Dialysis Facility
- Drug Abuse Treatment Facility
- Freestanding Renal Dialysis Centers
- Home Health Care Agency
- Hospice
- Psychiatric Facility
- Psychiatric Hospital
- Rehabilitation Facility
- Skilled Nursing Facility

Fees. See Office Visit Fees and Co-Pay.

Group Contract. See Contract

Homebound. A condition due to an illness or injury which restricts ability to leave the residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, of the assistance of another person or if the individual has a condition that leaving home is medically contraindicated (e.g. quarantined due to immunocompromised host, communicable disease).

Home Health Care Agency. A Facility Other Provider which:

- Provides Skilled Care and other services on a visiting basis for Covered Persons who are homebound; and
- Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

Hospital. An institution which meets the specifications of Article 5B, Chapter 16 of the West Virginia Code or hospital licensure laws of the state in which the facility is located.

Identification Card (ID Card). The health care card provided to you by Highmark WV, which shows your identification number.

Immediate Family. You and your spouse, parents, stepparents, grandparents, nieces, nephews, aunts, uncles, brothers, sisters, children and stepchildren by blood, marriage, or adoption.

Incurred (Incur). A charge is considered Incurred on the date the Covered Person receives the service or supply for which the charge is made.

Inpatient. A Covered Person who receives care as a registered bed patient in a Hospital or Facility Other Provider for whom a room and board charge is made.

Intensive Outpatient. Multi disciplinary, structured services (either in an approved hospital or non-hospital setting) provided at a greater frequency and intensity than routine outpatient treatment. These are generally up to three hours per day, up to five days per week. Common treatment modalities include individual, family, group and medication therapies.

Investigational. See Experimental or Investigational.

Medicaid / Medicaid Program. A state program of medical aid for low income persons established under Title XVIII of the Social Security act of 1965, as amended.

Medical Care. Professional services given by a Physician or a Professional Other Provider to treat an injury, ailment, condition, disease, disorder, or illness.

Medically Necessary (or Medical Necessity). Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) In accordance with generally accepted standards of medical practice;
- (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and
- (c) Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Medical Screening Examination. An appropriate examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency Medical condition exists.

Medicare / Medicare Program. The program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Medicare Approved. The status of a Provider that is certified by the United States Department of Health and Human Services to receive payment under Medicare.

Mental Illness. A condition classified as a mental disorder in the International Classification of Diseases of the U.S. Department of Health and Human Services (ICD-9-CM) (ICD-10-CM), excluding Drug Abuse and Alcoholism.

Network. The aggregate of all Network Providers for a Highmark WV product.

Network Coinsurance. A percentage of the Reimbursement Allowance or Actual Charge for Covered Services for which you are responsible when the Covered Services are received from a Network Provider, after the Deductible has been met and benefits for Covered Services have been paid by us as indicated in Section III.

Network Provider. The status of a Provider as designated by Highmark WV as a part of a network. It is to your financial advantage to use a Network Provider.

All Network Providers have agreed to file claims for Mountains State's Covered Persons. When you receive Covered Services from Network Providers, normally all you have to do is show your ID Card. The Network Provider will file a claim on your behalf, and will be reimbursed directly for Covered Services. A Network Provider has the right to request proof that any required Deductible, Fee or Network Coinsurance, if any, have been met before filing your claim with Highmark WV, and in the event these amounts have not been met, to request that you pay for the Covered Services (up to those amounts), at the time Covered Services are rendered. The Network Provider will still file a claim on your behalf to ensure that the amount you paid is credited toward meeting these amounts.

Non-Network. A Hospital, Facility Other Provider, Physician, or Professional Other Provider, which does not meet the definition of a Network Provider.

Non-Network Coinsurance. A percentage of the Reimbursement Allowance or Actual Charges for Covered Services for which you are responsible when the Covered Services are received from a Non-Network Provider, after the Deductible has been met and benefits for Covered Services have been paid by us as indicated in Section III.

Non-Network Liability. The amount in excess of the Reimbursement Allowance that you are responsible for when Covered Services are received, and not otherwise approved in advance by Highmark WV, from a Network Provider. The Non-Network Liability is in addition to the Non-Network Coinsurance and any other Deductible or Coinsurance for which you are responsible in your Contract. It will not be applied to any limits applicable to your Deductible, Network or Non-Network Coinsurance. The Non-Network Liability will vary depending on whether the services were received from an otherwise Participating Provider with us, though Non-Network.

For Services received from Non-Network Providers who are otherwise Participating Providers with us, this liability will be the difference between the Network Reimbursement Allowance and the Reimbursement Allowance in effect between us and the Participating, but Non-Network Provider. For services received from Non-Participating Providers, the liability will be the difference between the Network Reimbursement Allowance and the Non-Participating Provider's Actual Charge.

Non-Participating. Non-Participating Providers do not have agreements with us regarding payment for Covered Services. They are, therefore, under no obligation to file claims for you or to accept our payment as payment in full for Covered Services. Always ask your health care Providers about his / her Participating status before services are performed.

Office Visit Fee. An upfront charge, usually stated in dollars, for office visits with Physicians and Professional Other Providers.

Outpatient. A Covered Person who receives services or supplies while not an Inpatient.

Partial Hospitalization. An intensive, non-residential, level of service where Multi disciplinary medical and nursing services are required. This care is provided in a structured setting (either in an approved hospital or non-hospital setting) similar in intensity to Inpatient, requiring more than three hours per day, up to seven days per week. Common modalities include individual, family, group, and medication therapies.

Participating. Participating Providers have agreements with us regarding payment for Covered Services. However, a Participating Provider may not belong to the Network, and, as a result, you may incur a Non-Network Coinsurance and Non-Network Liability for using a Non-Network, though Participating Provider.

All Participating Providers have agreed to file claims for Highmark WV Covered Persons. When you receive Covered Services from Participating Providers, normally all you have to do is show your ID Card. The Participating Provider will file a claim on your behalf, and will be reimbursed directly for Covered Services. A Participating Provider has the right to request proof that any required Deductible, Network or Non-Network Coinsurance, or Non-Network Liability, if any, have been met before filing your claim with Highmark WV, and in the event these amounts have not been met, to request that you pay for the Covered Services (up to those amounts), at the time Covered Services are rendered. The Participating Provider will still file a claim on your behalf to ensure that the amount you paid is credited toward meeting these amounts.

Physician. A person who is qualified as a Physician under state law and licensed to diagnose, treat and perform procedures within the scope of their license.

Pre-Certification Review Penalty. An additional amount of expenses for Covered Services that you are required to pay for an Inpatient admission if you do not contact us as required in the Preadmission Certification Review Section.

Pre-existing Condition. A condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received from a Medical Care Provider within the 6-month period ending on the earlier of the first day of coverage or the first day of a Waiting Period, if applicable.

Prior Authorization. A determination made by Highmark WV that a health care Service proposed for or provided to a member is Medically Necessary. Prior Authorization may also be referred to as Pre-Certification. Prior Authorization is a determination of Medical Necessity only and does not guarantee coverage or payment.

Professional Other Provider. Persons or entities, designated by Highmark WV as Professional Other Providers or, for whose services payment would be required by law when they provide Covered Services within the scope of their licenses, including, but not limited to:

- Certified registered nurse anesthetist
- Dentist
- Doctor of chiropractic medicine
- Durable medical equipment providers
- Home infusion
- Hospice
- IV therapists
- Laboratory (must be Medicare Approved)
- Licensed practical nurse (L.P.N.)
- Licensed vocational nurse (L.V.N.)
- Mechanotherapist (licensed/certified before 11/3/1975)
- Nurse-midwife
- Physical therapist
- Physician's assistant
- Podiatrist
- Psychologist
- Psychotherapist
- Registered nurse (R.N.)
- Social worker

Provider. A Hospital, Facility Other Provider, Physician or Professional Other Provider.

Prudent Layperson. A person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought.

Psychiatric Facility. A Facility Other Provider that primarily provides Diagnostic Services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.

Psychiatric Hospital. A Facility Other Provider which is primarily engaged in providing Diagnostic Services and therapeutic services for the Inpatient treatment of Mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Psychologist. A Professional Other Provider who is a licensed Psychologist having either a doctorate in psychology or a minimum of five years of clinical experience. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

Rehabilitation Hospital. A facility, which, for compensation from its patients, is primarily engaged in providing Rehabilitation Services on an Inpatient basis. Services must be provided by, or under, the supervision of a Physician, with continuous nursing services provided under the supervision of a registered nurse.

Rehabilitation Services. Includes diagnostic tests, assessment, monitoring or treatments which are designed to remediate a patient's condition or to restore the patient to his or her optimal physical, medical, psychological, social, emotional, vocational and economic status. These services do not include services for Mental Illness, Drug Abuse, Alcoholism, vocational rehabilitation, long-term maintenance, or Custodial Care.

Reimbursement Allowance. The amount which Highmark WV has established under a fee schedule or other reimbursement methodology as the maximum allowable price it will reimburse for a particular Covered Service. This allowance is determined by Highmark WV in its sole discretion. Our payment in some agreements is fixed and unrelated to Actual Charges. Any waiver of a Fee, Deductible, Coinsurance, or Non-Network Liability by a Provider will be deemed an equivalent reduction of the Reimbursement Allowance. The Reimbursement Allowance may vary depending upon a Provider's Network or Participating status. The Reimbursement Allowance may exceed Actual Charges in some circumstances.

Residential Treatment Facility. A facility of distinct part of a facility that provides 24 hour therapeutically planned living and rehabilitative intervention environment for the treatment of disorders in the use of drugs, alcohol, other substances, and mental illness. Medical and supportive counseling services and education services are included.

Responsible Party. Any individual, partnership, society, association, firm, institution, company, public or private corporation, trust, estate, syndicate, or any federal, state county, municipal or other governmental entity or any agency thereof or any other entity who or which may be liable for payment to a Covered Person as a result of negligence, contract or otherwise, including, but not limited to, that Covered Person's own insurance company (for example, that Covered Person's own uninsured or underinsured motorist coverage for automobile insurance, medical payments provisions or homeowners coverage).

Service or Supply. A service, procedure, treatment, supply, product, drug, technology, equipment, device, setting or accommodation furnished or prescribed by a Provider. In order to qualify as a Covered Service, among other things, a Service must be within a Provider's scope of permitted practices under its applicable license.

Skilled Care. Care that requires the skill, knowledge, and training of a Physician or one of the following performing under the supervision of a Physician:

- Registered Nurse;
- Licensed Practical Nurse; or
- Physical Therapist.

In the absence of such care, the Covered Person's health would be seriously impaired. Skilled Care is care that cannot be taught to or administered by a layperson.

Skilled Nursing Facility. A Facility Other Provider that primarily provides continuous 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be given by a Physician or one of the following performing under the supervision of a Physician:

- registered nurse;
- licensed practical nurse; or
- physical therapist

A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- Custodial Care, rest, ambulatory or part-time care; or

- Treatment for pulmonary tuberculosis.

Stabilize. To provide medical treatment for an emergency medical condition necessary to assure with reasonable medical probability that no medical deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. This definition is not intended to prohibit, limit or delay the transportation required for a higher level of care than that possible at the treating facility.

Supply. See Service or Supply.

Surgery.

- The performance of generally accepted operative and other invasive procedures.
- The correction of fractures and dislocations.
- Usual and related preoperative and postoperative care.
- Other procedures as reasonably approved by us.

Temporomandibular Disorders (TMD). a group of musculo-skeletal conditions, often overlapping, that involve the temporo-mandibular joint or joints, the masticatory musculature, or both. These conditions are typically characterized by pain in the preauricular area which is usually aggravated by chewing or jaw function, and are frequently accompanied, either singularly or in combination, by limitation of jaw movement, joint sounds, palpable muscle tenderness or joint soreness. Benefits for TMD are limited to pain and dysfunction arising in and from the masticatory muscle-skeletal system.

Therapy Services. Services and supplies used to promote recovery from an injury, ailment, condition, disease, disorder, or illness. The services or supplies must be ordered by a Physician or Professional Other Provider performing within the scope of their license. These services and supplies are limited to the Therapy Services listed in this Contract.

Treatment(s). When a Covered Service is limited to a maximum number of Treatments, Treatment refers to each individual service that can be billed by a Physician, Professional Other Provider, Hospital, or Facility Other Provider under a separate procedure code. When more than one Treatment is provided during one Visit to a Physician, Professional Other Provider, Hospital, or Facility Other Provider, each Treatment billed under a separate procedure code will be counted toward any maximum number of Treatments that applies to that particular service. See Section III in this Certificate for maximums that apply to Covered Services.

Treatment Plan. A written course of services and information (which includes, but not limited to the name, address, phone, Date of Birth, ID number, Plan information, preliminary diagnosis, plan of action, place/type of therapy/service, medication, referral(s) to other providers, length of treatment, prognosis, goals, expected outcome, follow up activities, etc.) to evaluate medical necessity of proposed treatment(s).

Urgent Care. Medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment.

Visit(s). When a Covered Service is limited to a maximum number of Visits, Visit refers to one session or appointment with a Physician, Professional Other Provider, Hospital, or Facility Other Provider, regardless of the number of Treatments or services provided during that Visit. See Section III of this Certificate for maximums that apply to Covered Services.

Vocational Rehabilitation. The process of facilitating an individual in the choice of, or return to, a suitable situation. When necessary, assisting the individual to obtain training for such a vocation. Vocational training can also mean preparing an individual regardless of age, status, or physical condition to cope emotionally, psychologically, and physically with changing circumstances in life, including remaining at school or returning to school, work, or work equivalent.

Waiting Period. The period that must pass before an individual, employee or Eligible Dependent is eligible to enroll under the terms of the plan.

X. Preferred Prescription Drug

Note: The Prescription Drug Coinsurance is separate and does not apply to the health care coverage Deductible, Coinsurance Limits and the Maximum Out-of-Pocket. The terms and conditions of Sections I through IX shall apply to this Section X. In the event of a conflict, Section X shall control.]

A. PRESCRIPTION DRUG BENEFITS. See Section III for specifics or exceptions to the following.

If you need more information on specific Prescription Drug coverage under your Plan, please contact Highmark WV at the phone number or the internet address shown on your ID Card. You must pay a certain percentage or dollar amount for each Medically Necessary Prescription Order or Refill. This payment is referred to as your Prescription Drug Coinsurance. The Prescription Drug Coinsurance for Prescription Drugs received from Network Pharmacies is indicated in Section III.

Under the Network Prescription Drug Program, **you must utilize Network Pharmacies to receive benefits.** All Prescription Drugs must be prescribed by a Physician or Professional Other Provider and dispensed for your use as an Outpatient.

Except as otherwise directed on the Prescription Order by the Physician or Professional Other Provider, **if you request a Brand Name Prescription Drug when a Generic Prescription Drug is available, you will be required to pay the difference between the Prescription Drug Allowance for the Generic Prescription Drug and the Prescription Drug Allowance for the Brand Name Prescription Drug in addition to the Prescription Drug Coinsurance.** You will not have to pay the difference if no Generic Prescription Drug exists or if your Physician or Professional Other Provider states 'Brand Necessary'(Dispense as written, DAW) on the Prescription Order.

You may dispute a decision made by a Pharmacy concerning coverage and amount of payment by filing a claim for benefits with Highmark WV (or its designee). Such claims are subject to the procedures for initial claims for benefits and appeals described in Section VIII.

We may receive financial credits, rebates, discounts or other payments from Prescription Drug manufacturers. We retain these amounts for our use. We are not required to pass on to you and we do not pass on to you any such credits, rebates, discounts or any other such payments. These amounts are not considered in determining the Prescription Drug Allowance, the Prescription Drug Coinsurances or any other cost sharing amounts that you are required to pay.

1. Prescription Drugs and Refills received from a Network Retail Pharmacy. Refer to your Pharmacy Benefit Brochure for more specific details. For example, necessary phone numbers, procedures and services provided to you.

If a Medically Necessary Prescription Drug is filled through a Network Pharmacy, you simply present your ID Card to the Pharmacy and pay only the Prescription Drug Coinsurance.

You may review the Network Pharmacy List by contacting Highmark WV. The phone number and internet address are located on your ID card.

If you receive medications from a Network Pharmacy and present your ID card, you will not have to file a claim. If you forget your ID card when you go to a Network Pharmacy, the Pharmacy may ask you to pay in full for the prescription.

The procedure is simple. Just take the following steps:

- **Know Your Benefits.** Review this information to see if the services you received are eligible under your prescription program.
- **Get an Itemized Bill.** Itemized bills must include:
 - The name and address of the pharmacy provider;

- The patient's full name;
- The date of service or supply or purchase;
- A description of the service or medication/supply;
- The amount charged;
- Drug and medicine bills must show the prescription name and number and the prescribing provider's name.

Please note: If you've already made payment for the services you received, you must also submit proof of payment (receipt from the provider) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

- ***Copy Itemized Bills.*** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.
- ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. *Claim forms are available from your employee benefits department, or call the Customer Service telephone number on the back of your ID card.*
- ***Attach Itemized Bills to the Claim Form and Mail.*** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

Remember: Multiple services or medications for the same family member can be filed with one claim form. However, a separate claim form must be completed for each member.

Your claims must be submitted no later than the end of the benefit period following the benefit period for which benefits are payable.

2. Prescription Drugs and Refills received from a Non-Network Retail Pharmacy

No coverage is provided when Prescription Drugs are filled through a Non-Network Pharmacy. You are responsible for paying the Non-Network Pharmacy the full cost of the Prescription Drugs.

3. Home Delivery (Mail Order) Prescription Drug Benefits Important Note: Mail Order Prescription Drug Benefits are only available if indicated in Section III. Refer to your Pharmacy Benefit Brochure for more specific details.

For each Medically Necessary Mail Order Prescription Order or Refill, you must pay a certain percentage or dollar amount. This payment is referred to as your Mail Order Prescription Drug Coinsurance. The Prescription Drug Coinsurance for Mail Order Prescription Drugs is indicated in Section III.

All Mail Order Prescription Drugs and Refills must be prescribed by a Physician or Professional Other Provider. They must be dispensed for your use as an Outpatient.

a. Using the Mail Order Service for the first time

You may request a new prescription by mail, fax, or through the internet.

- ***Requests for New Prescriptions by mail.***
Ask your Physician or Professional Other Provider to write a new prescription for the maximum supply allowed by your Plan, plus refills (if appropriate) for up to one (1) year. Mail the new prescription(s), along with the form provided in your mail order packet to the address provided on the form.

- Requests for New Prescriptions by fax.
If you decide to order by fax, ask your Physician or Professional Other Provider to write a new prescription for the maximum supply allowed by your Plan, plus refills (if appropriate) for up to one (1) year. Give your Physician or Professional Other Provider your member ID number from your ID Card. Please ask your Physician or Professional Other Provider to call the phone number listed on your ID card.
- Requests for New Prescriptions online.
Refer to your packet for the internet address and how to register and order online.

Your medication will generally be delivered to your home within 7 to 11 days *after* you mail your order. Orders placed through the internet, telephone or fax may be received faster. Standard shipping is free. A Generic Prescription Drug will be dispensed unless a Brand Name Prescription Drug is requested by your Physician or Professional Other Provider or if a Brand Name Prescription Drug is not available.

b. Refilling your Prescription

Important Note: To make sure that you don't run out of your medication, remember to reorder 14 days before your medication runs out. You can find the refill date on the refill slip that comes with every order.

You may use the refill and order forms that will accompany your initial order. Mail the form also with your Prescription Drug Coinsurance in the return envelope.

You may also phone and use the automated refill system. Should you choose to call, have your member identification number (which is on your ID Card), the prescription number and your credit card number available.

You may also request refills online. Refer to your packet for the internet address and how to refill your order.

c. Paying for your Prescription

You may pay by debit card, credit card, check or money order.

B. FORMULARY

1 Covered Drugs (Open Formulary)

Covered drugs include;

- Those which, under Federal Law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription;"
- Legend drugs under applicable state law and dispensed by a licensed pharmacist;
- Prescription drugs listed in your program's prescription drug formulary including compounded medications, consisting of the mixture of at least two ingredients other than water, one of which must be a legend drug that requires a pharmacist dispenses it);
- Prescribed injectable insulin;
- Diabetic supplies, including needles and syringes; and
- Certain drugs that may require prior authorization.

Insulin syringes, needles, and/or selected disposable diabetic testing materials will be covered by the same coinsurance as the insulin, if dispensed in days supply corresponding to the amount of insulin dispensed. Insulin syringes, needles and/or disposable diabetic testing material dispensed without insulin will require coinsurance when dispensed.

C. RETAIL AND MAIL ORDER PRESCRIPTION DRUG MANAGEMENT

1. Preauthorization

The prescribing physician must obtain authorization from us prior to prescribing certain prescription drugs. The specific drugs or drug classifications which require preauthorization may be obtained by calling the toll-free Member Service telephone number or accessing the internet address appearing on your ID card.]

2. Managed Prescription Drug Coverage

A prescription order or refill which may exceed the manufacturer's recommended dosage over a specified period of time may be denied when presented to the pharmacy provider. The managed prescription drug coverage (MRxC) program also consists of online edits that encourage the safe and effective use of targeted medications.

We may contact the prescribing physician to determine if the prescription drug is medically necessary and appropriate. If it is determined by us that the prescription is medically necessary and appropriate, the prescription drug will be dispensed.

3. Quantity Level Limits

Quantity level limits may be imposed on certain prescription drugs. Such limits are based on the manufacturer's recommended daily dosage or as determined by us. Quantity level limits control the quantity covered each time a new prescription order or refill is dispensed for selected prescription drugs. Each time a prescription order or refill is dispensed, the pharmacy provider may limit the amount dispensed.

D. EXCLUSIONS AND LIMITATIONS SPECIFIC TO PRESCRIPTION DRUGS

In addition to the exclusions in Section VI, we do not provide benefits for the following services, supplies, or Charges.

1. Therapeutic devices or for artificial appliances.
2. Prescription Drugs that are received as an Inpatient.
3. Hypodermic needles, syringes or comparable devices, unless stated as Covered Services.
4. Fees for administering or injecting Prescription Drugs.
5. More than a 34-day supply of a Retail Prescription Drug.
6. Charges for more than a 90-day supply of a Maintenance Prescription Drug through the Home Delivery (Mail Order) program.
7. Any Prescription Refill dispensed more than one year after the date of the original Prescription Order.
8. A Prescription Drug which is entirely consumed or administered at the time and place where the Prescription Order is issued.
9. Drugs you can buy without a Prescription Order.
10. Over the counter medications other than certain preventive drugs and only if prescribed in accordance with any State or Federal mandates.
11. Prescription Drugs dispensed for cosmetic purposes that are used solely for beautifying or altering one's appearance in the absence of any underlying injury, ailment, condition, disease, disorder or illness.
12. More than the number of Prescription Refills specified by a Physician or Professional Other Provider.
13. Prescription Drugs for the Treatment of obesity or for weight reduction.
14. Prescription Drugs that are Experimental or Investigational for a given Treatment, as determined by us.

15. Prescription Drugs not specified as Covered Services or which are specifically excluded in the text.
16. Prescription Drugs that are determined to be not Medically Necessary.

DEFINITIONS

Brand Name Prescription Drug. A Prescription Drug that has been patented and is only produced by one manufacturer.

Contracting Mail Order Pharmacy. A Pharmacy which dispenses Prescription Drugs through the mail and which has a direct contractual obligation with us or our designee to provide these services.

Formulary. A list of Prescription Drugs that are Preferred Drugs.

Generic Prescription Drug. A Prescription Drug that is produced by more than one manufacturer. It is chemically the same and generally costs less than a Brand Name Prescription Drug.

Minimum Coinsurance. The minimum fixed dollar amount that you must pay for each Prescription Order or Refill. The Minimum Coinsurance fixed dollar amount is always compared to the Prescription Drug Coinsurance amount you would be required to pay based on the percentage of Prescription Drug Allowance that you are required to pay. You must pay the higher of the two amounts.

Non-Network Pharmacy. Any Pharmacy that is not a Network Pharmacy.

Open Formulary. A Prescription Drug program that pays benefits on one or two levels. If there are two levels of benefits, Prescription Orders filled with Generic Prescription Drugs usually receive the highest level of benefits. Brand Name Prescription Drugs usually receive the next level of benefits.

Pharmacy. A licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable law.

Network Pharmacy. A Preferred Pharmacy is a Pharmacy that has an agreement with us or our designee to provide the Covered Services and to collect from the Covered Person, only the Prescription Drug Coinsurance amount indicated in Section III.

Preferred Drug. A Prescription Drug that has been determined to be safe, effective and most cost effective in relation to its clinically equivalent counterparts.

Prescription Drug. Subject to your Plan's exclusions and limitations, a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is a Medically Necessary Covered Service. Prescription Drugs include a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Prescription Drug Allowance. An amount that we consider to be reasonable payment for a Prescription Drug considered to be a Covered Service. The Prescription Drug Allowance for Prescription Drugs from Network Pharmacies or Contracting Mail Order Pharmacies is the amount charged to you by the Network Pharmacy or the Contracting Mail Order Pharmacy. For Non-Network Pharmacies, the Prescription Drug Allowance is the amount that we consider to be a reasonable payment for a Prescription Drug.

Prescription Drug Coinsurance. The percentage of the Prescription Drug Allowance for a Prescription Order or Refill or fixed dollar amount listed in Section III, which you must pay for each Prescription Order or Refill.

Prescription Order or Refill. The directive to dispense a Prescription Drug issued by a Physician or Professional Other Provider whose scope of practice permits issuing such a directive.

XI. Statement of ERISA Rights

If this Plan qualifies as an ERISA Plan, as a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

A. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age III) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

B. CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your Enrollment Date in your coverage.

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

D. ENFORCE YOUR RIGHTS

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is

denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XII. Plan Information

If this Plan qualifies as an ERISA Plan, you may request the following information from your Plan Administrator:

Plan Year

Name of Plan

Name & Address of the Employer

Plan Sponsor's Employer Identification Number (EIN)

Plan Number

Type of Welfare Plan

Type of Administration of the Plan

Name, Business Address, and Business Phone Number of the Plan Administrator

Name, title and address of the principal place of business of each trustee of the Plan, if applicable.

Name of person designated as agent for service of legal process.

Participant eligibility requirements & conditions for receiving benefits.

Plan's right to terminate or amend the benefits.

Information regarding your health insurer or benefits administrator.

How Plan is Funded

Financial Plan Year

Sources/Methods of Contributions

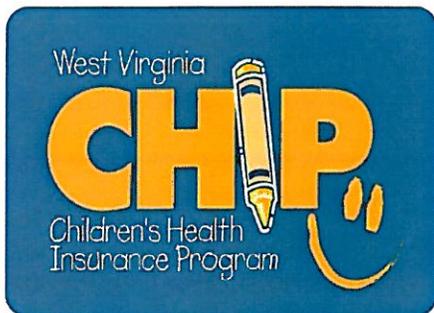


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WV Children's Health Insurance Program Dental Provider Guide 2012-2013



Precertification: 1-800-356-2392, Option 3

WVCHIP Helpline 1-877-982-2447

www.chip.wv.gov

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DEAR DENTAL PROVIDER:

IMPORTANT!

You assure dental access to kids by updating our website.

Since passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA) in 2009, all CHIP and Medicaid programs are required to provide an electronic list of dental providers to post on a public website. The listing helps CHIP members identify local dental providers who are available to provide services.

The initial posting of an electronic list was on the **InsureKidsNow.gov** website in August 2009. In the past our state maintained unpublicized lists so we could help refer members to a dentist who participates in CHIP and/or Medicaid in their local area. An electronic list now allows the public to access this information and dental practices can show if they are currently accepting new CHIP and/or Medicaid patients.

TO PROVIDE PRACTICE UPDATES:

*Please review your listing on the **InsureKidsNow.gov** website. Copy and fill out the form in Appendix A of this Manual if any information has changed, such as adding a new provider to your practice, change of address, phone number, or if anyone left your practice or retired. Fill in all areas of the form, and fax to WVCHIP office at (304) 558-2741.*

ACCEPTING NEW PATIENTS?

Since many dental providers offer CHIP and/or Medicaid services to a limited number of CHIP/Medicaid patients, please review the section that shows whether you currently accept new patients. **We update this list on a quarterly basis.** These regularly scheduled updates will encourage more complete and accurate listings of actively practicing dentists to assure the best possible access for children and families of our state.

For any questions regarding this notice, please contact Candace Vance, Health Benefits and Claims Analyst at (304) 957-7863. Thanks for helping children and families by providing up-to-date information on dental services in the quickest and most convenient way!

DENTAL SERVICES

The WVCHIP Benefit Plan covers a full range of health care services, including dental care. WVCHIP member families receive a copy of the Summary Plan Description (SPD) each July and upon enrollment in the program. The SPD provides information on benefits, requirements for coverage, and cost participation required by the family. The dental benefits plan year begins on January 1st and ends on December 31st each year. Benefit maximums and coverage of services is determined based on the Plan Year. Also, some dental services require precertification before the plan will cover them.

Most dental services require no copays, but **WVCHIP Premium members have \$25.00 copays for most non-preventive dental procedures with maximum copays of \$100.00 per member per benefit year and a \$150.00 maximum per family per benefit year. Families are informed that they have met their maximum copayment amount on the Explanation of Benefits (EOB) form. Providers can also check on copay status by calling HealthSmart (formerly Wells Fargo, TPA) at 1-800-35-2392. A Note About Dental Copayments - Unlike most copayments that are assessed per visit, dental copayments are **per service category**.** Therefore, if two procedures requiring copayments are completed during a visit, the total copayment paid by the family is \$50.00.

New Medical Oral Health Infant Program: Effective October 1, 2011, the West Virginia Children's Health Insurance Program (WVCHIP) began reimbursing primary care providers for the application of fluoride varnish to children ages six (6) months to under 36 months (3 years) who are at high risk of developing dental caries. To be eligible for payment of this service, providers must be certified through training for fluoride varnish application offered by the West Virginia University School of Dentistry. WV Medicaid is expected to add this benefit in January 2012. The medical professional must complete the program in two sequential phases. Phase 1 consists of an on-line training, and Phase 2 consists of a live, face-to-face training led by an Oral Health Champion (dentist and/or dental hygienist). The cost of Phase 1 is \$40 and can be accessed by going to <http://dentistry.hsc.wvu.edu/Oral-Health/WVInfantOH>. Once Phase 1 is successfully completed, WVU School of Dentistry will facilitate scheduling of Phase 2. Phase 2 will be conducted in the local area where the primary care provider practices, preferably in their office or possibly at another local venue.

The application of the fluoride varnish should include communication with and counseling of the child's caregiver, including a referral to a dentist. WVCHIP allows coverage for two fluoride varnish applications per year (one every six months). The first application must be provided and billed in conjunction with a comprehensive well-child exam. If you know of a physician who is interested in providing this service, please refer them to www.hsc.wvu.edu/sod/oral-health for more information regarding the required training. For more information, please refer to the

Dental Services (cont.)

Medical Infant/Child Health Program Fluoride Varnish by Primary Care Practitioners WVCHIP Coverage Policy found at our web site at www.chip.wv.gov.

WVCHIP ENROLLMENT GROUPS

A member card is issued within 15 days of the child's enrollment in WVCHIP or after any change in coverage. This card is used for medical, dental and prescription drug coverage and is effective the full 12 months that a child is enrolled and covered by the WVCHIP unless coverage ends. Duplicate cards are issued when a card is reported lost, stolen or damaged.

The enrollment group is marked on the insurance card. All children insured under WVCHIP participate in some level of cost sharing (copayments and premiums) that is indicated by the enrollment group. Each card shows the insured child's name and identification number.

WVCHIP Gold Plan – No dental copayments; no deductibles

WVCHIP Blue Plan – No dental copayments; no deductibles

WVCHIP Premium – \$25.00 copayments for some dental procedures, with maximum copayments of \$100.00 per child per benefit year or \$150.00 per family per benefit year. Please refer to the Appendix B for procedures that require copayments.

NOTE: WVCHIP members that are registered under the federal exception for Native Americans or Alaskan Natives have NO cost sharing, regardless of their enrollment group.

Diagnostic, Preventive and other Dental Services that do **NOT** require precertification

The passage of the Children's Health Insurance Reauthorization Act (CHIPRA) in 2009 mandated that CHIP cover dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

The following dental procedures are covered by WVCHIP and require no precertification unless benefit maximums are exceeded:

Preventive/Diagnostic: Covered 100% - no copayment

- ◆ Dental examinations every six months
- ◆ Cleaning every six months
- ◆ Fluoride treatment every six months
 - D1203 - Topical application of fluoride – child
 - D1204 - Topical application of fluoride – adult
 - D1206 – Topical fluoride varnish; therapeutic application for moderate to high caries risk patients
- ◆ Bitewings every six months
- ◆ Full mouth x-rays every 36 months (Panorex)
 - It is the member's responsibility to provide x-rays for any consults ordered or for additional services ordered from a new dental provider if the plan has already covered the maximum amount during the benefit year
- ◆ Sealants
 - Ages 2-6 if indicated on primary molars
 - Ages 6-12 on 1st permanent molars
 - Ages 12-18 on 2nd permanent molars
- ◆ Treatment of abscesses, including initial office visit and follow-up
- ◆ Analgesia
- ◆ IV/Conscious Sedation
- ◆ Other x-rays (covered in connection with another service)
- ◆ Consultations
- ◆
- ◆ Space Maintainers

Restorative: *

- ◆ Fillings as needed

Diagnostic, Preventive and Other Dental Services that do NOT require precertification (cont.)

Endodontics/Root Canals: *

- ◆ Pulpotomy
- ◆ Root canals

Surgery/Extractions: *

- ◆ Simple extractions
- ◆ Extractions – impacted (covered under medical and requires PA if performed as outpatient procedure)
- ◆ Extractions related to an abscess and root canal therapy
- ◆ Removal of dental related cysts under a tooth or on a gum, including x-rays needed to diagnose the condition
- ◆ Frenulectomy (frenectomy or frenotomy)
- ◆ Biopsy of oral tissue

Other Basic Covered Services: *

- ◆ Analgesia
- ◆ IV/Conscious Sedation
- ◆ Palliative Treatment
- ◆ Other X-rays (covered in connection with another covered service)
- ◆ Consultations

*** WVCHIP Premium Copays apply to these categories.**

Dental Services Requiring Precertification

The services listed below are covered when medically necessary and approved through the precertification process. Please call HealthSmart (formerly Wells Fargo TPA) at **1-800-356-2392 (choose Option 3)**, prior to performing the service to assure it will be covered. **If the precertification request is denied, WVCHIP will not cover the cost of the procedure.**

Dental Services Requiring Precertification (cont)

Note: *Retrospective review is available for WVCHIP members in instances where it is in the dental practitioner's opinion that a procedure that requires precertification is medically necessary and per recommended dental practices, and that delaying the procedure may subject the member to unnecessary or duplicative service, or will negatively impact the member's condition. In these instances, a request for precertification MUST be made by the provider within 10 business days of the date the service is performed. If the procedure does NOT meet medical necessity criteria upon review by HealthSmart (formerly Wells Fargo) then the precertification request will be DENIED and WVCHIP will not reimburse the provider for the service. Precertification DOES NOT assure eligibility or payment of benefits under this Plan.*

Prosthodontics *

- ◆ Complete dentures (including routine post-delivery care)
- ◆ Partial dentures (including routine post-delivery care)
- ◆ Adjustments to dentures
- ◆ Repairs to complete dentures
- ◆ Repairs to partial dentures
- ◆ Denture rebase procedures
- ◆ Denture relines procedures

Restorative/Periodontics Services *

- ◆ Dental crowns- 1 every 5 years
- ◆ Gingivectomy or gingivoplasty – 1 per quadrant/per year
- ◆ Osseous surgery – 1 per quadrant/per year
- ◆ Periodontal scaling and root planing – 1 per quadrant/per year
- ◆ Full mouth debridement – 1 every 6 months
- ◆ Orthognathic surgery
- ◆ Prosthodontics – covered for certain medically necessary conditions
- ◆ **Accident Related Dental Services:** The Least Expensive Professional Acceptable Alternative Treatment (LEPAAT) for accident-related dental services is covered when provided within six (6) months of an accident and required to restore damaged tooth structures. The initial treatment must begin within 72 hours of the accident. Biting and chewing accidents are not covered. Services provided more than six (6) months after the accident are not covered.
Note: For children under the age of 16, the six-month limitation may be extended if a treatment plan is provided within the initial six months and approved by Wells Fargo.

Dental Services Requiring Precertification (cont)

Emergency Dental Services: Medically necessary adjunctive services that directly support the delivery of dental procedures, which, in the judgment of the dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care to patients with medical, physical or behavioral conditions. These services include but are not limited to sedation, general anesthesia, and utilization of outpatient or inpatient surgical facilities. Contact HealthSmart (formerly Wells Fargo) for more information.

Orthodontic Services: (*) Orthodontic services are covered if medically necessary for WVCHIP members with malocclusion that create disabilities and/or impair their physical development. Coverage is not automatic and service must be precertified by HealthSmart (formerly Wells Fargo). Orthodontic coverage is limited to services medically necessary to correct dento-facial anomalies. The following conditions will be considered for coverage with supporting documentation:

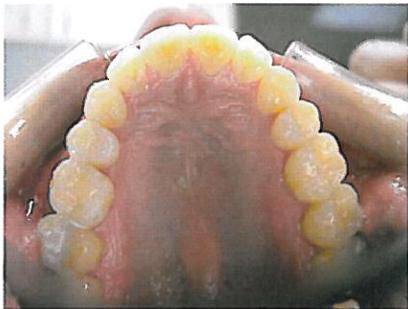
- Member with syndromes or craniofacial anomalies such as cleft palate, Alperst Syndrome or craniofacial dysplasia
- Severe malocclusion associated with dento-facial deformity (e.g. a patient with a full tooth Class II malocclusion with a demonstrable impinging overbite into the palate)

A standard American Board of Orthodontics (ABO) series of photographs, including 3 extra-oral and 5 intro-oral views (see examples on Page 9) must be submitted with all requests for precertification. Requests for precertification submitted with photographs that are not of diagnostic quality will be returned without review. Failure to submit any of the following documentation will result in a denial of the request for orthodontic services:

- Panoramic Film
- Cephalometric Tracing
- Cephalometric X-ray
- Photographs – A standard series of 5 Intra and 3 Extra Oral photographs that meets the American Board of Orthodontics standards
- Treatment Plan, including findings, diagnosis, prognosis, length of treatment, and phases of treatment

Precertification requests that are denied by initial review may be appealed. Upper and lower study casts trimmed to the correct occlusion may be requested for a second level review. Failure to trim study casts to correct occlusion will delay decision.

Examples of AAO Photographs (extra-oral and intro-oral)



DR. ORTHODONTIST, D.D.S.
123 MAIN STREET
ANYTOWN, WV 12345
(555) 555-1212

PATIENT: JANE DOE
DATE: JANUARY 1, 2011
RECORDS: FINAL
AGE: 29



**Precertification from Wells Fargo assures that the claim will be paid when submitted EXCEPT when a child has disenrolled from the plan on or before the date of service. If the request for precertification is denied, families will be responsible for paying for the procedure if the child has it.*

Note: Comprehensive orthodontic treatment is payable only once in the member's lifetime.

Dental Services Not Covered

- ◆ Treatment of temporomandibular joint (TMJ) disorders
- ◆ Intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for TMJ not caused by disease or physical trauma
- ◆ Antibiotic Injections
- ◆ Tests/Lab Exams
- ◆ Onlays/Inlays
- ◆ Orthodontic services for cosmetic purposes
- ◆ Gold Restorations
- ◆ Precision Attachments
- ◆ Replacements of crowns (covered once every 5 years)
- ◆ Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances
- ◆ Charges for copies of member records, charts or x-rays, or any costs associated with forwarding/ mailing copies of members records, charts or x-rays
- ◆ Fees submitted by a dentist which is for the same services performed on the same date for the same member by another dentist
- ◆ Duplicate, provisional and temporary devices, appliances and services
- ◆ Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan
- ◆ Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it
- ◆ Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners
- ◆ Fabrication of athletic mouth guard
- ◆ Dental implants and related services
- ◆ Experimental/ investigational or services for research purposes
- ◆ Splinting
- ◆ Out of state providers unless prior approval is obtained
- ◆ Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law
- ◆ Telephone consultations
- ◆ **Any charges/services that are covered in whole or in part by another plan**
- ◆ Any other procedure not listed as covered

Timely Claims Filing

Dental claims must be filed within **six months** of the date of service. Claims not submitted within this period will not be paid, and WVCHIP will not be responsible for payment.

Members are responsible for presenting the appropriate member card indicating coverage at the time of service. Members are responsible for payment for service if they neglect to provide the appropriate member card for coverage that causes the provider to miss the timely claims filing limitations.

Claims Filing Instructions

Instructions to the Dentist:

1. Prior to commencement of treatment, compile a treatment plan describing treatment and corresponding fees and submit to HealthSmart (formerly Wells Fargo Third Party Administrators, Inc.) for predetermination of benefits.
2. If treatment plan includes crowns or bridgework, please include mounted x-rays.

Submit all claim forms and invoices to the address below.

HealthSmart (formerly known as Wells Fargo, TPA)
P.O. Box 2451
Charleston, WV 25329-2451
Toll Free: 304-353-7820 or toll free 800-356-2392
Fax: 304-353-8716

Appealing Health Services

Appeal Process

Each WVCHIP member and provider is assured a right to have a review of health services matters under this Plan. Health services matters may include (but are not limited to) such issues as correct or timely claims payment; a delay, reduction, a denial of a service, including pre-service decisions; and suspension or termination of a service, including the type and level of service. This same process can apply to prescription drugs or supplies available through the Plan.

Exception from Review: WVCHIP does not provide a right to review any matter whose only satisfactory remedy or decision would require automatic changes to the program's State Plan, or in Federal or State law governing eligibility, enrollment, the design of the covered benefits package that affects all applicants or enrollees or groups of applicants or enrollees, without respect to their individual circumstances.

WVCHIP assures the right of appeal in three steps or levels, except for emergencies, as described below.

1st level: The member, provider or representative must start the process within 60 days of learning of the denial of payment for service.

To start the appeal process, contact HealthSmart (formerly Wells Fargo [contact information on page 11]) to explain the issue. This allows them to review the issue and present information concerning actions they have taken (such as a benefit limit, timely filing issue, etc.). In most cases, they will give the needed information on the date of this phone contact. They will give a response no later than 7 days after the initial phone contact with them.

Appealing Health Services (Cont)

2nd level: If the information the member or provider receives after taking the first step does not resolve the issue, the member or provider must take it to this next step within 30 days after the 1st level response.

The member or provider must write a letter explaining the problem and why there is continued disagreement with the information or response at the 1st level. All information pertinent to the appeal must be included with the request:

1. a written statement explaining the issue
2. all copies of supporting documents or statements that have been provided about the issue
3. a copy of the denied claim (the Explanation of Benefits) and/or written statement provided to either the member or provider by HealthSmart (formerly Wells Fargo TPA)
4. Appeal letters in Level 2 should be mailed to:

Incorrect Payment, Dental
Timely Filing, Dental

HealthSmart (formerly Wells Fargo TPA)
P.O. Box 2451
Charleston, WV 25329
1-800-356-2392

A written response will be issued within 30 days. For payment issues the claim will be reprocessed for payment if that is the proper resolution. For all other issues, a letter explaining the actions they are prepared to take, or the reasons for their action with respect to benefits (an Explanation of Benefits).

Appealing Health Services (Cont)

3rd level: After receiving the written response, the member or provider may appeal this decision to a third step review by requesting that the Executive Director review the Level 2 case file. Copies of all written statements of facts, issues, letters and relevant information provided in the case file must be mailed to:

**WVCHIP
Executive Director
2 Hale Street, Suite 101
Charleston, West Virginia 25301**

Within 30 days, the Director will send a written decision which takes into account all written materials provided by both parties at Level 3. The decision will explain whether the actions taken at Level 2 will be upheld or changed. If the issue of appeal is about clinical or medical matters, the Executive Director may consider a review by the consulting Medical Director.

Total Time Limit for the Appeal Process

Many appeals are decided within thirty (30) days; however, any appeal must be completed within ninety (90) days from the date of the initial phone contact to the issuance of a written decision at Step 3.

IMPORTANT NOTE: Emergency Medical Condition Process

In cases when the standard time frame could jeopardize the health or life of a member, an expedited review process may take place within 72 hours (or up to a maximum of 14 days, if the member requests an extension). After starting Level 1, and making a written notice by facsimile copy of a request for an emergency review, you may go directly to Level 3 for resolution.

Sample Member Cards

HealthSmart
BENEFIT SOLUTIONS

Medical & Prescription Drug Card

Member

CHIP

Group #: 7771
WVCHIP GOLD
Member: JOHN SAMPLE
Member ID: SMPL0001

Medical Plan

Aetna Signature Administrators' PPO
By **aetna**

www.aetna.com/asa

Medical Copays:
Non-Well Visits: \$5. Inpatient Services: \$0 per admit.
Outpatient Services: \$0 per service. Emergency Room: \$0 per visit. Dental Services: \$0. Preventive: \$0.

Pharmacy Plan

RxBIN: 003858
RxCPCN: A4
RxGRP: WVCA

EXPRESS SCRIPTSSM

Express-Scripts.com
Pharmacist use only: 800-824-0898
Member Customer Service: 877-256-4680

\$0 for generic \$5 for brand

1072 1072 WV-7771-1--- M(0) D(0) V(0) 0EF9
*0*20120504T09J0210000000010002000110
Env [1] 2 of 1 Carrier [1]



J021
1072 WV-7771-1--- M(0) D(0) V(0) 0ADA
*0*20120504T09J0210000000010002000110
Env [1] 2 of 1 Carrier [1]

Claims Submission

Please submit claims to:
EDI: ID# 87815
Mail: HealthSmart Benefit Solutions
PO Box 2451
Charleston, WV 25329-2451

Aetna participating doctors and hospitals are independent providers and are neither agents nor employees of Aetna.

Please submit Pharmacy claims to:
Express Scripts
P.O. Box 66583
St. Louis, MO 63166

Process Pharmacy Claims as Dependents

Eligibility

This card does not guarantee coverage. For assistance with eligibility, precertification, benefits or claim questions, contact

HealthSmart Benefit Solutions
800-356-2392
tpa.healthsmart.com

Contact the WVCHIP Helpline at 877-982-2447 to report suspected fraud.

HealthSmart
BENEFIT SOLUTIONS

Medical & Prescription Drug Card

Member

CHIP

Group #: 7771
WVCHIP BLUE
Member: JOHN SAMPLE
Member ID: SMPL0001

Medical Plan

Aetna Signature Administrators' PPO
By **aetna**

www.aetna.com/asa

Medical Copays:
Non-Well Visits: \$15. Inpatient Services: \$25 per admit.
Outpatient Services: \$25 per service. ER: \$35 per visit (waived if admitted). Dental Services: \$0. Preventive: \$0.

Pharmacy Plan

RxBIN: 003858
RxCPCN: A4
RxGRP: WVCA

EXPRESS SCRIPTSSM

Express-Scripts.com
Pharmacist use only: 800-824-0898
Member Customer Service: 877-256-4680

\$0 for generic. \$10 for brand

1072 1072 WV-7771-13--- M(0) D(0) V(0) 0EF9
*0*20120504T09J0210000000010002000110
Env [1] 2 of 1 Carrier [1]



J023
1072 WV-7771-13--- M(0) D(0) V(0) 0ADA
*0*20120504T09J0210000000010002000110
Env [1] 2 of 1 Carrier [1]

Claims Submission

Please submit claims to:
EDI: ID# 87815
Mail: HealthSmart Benefit Solutions
PO Box 2451
Charleston, WV 25329-2451

Aetna participating doctors and hospitals are independent providers and are neither agents nor employees of Aetna.

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Express Scripts
P.O. Box 66583
St. Louis, MO 63166

Process Pharmacy Claims as Dependents

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HealthSmart Benefit Solutions
800-356-2392
tpa.healthsmart.com

Contact the WVCHIP Helpline at 877-982-2447 to report suspected fraud.

HealthSmart
BENEFIT SOLUTIONS

Medical & Prescription Drug Card

Member

CHIP

Group #: 7771
WVCHIP PREMIUM PLAN
Member: JOHN SAMPLE
Member ID: SMPL0001

Medical Plan

Aetna Signature Administrators' PPO
By **aetna**

www.aetna.com/asa

Medical Copays:
Non-Well Visits: \$30. Inpatient Services: \$25 per admit. Outpatient Services: \$25 per service. ER: \$35 per visit (waived if admitted). Dental Services: \$25 (with non-preventive services). Preventive Services: \$0.

Pharmacy Plan

RxBIN: 003858
RxCPCN: A4
RxGRP: WVCA

EXPRESS SCRIPTSSM

Express-Scripts.com
Pharmacist use only: 800-824-0898
Member Customer Service: 877-256-4680

\$0 for generic \$15 for brand

1072 1072 WV-7771-14--- M(0) D(0) V(0) 0EF9
*0*20120604T14J0330000000010002000110
Env [1] 2 of 1 Carrier [1]



J022
1072 WV-7771-14--- M(0) D(0) V(0) 0ADA
*0*20120604T14J0330000000010002000110
Env [1] 2 of 1 Carrier [1]

Claims Submission

Please submit claims to:
EDI: ID# 87815
Mail: HealthSmart Benefit Solutions
PO Box 2451
Charleston, WV 25329-2451

Aetna participating doctors and hospitals are independent providers and are neither agents nor employees of Aetna.

Please submit Pharmacy claims to:
Express Scripts
P.O. Box 66583
St. Louis, MO 63166

Process Pharmacy Claims as Dependents

Eligibility

This card does not guarantee coverage. For assistance with eligibility, precertification, benefits or claim questions, contact

HealthSmart Benefit Solutions
800-356-2392
tpa.healthsmart.com

Contact the WVCHIP Helpline at 877-982-2447 to report suspected fraud.

Appendix A
Dental Provider Information Fax

Name of Practice: _____

Phone #: _____ Fax: _____ Email: _____

Physical Address _____

City: _____ State: _____ ZIP: _____

Website Address: _____

NPI #* _____ or State Medicaid#:* _____

List Providers in Practice:

Last Name _____, First Name _____

Phone # (if different from practice) _____

Address (if different from practice) _____

NPI # _____ or State Medicaid#: _____

Provider Affiliation: Private Practice _____
Community Health Center _____
Health Department _____
Other _____

Active Status: Yes _____ No _____

Provider Specialty: General Dentist _____
Pediatric Dentist _____
Oral Surgeon _____
Orthodontist _____
Endodontist _____
Periodontist _____
Number of Dental Hygienists: _____

Accepts New Patients: _____ (Y/N) Can Provide Sedation: _____ (Y/N)

Can accommodate Special Needs: _____ (Y/N)

Can provide services for children with mobility limitations: _____ (Y/N)

Can provide services for children who may have difficulty communicating or cooperating: _____ (Y/N)

****Please copy sheet and use for each practitioner in the group.**

Please fax back to WVCHIP at 304-558-2741 or email to paula.m.atkinson@wv.gov.

Appendix B – Dental Procedure Codes

PRECERTIFICATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
DIAGNOSTIC				
CLINICAL ORAL EVALUATION				
D0120	Periodic oral examination	1 per 6 months	Not billable with D0140, D0145, D0150 or D9310	
D0140	Limited oral evaluation – problem focused	Emergency	Not billable with D0120, D0145, D0150 or D9310	
D0145	Oral evaluation for patient under three years of age and counseling with primary care giver	1 per 6 months	Age restriction up to 36 months. Not billable with D0120, D0140, D0150 or D9310	
D0150	Comprehensive oral evaluation – new or established patient	1 per year	Not billable with D0120, D0140, D0145 or D9310	
RADIOGRAPHY/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)				
D0210	Intraoral complete series of radiographic images	1 per 2 years	Not billable with D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0273 or D0274	
D0220	Intraoral periapical – first radiographic image	1 per day	Not billable with D0210 or D0240	
D0230	Intraoral periapical each additional radiographic image	8 per 3 months	Not billable with D0120, D0240. Must be billed with D0220	
D0240	Intraoral occlusal radiographic image	1 per 6 months	Not billable with D0120, D0220, or D0230	
D0250	Extraoral – first radiographic image	1 per 3 years		
D0260	Extraoral – each additional radiographic image	3 per 3 years	Must be billed with D0250	
D0270	Bitewings – single radiographic image	4 per year	Not billable with D0210, D0272, D0273 or D0274	
D0272	Bitewings – two radiographic images	1 per year	Not billable with D0210, D0273 or D0274	
D0273	Bitewings – three radiographic images	1 per year	Not billable with D0210, D0272 or D0274	
D0274	Bitewings – four radiographic images	1 per year	Not billable with D0210, D0272, or D0273	
D0290	Posterior/anterior or lateral skull and facial bone survey radiographic image	2 per year		
D0310	Sialography			
D0330	Panoramic radiographic image	1 per 3 years		

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D0340	Cephalometric radiographic image	1 per year		
D0350	Oral/facial photographic image		This code excludes conventional radiographics – For orthodontics	
TESTS AND EXAMINATIONS				
D0470	Diagnostic study models	2 per year		
PREVENTIVE				
DENTAL PROPHYLAXIS				
D1110	Prophylaxis – adult	1 per 6 mo.	13 – 19 years of age; not reimbursable with D1120	
D1120	Prophylaxis – child	1 per 6 mo.	Up to 13 years of age; not reimbursable with D1110	
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)				
D1206	Topical application of fluoride varnish	2 per year		
D1208	Topical application of fluoride	2 per year	Replaces Codes D1203 and D1204; effective 1/1/2013	
OTHER PREVENTIVE SERVICES				
D1351	Sealant – per tooth (posterior teeth)	1 sealant per tooth per 3 years	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration. Requires dental areas configuration.	\$25
SPACE MAINTENANCE (PASSIVE APPLIANCES)				
D1510	Space maintainer – fixed unilateral	4 per year	Per quadrant – 10=UR, 20=UL, 30=LL, 40=UR must be included on claim form for payment consideration. Must be billed with the number codes	
D1515	Space maintainer – fixed bilateral	2 per year	Upper arch=01 or lower arch=02 must be included on claim form for payment consideration. Must be billed with the number codes.	
D1520	Space maintainer – removable – unilateral	4 per year	See D1510	
D1525	Space maintainer – removable – bilateral	2 per year	See D1515	
D1550	Re-cementation of space maintainer	1 per year		

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
RESTORATIVE				
AMALGAM RESTORATIONS (INCLUDING POLISHING)				
D2140	Amalgam – one surface, primary or permanent	5 surfaces per tooth # per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents) liners, bases & local anesthesia are included in the fee and may not be billed separately. Reimbursement is not available when surface filling has been billed for the same tooth on the same day. Radiographs with documentation must be documented in the medical record for date of service.	\$25
D2150	Amalgam – two surfaces, primary or permanent	5 surfaces per tooth # per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents) liners, bases & local anesthesia are included in the fee and may not be billed separately. Reimbursement is not available when surface filling has been billed for the same tooth on the same day. Radiographs with documentation must be documented in the medical record for date of service.	
D2160	Amalgam – three surfaces, primary or permanent	5 surfaces per tooth # per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents) liners, bases & local anesthesia are included in the fee and may not be billed separately. Reimbursement is not available when surface filling has been billed for the same tooth on the same day. Radiographs with documentation must be documented in the medical record for date of service.	
D2161	Amalgam – four or more surfaces, primary or permanent	5 surfaces per tooth # per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents) liners, bases & local anesthesia are included in the fee and may not be billed separately. Reimbursement is not available when surface filling has been billed for the same tooth on the same day. Radiographs with documentation must be documented in the medical record for date of service. Not billable with D2140, D2150, D2160 on same tooth number	

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
RESIN-BASED COMPOSITE RESTORATIONS – DIRECT				
D2330	Resin – based composite – one surface, anterior	5 surfaces per tooth # per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service (DOS).	\$25
D2331	Resin – based composite – two surfaces, anterior	5 surfaces per tooth # per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	
D2332	Resin – based composite – three surfaces, anterior	5 surfaces per tooth # per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	
D2335	Resin – based composite – four or more surfaces or involving incisal angle (anterior)	5 surfaces per tooth # per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	
D2390	Resin – based composite crown, anterior	1 tooth # per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	CO-

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	PAY
D2390	(Continued from page 20)		may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS	
D2391	Resin – based composite – one surface, posterior	5 surfaces per tooth # per 3 years	Tooth numbers 1-5, 12-21, A, B, I, J, K, L, S, T must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	
D2392	Resin – based composite – two surfaces, posterior	5 surfaces per tooth # per 3 years	Tooth numbers 1-5, 12-21, A, B, I, J, K, L, S, T must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	
D2393	Resin – based composite – three surfaces, posterior	5 surfaces per tooth # per 3 years	Tooth numbers 1-5, 12-21, A, B, I, J, K, L, S, T must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS	
D2394	Resin – based composite – four or more surfaces (poster)	5 surfaces per tooth # per 3 years	Tooth numbers 1-5, 12-21, A, B, I, J, K, L, S, T must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
CROWNS – SINGLE RESTORATIONS ONLY				
D2751	Crown – porcelain fused to predominantly based metal	1 tooth number per 5 years	Requires PA with documentation identifying tooth numbers 1-32 and A, B, I, J, K, L, S & T. Tooth numbers must also be documented on the claim form for payment consideration	\$25
D2791	Crown – full cast predominantly base metal	1 tooth #r per 5 years	Requires PA with documentation identifying tooth numbers 1-32 and A, B, I, J, K, L, S & T. Tooth numbers must also be documented on the claim form for payment consideration	
OTHER RESTORATIVE SERVICES				
D2920	Re-cement crown	1 per tooth # per 1 year	Tooth numbers 1-32, A-t must be included on the claim form for payment consideration	\$25
D2930	Prefabricated stainless steel crown – primary tooth	1 per tooth # per 1 year	Does not require PA when billed with D3220 for same date of service and on the same tooth. Tooth number A-T primary teeth must be documented on the claim form for payment consideration. Use only when a regular filling is not applicable. Radiographs with documentation must be documented in the medical record for date of service (DOS)	
D2931	Prefabricated stainless steel crown – permanent tooth	1 per tooth # per 1 year	Requires PA with radiographs. Tooth number A-T primary teeth must be documented on the claim form for payment consideration. Use only when a regular filling is not applicable. Radiographs with documentation must be documented in the medical record for DOS	
D2932	Prefabricated resin crown	1 per tooth# per 1 year	Requires PA with radiographs. Tooth number A-T primary teeth must be documented on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for DOS	
D2933	Prefabricated stainless steel crown with resin window		Requires PA with radiographs. Tooth number A-T primary teeth must be documented on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for DOS	
D2940	Protective restoration	2 per year per tooth #	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration. Not allowed in conjunction with root canal therapy, pulpotomy, pulpectomy or on the same DOS as a restoration	
D2950	Core build-up, including any pins for permanent teeth only	1 per year per tooth #	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration	

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D2951	Pin retention – per tooth, in addition to restoration	1 per 3 years per tooth #	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration.	
D2952	Cast post and core in addition to crown	1 per 3 years per tooth #	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration.	
D2954	Prefab post and core in addition to crown	1 per 3 years per tooth #	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration.	
ENDODONTICS – INCLUDES LOCAL ANESTHESIA				
PULPOTOMY				
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentioceamental junction and application of medicament	1 per 3 years per tooth#	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration. Not reimbursable with D3310, D3320, or D3330. This is not to be construed as the first stage of root canal therapy. Not to be used for apexogenesis.	\$25
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW UP CARE)				
D3310	Endodontic therapy, anterior (excluding final restoration)	1 tooth # per lifetime	Tooth numbers 6-11, 22-27 must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3320 or D3330	
D3320	Endodontic therapy bicuspid (excluding final restoration)	1 tooth # per lifetime	Tooth numbers 4, 5, 12, 13, 20, 21, 28, 29 or C, H, Q, N must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3310, or D330	
D3330	Endodontic therapy, molar (excluding final restoration)	1 tooth # per lifetime	Tooth numbers 1-3, 14-19, 30-32 and primary teeth #A, B, I, J, K, L, S and T, if no permanent successor present; must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3310 or D3320	
ENDODONTIC RETREATMENT				
D3346	Retreatment of previous root canal therapy – anterior	1 tooth # per lifetime	Tooth numbers 6-11 and 22-27 must be documented on the claim form for payment consideration, includes all diagnostic tests, radiographs, and post-operative treatments and may not be billed separately	
D3347	Retreatment of previous root canal therapy – bicuspid	1 tooth # per lifetime	Tooth numbers 4, 5, 12, 13, 20, 21, 28 and 29 must be documented on the claim form for payment consideration, includes all diagnostic tests, radiographs, and post-operative treatments and may not be billed separately	
D3348	Retreatment of previous root canal therapy – molar	1 tooth # per lifetime	Tooth numbers 1-3, 14-19, and 30-32 must be documented on the claim form for payment consideration; includes all diagnostic tests, radiographs, and post-operative treatments and may not be billed separately	

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTONS	CO-PAY
APEXIFICATION/RECALCIFICATION PROCEDURES				
D3351	Apexification/recalcification/pulpal regeneration-initial visit (apical closure/calccific repair of perforations, root resorption, pulp space disinfection, etc)		Tooth numbers 1-32 must be documented on the claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs and post-operative treatment and may not be billed separately	\$25
D3352	Apexification/recalcification/pulpal regeneration – interim medication replacement (apical closure/calccific repair of perforations, root resorption, etc.)	3 treatment per tooth # per lifetime	Tooth numbers 1-32 must be documented on the claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs and post-operative treatment and may not be billed separately	
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calccific repair of perforations, root resorption, etc.)	1 tooth # per lifetime	Tooth numbers 1-32 must be documented on the claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs and post-operative treatment and may not be billed separately	
APICOCECTOMY/PERIRADICULAR SERVICES				
D3410	Apicoectomy/perriardicular surgery-anterior	1 tooth # per lifetime	Requires PA with documentation, tooth number(s) and radiographs as appropriate. Tooth numbers 6-11, 22-27 must be documented on the claim form for payment consideration	
D3421	Apicoectomy/surg bicuspid	1 tooth # per lifetime	Requires PA with documentation, tooth number(s) and radiographs as appropriate. Tooth numbers 4, 5, 12, 13, 20, 21, 28, 29 must be documented on the claim form for payment consideration	
D3999	Unspecified endodontic procedure, by report		Requires PA with radiographs, documentation and description of procedure to be performed. This code should be used only if a more specific CDT code is not available.	
PERIODONTICS				
SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE CARE)				
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant	1 quad per year	Requires PA with documentation, identification of the quadrant(s) and radiographs as appropriate. Quadrants are defined as 10=UR, 20=UL, 30=LL, 40=LR. Not reimbursed with D4211. Must be billed with the number codes	\$25

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTONS	CO-PAY
D4211	Gingivectomy or gingivoplasty – one to three teeth	1 quad per year	Requires PA with documentation, identification of the quadrant, and radiographs as appropriate. Quadrants are defined as 10=UR, 20=UL, 30=LL, 40=LR. Not reimbursed with D4210. Must be billed with the number codes	
D4260	Osseous surgery (including flap entry and closure) four or more contiguous teeth or tooth bounded spaces per quadrant	1 quad per year	Requires PA with documentation, identification of the quadrant, and radiographs as appropriate. Quadrants are defined as 10=UR, 20=UL, 30=LL, 40=LR. Not reimbursed with D4210. Must be billed with the number codes	
D4261	Osseous surgery (including flap entry and closure) one to three contiguous teeth or tooth bounded spaces per quadrant	1 per quad per year	Requires PA with documentation, identification of the quadrant, and radiographs as appropriate. Quadrants are defined as 10=UR, 20=UL, 30=LL, 40=LR. Not reimbursed with D4210. Must be billed with the number codes	
NON-SURGICAL PERIODONTAL SERVICE				
D4341	Periodontal scaling /root planing – four /more teeth per quadrant	1 quad per year	Requires PA. Quadrants are defined as 10=UR, 20=UL, 30=LL, 40=LR. Not reimbursed with D4342. Must be billed with the number codes	
D4342	Periodontal scaling/root planing – one to three teeth per quadrant	1 quad per year	Requires PA. Quadrants are defined as 10=UR, 20=UL, 30=LL, 40=LR. Not reimbursed with D4341. Must be billed with the number codes	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per 6 months	Requires PA. Only covered when there is substantial gingival inflammation (gingivitis in all 4 quadrants).	
PROSTHODONTICS (REMOVABLE)				
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)				
D5110	Complete denture – maxillary	1 per 5 years	Requires PA	
D5120	Complete denture – mandibular	1 per 5 years	Requires PA	
D5130	Immediate denture – maxillary	1 per 5 years	Requires PA	
D5140	Immediate denture – mandibular	1 per 5 years	Requires PA	
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)				
D5213	Maxillary partial denture – cast metal base framework with resin denture bases (including any conventional clasps, rests and teeth)	1 per 5 years	Requires PA. Partials and complete dentures may not be re-based or relined with a period of one (1) year after construction)	\$25

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D5214	Mandibular partial denture – cast metal base framework with resin denture bases (including any conventional clasps, rests and teeth)	1 per 5 years	Requires PA. Partial and complete dentures may not be re-based or relined with a period of one (1) year after construction)	
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	1 per 5 years	Requires PA. Partial and complete dentures may not be re-based or relined with a period of one (1) year after construction)	
ADJUSTMENTS TO DENTURES				
D5410	Adjust complete denture upper	3 per year	<u>Adjustments</u> not covered within 3 months of placement	
D5411	Adjust complete denture lower	3 per year	<u>Adjustments</u> not covered within 3 months of placement	
D5421	Adjust partial denture upper	3 per year	<u>Adjustments</u> not covered within 3 months of placement	
D5422	Adjust partial denture lower	3 per year	<u>Adjustments</u> not covered within 3 months of placement	
REPAIRS TO COMPLETE DENTURES				
D5510	Repair broken complete denture base	2 per year per arch	Upper arch=01, Low arch=02; must be documented on the claim form for payment consideration	
D5520	Replace missing or broken teeth- complete denture (each tooth)	2 per year per tooth #	Tooth numbers 1-32 must be documented on the claim form for payment consideration	
REPAIRS TO PARTIAL DENTURES				
D5610	Repair resin denture base	2 per year per arch	Upper arch=01, Low arch=02; must be documented on the claim form for payment consideration. Must be billed with the number codes	
D5620	Repair cast framework	2 per year per arch	Upper arch=01, Low arch=02; must be documented on the claim form for payment consideration. Must be billed with the number codes	
D5630	Repair/replace broken clasp	2 per year		
D5640	Replace broken tooth – per tooth	2 per year	Tooth numbers 1-32 must be documented on the claim form for payment consideration	

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D5650	Add tooth to existing partial	2 per year	Tooth numbers 1-32 must be documented on the claim form for payment consideration	
D5660	Add clasp to partial			
DENTURE REBASED PROCEDURES				
D5710	Rebase complete maxillary denture	1 per 5 years		\$25
D5711	Rebase complete mandibular denture	1 per 5 years		
D5720	Rebase maxillary partial denture	1 per 5 years		
D5721	Rebase mandibular partial denture	1 per 5 years		
DENTURE RELINE PROCEDURES				
D5730	Reline complete maxillary denture (chair side)	1 per 2 years	Not covered within first 6 months of placement unless it is for an immediate denture	
D5731	Reline complete mandibular denture (chair side)	1 per 2 years	Not covered within first 6 months of placement unless it is for an immediate denture	
D5740	Reline maxillary partial denture (chair side)	1 per 2 years	Not covered within first 6 months of placement	
D5741	Reline mandibular partial denture (chair side)	1 per 2 years	Not covered within first 6 months of placement	
D5750	Reline complete maxillary denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement	
D5751	Reline complete mandibular denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement	
D5760	Reline maxillary partial denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement	
D5761	Reline mandibular partial denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement	
PROSTHODONTIC FIXED				
FIXED PARTIAL DENTURE PONTICS – EACH ABUTMENT AND EACH PONTIC CONSTITUTE A UNIT IN A BRIDGE				
D6211	Pontic – cast predominantly base metal	1 per 5 years	Requires PA. Tooth numbers 1-32 must be documented on the claim form for payment consideration	\$25

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D6211	Pontic – cast predominantly base metal	1 per 5 years	Requires PA. Tooth numbers 1-32 must be documented on the claim form for payment consideration	
D6241	Pontic – Porcelain fused to predominantly based metal	1 per 5 years	Requires PA. Tooth numbers 1-32 must be documented on the claim form for payment consideration	
D6545	Retainer – cast metal for resin bonded fixed prosthesis	1 per 5 years	Requires PA. Tooth numbers 1-32 must be documented on the claim form for payment consideration	
OTHER FIXED DENTURE SERVICES				
D6930	Recement fixed partial bridge	1 per year		\$25
ORAL AND MAXILLOFACIAL SURGERY (COVERED UNDER THE MEDICAL PLAN)				
EXTRACTION – INCLUDES LOCAL ANESTHESIA AND POST-OPERATIVE CARE ANY NECESSARY SUTURE INCLUDED IN FEE FOR EXTRACTION				
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration	
D7220	Removal of impacted tooth – soft tissue	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration	
D7230	Removal of impacted tooth – partially bony	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration	
D7240	Removal of impacted tooth – completely bony	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration	
OTHER SURGICAL PROCEDURES				
D7260	Oroantral fistula closure		Requires PA	\$25

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D7270	Tooth reimplantation and/or stabilization of accidental avulsed or displaced tooth		Tooth numbers 1-32 and primary teeth #A, B, I, J, K, L, S, and T must also be documented on the claim form for payment consideration	
D7280	Surgical access of unerupted tooth		Tooth numbers 1-32 must also be documented on the claim form for payment consideration	
D7283	Placement of device to facilitate eruption of impacted tooth		Tooth numbers 1-32 must also be documented on the claim form for payment consideration	
D7285	Biopsy of oral tissue – hard (bone, tooth)			
D7286	Biopsy of oral tissue – soft (all others)			
ALVEOLOPLASTY – SURGICAL PREPARATION OF RIDGE FOR DENTURE				
D7310	Alveoplasty in conjunction with extractions – four or more teeth or tooth spaces per quadrant	1 quadrant UR, UL, LL, LR per lifetime	Quadrant 10=UR, 20=UL, 30=LL, 40=LR must also be documented on the claim form for payment consideration. Alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery	\$25
D7320	Alveoplasty not in conjunction with extractions – four or more teeth or tooth spaces per quadrant	1 quadrant UR, UL, LL, LR per lifetime	Quadrant 10=UR, 20=UL, 30=LL, 40=LR must also be documented on the claim form for payment consideration	
VESTIBULOPLASTY				
D7340	Vestibuloplasty – ridge extension (second epithelization)		Requires PA with documentation and radiographs as appropriate	\$25
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied & hyperplastic tissue)		Requires PA with documentation and radiographs as appropriate	
D7410	Excision of benign lesion up to 1.25 cm			
D7411	Excision of benign lesion > 1.25 cm			
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm			
D7441	Excision of malignant tumor – lesion diameter > than 1.25 cm			

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm			
D7451	Removal benign odontogenic cyst or tumor lesion > 1.25 cm			
D7460	Removal of benign nonodontogenic cyst or tumor lesion diameter up to 1.25 cm			
D7461	Removal of benign nonodontogenic cyst or tumor lesion diameter greater > 1.25			
EXCISION OF BONE TISSUE				
D7471	Removal of lateral exostosis (maxilla or mandible)		UA=01, LA=02 must be documented on the claim form for payment consideration. Must be billed with the number codes	\$25
D7472	Removal of torus palatines			
D7473	Removal of torus mandibularis			
D7485	Surgical reduction of osseous tuberosity			
D7490	Radical resection of mandible with bone graft		Requires PA with documentation and radiographs as appropriate	
SURGICAL INCISION				
D7510	Incision of Drainage (I&D) of abscess – intraoral soft tissue			
D7520	I&D of abscess – extraoral soft tissue			
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue			
D7550	Partial ostectomy - sequestrectomy for removal of non-vital bone		Requires PA with documentation. This code should only be used if a more specific code is not available	
D7560	Maxillary sinusotomy for removal of tooth fragment of foreign body			

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
TREATMENT OF SIMPLE FRACTURES				
D7610	Maxilla – open reduction			\$25
D7620	Maxilla – closed reduction			
D7630	Mandible – open reduction			
D7640	Mandible – closed reduction			
D7671	Alveolus – open reduction			
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches		Requires PA with documentation and radiographs as appropriate	
TREATMENT OF FRACTURES (COMPOUND)				
D7710	Maxilla – open reduction			\$25
D7720	Maxilla – closed reduction			
D7730	Mandible – open reduction			
D7740	Mandible – closed reduction			
D7750	Malar and/or zygomatic arch – open reduction			
D7770	Alveolus – open reduction stabilization of teeth			
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches		Requires PA	
REPAIR OF TRAUMATIC WOUNDS				
D7910	Suture of recent small wounds up to 5 cm		Excludes closure of surgical incisions	
D7911	Complicated suture – up to 5 cm	1 unit; not reimbursable with D7912	Excludes closure of surgical incisions	
D7912	Complicated suture – greater than 5 cm	1 unit; not reimbursable with D7911	Excludes closure of surgical incisions	
D7920	Skin graft		Requires PA	
D7941	Osteotomy mandibular rami		Requires PA	

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft		Requires PA	
D7941	Osteotomy – mandibular rami		Requires PA	
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft		Requires PA	
D7944	Osteotomy – segmented or subapical – per sextant or quadrant		Requires PA	
D7946	LeFort I (maxilla-total)		Requires PA	
D7947	LeFort I (maxilla – segmented)		Requires PA	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for mid-face hypoplasia or retrusion) – without bone graft		Requires PA	
D7949	LeFort II or LeFort III – with bone graft		Requires PA	
D7950	Osseous, osteoperiosteal or cartilage graft of the mandible or facial tones			
D7955	Repair of maxillofacial soft and/or hard tissue defect			
D7960	Frenuloplasty		Requires PA	
D7970	Excision of hyperplastic tissue – per arch		Requires PA	
D7980	Sialolithotomy		Requires PA	
D7981	Excision of Salivary gland		Requires PA	
D7982	Sialodochoplasty		Requires PA	
D7991	Coronoidectomy		Requires PA	
ORTHODONTICS				\$25
D8010	Limited orthodontic treatment of the primary dentition	2 per year	Requires PA with documentation, radiographs	
D8020	Limited orthodontic treatment of the transitional dentition	2 per year	Requires PA with documentation, radiographs	

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D8030	Limited orthodontic treatment of the adolescent dentition	2 per year	Requires PA with documentation, radiographs	
D8040	Limited orthodontic treatment of the adult dentition	2 per year	Requires PA with documentation, radiographs	
D8050	Interceptive orthodontic treatment of the primary dentition	2 per year	Requires PA with documentation, radiographs	
D8060	Interceptive orthodontic treatment of the transitional dentition	2 per year	Requires PA with documentation, radiographs	
D8070	Comprehensive orthodontic treatment of the transitional dentition	1 per lifetime	Requires PA with documentation, radiographs	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	1 per lifetime	Requires PA with documentation, radiographs	
D8090	Comprehensive orthodontic treatment of the adult dentition	1 per lifetime	Requires PA with documentation, radiographs	
D8210	Removable Appliance therapy	2 per lifetime		
D8220	Fixed appliance therapy	2 per year	Requires PA with documentation, radiographs	
D8680	Orthodontic retention (removal of appliances construction and placement of retainer		Requires PA with documentation, radiographs	
D8692	Replacement of lost or broken retainer	2 per Lifetime		
D8693	Rebonding or recementing; and/or repair, as required of fixed retainers	1 per lifetime	Requires PA	
D8699	Unspecified orthodontic procedure by report		Requires PA	
PALLIATIVE TREATMENT				
D9110	Palliative (emergency) treatment of dental pain – minor procedure			\$25
ANESTHESIA				
D9220	Deep sedation/general anesthesia – First 30 minutes	Maximum 1 unit/day	Class 4 anesthesia permit required	\$25

CDT CODES	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D9221	Deep sedation/general anesthesia – each additional 15 minute unit, up to 2 additional units.		Class 4 anesthesia permit required; Must be billed with D9221	
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	Maximum 1 unit/day		
D9241	Intravenous conscious sedation/analgesia – First 30 minutes	Maximum 1 unit	Class 3 or 4 permit required	
D9242	Intravenous conscious sedation/analgesia – Each additional 15 minute unit	Maximum 2 units	Class 3 or 4 permit required; Must be billed with D9241	
OTHER SERVICES				
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)		Not reimbursable on same day as D1020, D1040, D1045, D1050	
D9420	Hospital or ambulatory surgical center call			

***Prior authorization must be obtained when service limits are exceeded**

Appendix C

**West Virginia Children's Health Insurance Program
Request for Precertification for Comprehensive
Orthodontic Treatment**

Patient Name: _____ DOB: _____

I.D. Number: _____ Exam Date: _____

Provider Name: _____ Provider Phone: _____

Provider Fax: _____ Provider # _____

Complete Diagnosis:

Current Treatment Status:

Recommendation for Orthodontic Treatment:

Orthodontic Treatment – Procedure Code _____

Post-Treatment Stabilization – Procedure Code _____

Total Fee (Usual and Customary Fee) _____

Precertification from HealthSmart (formerly Wells Fargo) assures claims will be paid when submitted EXCEPT when the child disenrolls from the plan on or before the date of service. If the precertification request is denied, the parent or guardian is responsible for paying for procedures completed without a precertification approval.*

***It is the provider's responsibility to verify eligibility of WVCHIP member card or calling the WVCHIP Helpline at 1-877-982-2447.**

Information Required for Assessing Handicapping Malocclusion

1. Overjet _____ 2. Overbite _____
3. Molar Relationship R _____ L _____
4. Skeletal Relationship I _____ II _____ III _____
5. Missing Teeth _____
6. Impacted Teeth _____
7. Crowding _____
8. Cleft Palate Yes _____ No _____
9. Cross Bite
 A – Anterior Teeth _____
 B – Posterior Teeth L _____
 C – Posterior Teeth R _____
10. Open Bite
 A – Anterior Teeth _____
 B – Posterior Teeth L _____
 C – Posterior Teeth R _____
11. Comments: _____

Send precertification request form and documentation (panoramic Film; cephalometric tracing; cephalometric x-ray; photographs – a standard series of 5 Intra and 3 Extra Oral photographs that meets the American Board of Orthodontics standards, and treatment plan, including findings, diagnosis, prognosis, length of treatment, and phases of treatment) to:

HealthSmart (formerly Wells Fargo, TPA)
P.O. Box 2451
Charleston, WV 25329-2451

Provider's Signature

Date



American Dental Association
www.ada.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
- B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
- C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
- D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
- E. All dates must include the four-digit year.
- F. If the number of procedures reported exceeds the number of lines available on one claim form, any remaining procedures must be listed on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54 **NPI (National Provider Identifier):** This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web site: www.ada.org/goto/npi

ADDITIONAL PROVIDER IDENTIFIER

52A and 58 **Additional Provider ID:** This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer, Federal government). Some Legacy IDs have an intrinsic meaning.

PROVIDER SPECIALTY CODES

56A **Provider Specialty Code:** Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
Dentist	
A dental professional qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at: www.wpc-edl.com/codes/taxonomy

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA's web site at: www.ada.org/goto/dentalcode



WVCHIP
2 Hale Street
Suite 101
Charleston, WV 25301



Healthy Teeth are Important!
Teeth help you eat, talk, and smile.

Dental Care should begin early, even before the first tooth appears. It is important to develop good oral hygiene habits early in order to help make your child's teeth last a lifetime.

To find a WVCHIP dental provider near you go to the web site insurekidsnow.gov

FEP BlueVision®

<http://www.fepblue.org>



2012

A Nationwide Vision PPO Plan

Who may enroll in this plan: All Federal employees and annuitants in the United States and overseas who are eligible to enroll in the Federal Employees Dental and Vision Insurance Program.

Enrollment Options for this Plan:

- High Option – Self Only
- High Option – Self Plus One
- High Option – Self and Family
- Standard Option – Self Only
- Standard Option – Self Plus One
- Standard Option – Self and Family



The FEP BlueVision credentialing process was constructed to meet and exceed NCQA requirements.



The FEP BlueVision fabrication system has received full certification from the COLTS Laboratories “Quality First” program, a leading, independent ophthalmic testing organization.



The FEP BlueVision laboratories have ISO 9001:2008 certification. The International Organization for Standardization with ISO 9000 is the international reference for quality management requirements.



Federal Employees
Dental and Vision Insurance Program

Authorized for distribution by the:



United States
Office of Personnel Management
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The Act directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants and their eligible family members. In response to the legislation, OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP). OPM has contracted with dental and vision insurers to offer an array of choices to Federal employees and annuitants.

This brochure describes the benefits of FEP BlueVision under the Blue Cross and Blue Shield Association's contract OPM-06-00060-2 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

FEP BlueVision
711 Troy Schenectady Road, Suite 301
Latham, New York 12110
1-888-550-BLUE (2583)
www.fepblue.org

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations and exclusions of this brochure. It is your responsibility to be informed about your benefits. You, and your family members, do not have a right to benefits that were available before January 1, 2012 unless those benefits are also shown in this brochure.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated eligible family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits.

OPM negotiates benefits and rates with each carrier annually. Rates are shown at the end of this brochure.

FEP BlueVision is responsible for the selection of in-network providers in your area. Contact us at 1-888-550-2583 for the names of participating providers or to request a provider directory. You may also request or view the most current directory via our website at www.fepblue.org. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not on a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in-network. If your provider is not currently participating in the provider network, you can nominate him or her to join. Nomination forms are available on our web site, or call us and we will take your nomination over the phone. You cannot change plans, outside of Open Season, because of changes to the provider network.

Provider networks may be more extensive in some areas than others. **Please be aware that the FEP BlueVision network is different from the network of your health plan.**

This FEP BlueVision plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program.

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website, www.fepblue.org and click on the link to FEP BlueVision, and then click on the "Privacy Policies" link at the bottom of the page. If you do not have access to the internet or would like further information, please contact us by calling 1-888-550-2583.

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How We Have Changed for 2012

Under High Option, the \$65 copay for plastic photosensitive lenses (Transitions®) has been eliminated.

Eligible FSAFEDS expenses may be automatically submitted electronically through paperless reimbursement.

FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas regional, dental Preferred Provider Organizations (PPO), and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Visit www.opm.gov/insure/dental or www.opm.gov/insure/vision for more information.
Enroll Through BENEFEDES	You enroll through the Internet at www.BENEFEDS.com . Please see Section 2, Enrollment, for more information.
Dual Enrollment	If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) can not be covered by two FEDVIP dental plans or two FEDVIP vision plans.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2011 Open Season, your coverage will begin on January 1, 2012. Premium deductions will start with the first full pay period beginning on/after January 1, 2012. You may use your benefits as soon as your enrollment is confirmed.
Pre-Tax Salary Deduction for Employees	Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars.
Annual Enrollment Opportunity	Each year, an Open Season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, Open Season runs from November 14, 2011 through December 12, 2011. You do not need to re-enroll each Open Season unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual Open Season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment, for more information.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information.

Section 1 Eligibility

Federal Employees	If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP, if you are eligible for the Federal Employees Health Benefits (FEHB) Program. Enrollment in the FEHB Program is not required.
Federal Annuitants	<p>You are eligible to enroll if you:</p> <ul style="list-style-type: none">retired on an immediate annuity under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS), or another retirement system for employees of the Federal Government;retired for disability under CSRS, FERS, or another retirement system for employees of the Federal Government. <p>Your FEDVIP enrollment will continue into retirement, if you retire on an immediate annuity or for disability under CSRS, FERS or another retirement system for employees of the Government, regardless of the length of time you had FEDVIP coverage as an employee. There is no requirement to have coverage for 5 years of service prior to retirement in order to continue coverage into retirement, as there is with the FEHB Program.</p> <p>Your FEDVIP coverage will end if you retire on a Minimum Retirement Age (MRA) + 10 retirement and postpone receipt of your annuity. You may enroll in FEDVIP again when you begin to receive your annuity.</p> <p>Advise BENEFEDS of your new payroll office number.</p>
Survivor Annuitants	If you are a survivor of a deceased Federal/U.S. Postal Service employee or annuitant and you are receiving an annuity, you may enroll or continue the existing enrollment.
Compensationers	A compensationer is someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation Programs (OWCP) due to an on-the-job injury/illness who is determined by the Secretary of Labor to be unable to return to duty. You are eligible to enroll in FEDVIP or continue FEDVIP enrollment into compensation status.
Family Members	<p>Eligible family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.</p> <p>FEDVIP rules and FEHB rules for family member eligibility are NOT the same. For more information on family member eligibility visit the website www.opm.gov/insure/dental or www.opm.gov/insure/vision or contact your employing agency or retirement system.</p>
Not Eligible	<p>The following persons are not eligible to enroll in FEDVIP, regardless of FEHB eligibility or receipt of an annuity or portion of an annuity:</p> <ul style="list-style-type: none">Deferred annuitantsFormer spouses of employees or annuitantsFEHB Temporary Continuation of Coverage (TCC) enrolleesAnyone receiving an insurable interest annuity who is not also an eligible family member

Section 2 Enrollment

Enroll Through BENEFEDS

You must use **BENEFEDS** to enroll or change enrollment in a FEDVIP plan. **BENEFEDS** is a secure enrollment website (www.BENEFEDS.com) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans or options, your enrollment will continue automatically. Please note: your plans' premiums may change for 2012.

Note: You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, PostalEase, EBIS, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

Enrollment Types

Self Only: A Self Only enrollment covers only you as the enrolled employee or annuitant. You may choose a Self Only enrollment even though you have a family; however, your family members will not be covered under FEDVIP.

Self Plus One: A Self Plus One enrollment covers you as the enrolled employee or annuitant plus one eligible family member whom you specify. You may choose a Self Plus One enrollment even though you have additional eligible family members, but the additional family members will not be covered under FEDVIP.

Note: A Self Plus One enrollment option does not exist under the FEHB Program.

Self and Family: A Self and Family enrollment covers you as the enrolled employee or annuitant and all of your eligible family members. You must list all eligible family members when enrolling.

Dual Enrollment

If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) can not be covered by two FEDVIP dental plans or two FEDVIP vision plans.

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee or annuitant, you may enroll in a dental and/or vision plan during the November 14 through December 12, 2011 Open Season. Coverage is effective January 1, 2012.

During future annual Open Seasons, you may enroll in a plan, or change or cancel your dental and/or vision coverage. The effective date of these Open Season enrollments and changes will be set by OPM. If you want to continue your current enrollment, do nothing. **Your enrollment carries over from year to year, unless you change it.**

New hire/Newly eligible

You may enroll within 60 days after you become eligible as:

- a new employee;
- a previously ineligible employee who transferred to a covered position;
- a survivor annuitant if not already covered under FEDVIP; or
- an employee returning to service following a break in service of at least 31 days.

Your enrollment will be effective the first day of the pay period following the one in which BENEFEDS receives and confirms your enrollment.

Qualifying Life Event

A qualifying life event (QLE) is an event that allows you to enroll, or if you are already enrolled, allows you to change your enrollment outside of an Open Season.

The following chart lists the QLEs and the enrollment actions you may take:

Qualifying Life Event	From Not Enrolled to Enrolled	INCREASE: Enrollment Type	DECREASE: Enrollment Type	Cancel	CHANGE: From One Plan to Another
Acquiring an eligible family member	No	Yes	No	No	No
Losing a covered family member	No	No	Yes	No	No
Losing other dental/ vision coverage (eligible or covered person)	Yes	Yes	No	No	No
Moving out of regional plan's service area	No	No	No	No	Yes
Going on active military duty, non-pay status (enrollee and spouse)	No	No	No	Yes	No
Returning to pay status from active military duty (enrollee and spouse)	Yes	No	No	No	No
Annuity/ compensation restored	Yes	Yes	Yes	No	No
Transferring to an eligible Federal position*	No	No	No	Yes	No

*Position must be in a Federal agency that provides dental and/or vision coverage with 50 percent or more employer-paid premium.

The timeframe for requesting a QLE change is from 31 days before to 60 days after the event. There are two exceptions:

- There is no time limit for a change based on moving from a regional plan's service area; and
- You cannot request a new enrollment based on a QLE before the QLE occurs, except for enrollment because of a loss of dental or vision insurance. You must make the change no later than 60 days after the event.

Generally, enrollments and enrollment changes made based on a QLE are effective on the first day of the pay period following the one in which BENEFEDS receives and confirms the enrollment or change. BENEFEDS will send you confirmation of your new coverage effective date.

Once you enroll in a plan, your 60-day window for that type of plan ends, even if 60 calendar days have not yet elapsed. That means once you have enrolled in either a dental or a vision plan, you cannot change or cancel that particular enrollment until the next Open Season, unless you experience a QLE that allows such a change or cancellation.

Canceling an enrollment

You may cancel your enrollment only during the annual Open Season. An eligible family member's coverage also ends upon the effective date of the cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the Open Season effective date.

When Coverage Stops

Coverage ends when you:

- no longer meet the definition of an eligible employee or annuitant;
- begin a period of non-pay status or pay that is insufficient to have your FEDVIP premiums withheld and you do not make direct premium payments to BENEFEDS;
- are making direct premium payments to BENEFEDS and you stop making the payments; or
- cancel the enrollment during Open Season.

Coverage for a family member ends when:

- you as the enrollee lose coverage; or
- the family member no longer meets the definition of an eligible family member.

Continuation of Coverage

Under FEDVIP, there is no 31-day extension of coverage. The following are also NOT available under the FEDVIP plans:

- Temporary Continuation of Coverage (TCC);
- spouse equity coverage; or
- right to convert to an individual policy (conversion policy).

FSAFEDS/High Deductible Health Plans and FEDVIP

If you are planning to enroll in an FSAFEDS Health Care Flexible Spending Account (HCFSAs) or Limited Expense Health Care Flexible Spending Account (LEX HCFSAs), you should consider how coverage under a FEDVIP plan will affect your annual expenses, and thus the amount that you should allot to an FSAFEDS account. Please note that insurance premiums are not eligible expenses for either type of FSA.

Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense and file a claim in the time period permitted. This is known as the “Use-it-or-Lose-it” rule. Carefully consider the amount you will elect.

Current FSAFEDS participants must re-enroll to participate in 2012. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-800-952-0450.

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you may use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB and FEDVIP plans.

Using your FSA pre-tax dollars for your eyecare and eyewear needs is a great way to get more out of your benefit dollar. And FEP BlueVision will submit your eligible FSAFEDS out-of-pocket expenses electronically, so you don't have to.

Using your FSAFEDS account for your eyecare and eyewear expenses is simple:

- Visit your provider for your routine eye examination and eyewear
- Pay any out-of-pocket expenses
- FEP BlueVision will submit your expenses for reimbursement for you.

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation	Two ID cards are issued for each member, regardless of coverage option. If additional cards are needed, you may request them through our website, www.fepblue.org or call us at 1-888-550-2583. All eligible dependents listed on your enrollment share your identification number. You do not need an ID card for each member of your family.
Plan Providers	<p>We list in-network plan providers in the provider directory, which is updated frequently. The most current list can be found on our website at www.fepblue.org. It is your responsibility to ensure that the provider chosen is an active participant in the program, at the time you receive services. The FEP BlueVision network is specific to routine vision care and is different from the network for your medical plan.</p> <p>In some cases, due to local regulations or business practices, the doctor may be independent of the retail location. You should confirm that both the doctor and the retail location are participating prior to seeking services.</p>
In-Network	<p>In-network providers are referred to as participating providers. The FEP BlueVision in-network benefit is paperless and extremely user-friendly for members. When scheduling an appointment, you should identify yourself as a member of FEP BlueVision and provide your name and identification number. The provider is then responsible for verifying eligibility by contacting FEP BlueVision either by telephone or via the web.</p> <p>Under Standard Option, you must stay in-network for covered services. If you receive care from a non-participating provider, we will not pay for any services unless you reside in a limited access area. Please see Section 4, Your Cost For Covered Services.</p>
Out-of-Network	<p>Out-of-network providers are referred to as non-participating providers. High Option: We will provide fee schedule allowances as described in Section 4, Your Cost For Covered Services, for covered services performed by non-participating providers. However, since these providers do not participate with FEP BlueVision, you may be responsible for any amounts over the fee schedule allowances. Please see Section 8, Claims Filing and Disputed Claims Processes, for information.</p> <p>Under Standard Option, you must stay in-network for covered services. If you receive care from a non-participating provider, we will not pay for any services unless you reside in a limited access area. Please see Section 4, Your Cost For Covered Services.</p>
Pre-Authorization	<p>Pre-authorization is only required for:</p> <ul style="list-style-type: none">• Medically necessary contact lenses in the treatment of certain eye health conditions and is obtained by the participating provider.• The treatment of low vision and is obtained by the participating provider.• Discounts for laser vision correction and is obtained by the member.
First Payor	When you visit a provider who participates with both your FEHB plan and your FEDVIP plan, the FEHB plan will pay benefits first. The FEDVIP plan allowance will be the prevailing charge in these cases. You are responsible for the difference between the FEHB and FEDVIP benefit payments and the FEDVIP plan allowance.
Coordination of Benefits	We do not coordinate benefits with non-FEHB health plans.
Limited Access Areas	If you live in an area that does not have adequate access to an FEP BlueVision network provider and you receive covered services from an out-of-network provider, we will pay up to 100% of our Plan Allowance. You are responsible for any difference between the amount billed and our payment. To determine if you are in a limited access area call us at 1-888-550-2583. Please see Section 4, Your Cost for Covered Services, for more information. Please see Section 8, Claims Filing and Disputed Claims Processes, for information.

Section 4 Your Cost for Covered Services

This is what you pay out-of-pocket for covered care:

Copayment There are no copayments for covered eye examinations, standard eyeglass lenses, plan frames, or contact lenses in lieu of eyeglasses. There may be copayments for optional lens types and treatments.

Annual Benefit Maximum

- Standard Option: one routine eye examination every calendar year; one pair of standard eyeglass lenses or contact lenses every calendar year; one frame every other calendar year. (Contact lens benefit available in lieu of eyeglasses.)
- High Option: one routine eye examination every calendar year; one pair of standard eyeglass lenses or contact lenses every calendar year; one frame every calendar year. (Contact lens benefit available in lieu of eyeglasses.)

In-Network Services Members are only responsible for any cost that exceeds the Plan Allowances (as described in Section 5, Vision Services and Supplies) and copayments for optional lenses and treatments (as described in Section 5, Vision Services and Supplies). To receive covered benefits, you must stay in-network if you are enrolled in Standard Option.

Out-of-Network Services If you are enrolled in Standard Option, you must stay in-network for covered services. If you receive care from a non-participating provider, we will not pay for any services unless you reside in a limited access area.

If you are enrolled in High Option and you choose to visit a non-participating provider, you will be reimbursed according to the following fee schedule allowances shown in the chart below. You are responsible for charges billed over the amounts shown.

Services/Materials	We Pay
Exam	Up to \$30
Single Vision Lenses	Up to \$25
Bifocal Lenses	Up to \$35
Trifocal Lenses	Up to \$45
Lenticular Lenses	Up to \$45
Elective Contact Lenses	Up to \$75
Medically Necessary Contact Lenses	Up to \$225
Frames	Up to \$30

Please see Section 3, How You Obtain Care, for more information.

Limited Access Areas Members who reside in areas not meeting access standards* can visit an out-of-network provider, pay billed charges and then be reimbursed based on the Plan Allowance.

***NOTE: Access Standards**

Urban zip codes: at least 90% of Federal eligibles (employees and annuitants) in a network access area (zip code plus 15 driving-miles) must have access to a vision care preferred provider.

Rural zip codes: at least 80% of Federal eligibles (employees and annuitants) in a network access area (zip code plus 35 driving-miles) must have access to a vision care preferred provider.

Plan Allowance: The maximum benefit payment for services provided in areas not meeting the access standards are shown in the chart below. You are responsible for charges billed over the amounts shown.

Services/Materials	Standard Option We Pay	High Option We Pay
Exam	Up to \$50	Up to \$50
Single Vision Lenses	Up to \$72	Up to \$72
Bifocal Lenses	Up to \$109	Up to \$109
Trifocal Lenses	Up to \$136	Up to \$136
Lenticular Lenses	Up to \$136	Up to \$136
Contact Lenses	Up to \$130	Up to \$150
Medically Necessary Contact Lenses	Up to \$600	Up to \$600
Frames	Up to \$130	Up to \$150

Section 5 Vision Services and Supplies

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted protocols.

Benefit Description	You Pay	
	Standard Option	High Option
Diagnostic		
<p>Eye exam: covered in full every calendar year. Includes dilation, if professionally indicated.</p> <p>92002/92004 New patient exams</p> <p>92012/92014 Established patient exams</p> <p>S0620 Routine ophthalmologic exam w/refraction - new patient</p> <p>S0621 Routine ophthalmologic exam w/refraction - established patient</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: All charges</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: Expenses in excess of the fee schedule allowance of \$30</p>
Eyewear	Standard Option	High Option
<p>You may choose prescription glasses or contacts.</p>		
<p>Lenses: one pair covered in full every calendar year.</p> <p>V2100-2199 Single Vision</p> <p>V2200-2299 Conventional (Lined) Bifocal</p> <p>V2300-2399 Conventional (Lined) Trifocal</p> <p>V2121, V2221, V2321 Lenticular</p> <p>Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses.</p> <p>Note: Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions \geq +/- 6.00 diopters.</p> <p>Note: All lenses include scratch resistant coating with no additional copayment. There may be an additional charge at Walmart and Sam's Club.</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: All charges</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: Expenses in excess of fee schedule allowance of:</p> <p>\$25 single vision</p> <p>\$35 lined bifocal</p> <p>\$45 lined trifocal</p> <p>\$45 lenticular</p>
<p>Frame: <i>High Option:</i> covered once every calendar year.</p> <p><i>Standard Option:</i> covered once every other calendar year.</p> <p>V2020 Frame</p> <p>*Note: Additional discounts are available from participating providers except Walmart and Sam's Club.</p>	<p>In-Network:</p> <p>Collection Frame: Nothing</p> <p>Non-Collection Frame: Expenses in excess of a \$130 allowance. Additionally, a 20% discount applies to any amount over \$130*</p> <p>Out-of-Network: All charges</p>	<p>In-Network:</p> <p>Collection Frame: Nothing</p> <p>Non-Collection Frame: Expenses in excess of a \$150 allowance. Additionally, a 20% discount applies to any amount over \$150*</p> <p>Out-of-Network: Expenses in excess of fee schedule allowance of \$30</p>

Eyewear - continued on next page

Benefit Description	You Pay	
	Standard Option	High Option
<p>Eyewear (cont.)</p> <p>Note: Your eyewear will be delivered to your provider from the FEP BlueVision laboratory generally within two to five business days. More delivery time may be needed when out-of-stock frames, AR (anti-reflective) Coating, specialized prescriptions or a non-collection frame is selected.</p> <p>Note: "Collection" frames with retail values up to \$225 are available at no cost at most participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.</p>	<p>In-Network:</p> <p>Collection Frame: Nothing</p> <p>Non-Collection Frame: Expenses in excess of a \$130 allowance. Additionally, a 20% discount applies to any amount over \$130*</p> <p>Out-of-Network: All charges</p>	<p>In-Network:</p> <p>Collection Frame: Nothing</p> <p>Non-Collection Frame: Expenses in excess of a \$150 allowance. Additionally, a 20% discount applies to any amount over \$150*</p> <p>Out-of-Network: Expenses in excess of fee schedule allowance of \$30</p>
<p>Contact Lenses</p> <p>Contact Lenses: covered once every calendar year – in lieu of eyeglasses.</p> <p>V2500-V2599 Contact Lenses</p> <p>Note: In some instances, participating providers may charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the Contact Lenses received is less than the allowance, you may submit a claim for the remaining balance (the combined reimbursement will not exceed the total allowance).</p> <p>*Note: Additional discounts are available from participating providers except Walmart and Sam's Club.</p> <p>**Note: Pre-authorization is required.</p>	<p>In-Network:</p> <p>Expenses in excess of a \$130 allowance (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a 15% discount applies to any amount over \$130.*</p> <p>Expenses in excess of \$600 for medically necessary contact lenses.**</p> <p>Out-of-Network: All charges</p>	<p>In-Network:</p> <p>Expenses in excess of a \$150 allowance (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a 15% discount applies to any amount over \$150.*</p> <p>Expenses in excess of \$600 for medically necessary contact lenses.**</p> <p>Out-of-Network: Expenses in excess of fee schedule allowance of:</p> <p>\$75 elective contact lenses</p> <p>\$225 medically necessary contact lenses</p>
<p>Other Vision Services</p> <p>Optional Lenses and Treatments:</p> <p>Ultraviolet Protective Coating</p> <p>Polycarbonate Lenses (if not child, monocular or prescription \geq +/-6.00 diopters)</p> <p>Blended Segment Lenses</p> <p>Intermediate Vision Lenses</p> <p>Standard Progressives</p> <p>Premium Progressives (Varilux®, etc.)</p> <p>Photochromic Glass Lenses</p> <p>Plastic Photosensitive Lenses (Transitions®)</p> <p>Polarized Lenses</p> <p>Standard Anti-Reflective (AR) Coating</p> <p>Premium AR Coating</p> <p>Ultra AR Coating</p> <p>Hi-Index Lenses</p>	<p>In-Network Only</p> <p>No Copay</p> <p>\$30</p> <p>\$20</p> <p>\$30</p> <p>\$50</p> <p>\$90</p> <p>\$20</p> <p>\$65</p> <p>\$75</p> <p>\$35</p> <p>\$48</p> <p>\$60</p> <p>\$55</p>	<p>In-Network Only</p> <p>No Copay</p> <p>\$30</p> <p>\$20</p> <p>\$30</p> <p>No Copay</p> <p>\$90</p> <p>\$20</p> <p>No Copay</p> <p>\$75</p> <p>\$35</p> <p>\$48</p> <p>\$60</p> <p>\$55</p>

Benefit Description	You Pay	
	Standard Option	High Option
Extra Discounts and Savings Prescription glasses <ul style="list-style-type: none"> • Optional Lens Treatments (only available from FEP BlueVision providers) <ul style="list-style-type: none"> - Progressive Lens Options: Members may receive a discount on additional progressive lens options: 		
Select Progressive Lenses	\$70	\$70
Ultra Progressive Lenses	\$195	\$195

Replacement Contact Lens Program: FEP BlueVision offers a contact lens replacement program to members. This exclusive mail order program provides you with the guaranteed lowest prices on contact lens replacement materials. Members may call 1-800-536-7123 with a current prescription.

Laser Vision Correction: FEP BlueVision members can realize substantial discounts on laser correction procedures (LASIK and PRK). Members are entitled to savings of up to 25% off the provider’s usual and customary fees, or a 5% discount on any advertised special, from participating physicians and affiliated laser centers. (Some centers provide a flat fee equating to these discount levels.) To insure that the discount is applied correctly, the member must obtain pre-authorization for this service.

Contact us at 1-888-550-2583 for the names of participating providers and to receive a pre-authorization number.

Additional Benefits

Medically Necessary Contact Lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear. Participating providers will obtain the necessary pre-authorization for these services.

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. After pre-authorization by FEP BlueVision, covered low vision services (both in- and out-of-network) will include one comprehensive low vision evaluation every 5 years, with a maximum charge of \$300; maximum low vision aid allowance of \$600 with a lifetime maximum of \$1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period, with a maximum charge of \$100 each visit. Participating providers will obtain the necessary pre-authorization for these services.

Warranty: FEP BlueVision “Collection” frames and all eyeglass lenses manufactured in FEP BlueVision laboratories are guaranteed for one year from the original date of dispensing. Warranty limitations may apply to provider – or retailer – supplied frames and/or eyeglass lenses. Please ask your provider for details of the warranty that is available to you.

Section 6 International Services and Supplies

If you travel or live outside the United States and Puerto Rico, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this section, the same definitions, limitations, and exclusions also apply.

Please note that pre-authorization does not apply when you receive care outside of the United States and Puerto Rico. You or your provider must submit an explanation of medical necessity for the services listed in Section 3, How You Obtain Care, when you receive these services outside of the United States and Puerto Rico.

International Claims Payment For professional care you receive overseas, we provide benefits as indicated below. You are responsible for any difference between our payment and the amount billed, in addition to any copayment amounts. You must also pay any charges for noncovered services.

Finding an International Provider We do not maintain a network of providers outside the United States and Puerto Rico. You may visit any international provider of your choice.

Filing International Claims International providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** Claim forms are available at www.fepblue.org. To file a claim for covered vision care services received outside the United States and Puerto Rico, send completed claim forms and itemized bills to:

FEP BlueVision

P.O. Box 2010

Latham, New York 12110-2010

Or you may fax your claim to 518-220-6555. Please contact us at fepmemberhelp@davisvision.com to let us know if you would like to submit your claim via email. We will respond with instructions on how to securely submit your claim.

Customer Service Website and Phone Numbers www.fepblue.org or 1-888-550-2583 or call collect 1-518-220-2583.

Laser Vision Correction The discount on laser correction procedures (LASIK and PRK) is only available through network providers. Therefore, the discount on these procedures is not available for services received overseas.

International Plan Allowances You may need to pay the provider in-full at the time of service and you will be reimbursed up to the amounts shown below:

Services/Materials	We Pay	
	Standard Option	High Option
Exam	Up to \$60	Up to \$60
Single Vision Lenses	Up to \$72	Up to \$72
Bifocal Lenses	Up to \$109	Up to \$109
Trifocal Lenses	Up to \$136	Up to \$136
Lenticular Lenses	Up to \$136	Up to \$136
Contact Lenses	Up to \$130	Up to \$150
Medically Necessary Contact Lenses	Up to \$600	Up to \$600
Frames	Up to \$130	Up to \$150

Section 7 General Exclusions – Things We Do Not Cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care or treatment of a covered condition.**

We do not cover the following:

- Services provided by non-participating providers for Standard Option members;
- Any vision service, treatment or materials not specifically listed as a covered service;
- Services and materials that are experimental or investigational;
- Services or materials which are rendered prior to your effective date;
- Services and materials incurred after the termination date of your coverage unless otherwise indicated;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services or materials provided as a result of intentionally self-inflicted injury or illness;
- Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- State or territorial taxes on vision services performed;
- Medical treatment of eye disease or injury;
- Visual therapy;
- Special lens designs or coatings other than those described in this brochure;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel;
- Prosthetic devices and services;
- Insurance of contact lenses;
- Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

If your vision care provider is in the participating network, he or she will file the claim for you, and payment will be sent directly to the vision care provider.

If you live in a limited access area, overseas or if you obtain services from a non-participating provider (High Option only), you are responsible for filing the claim. You can obtain claim forms at www.fepblue.org or call 1-888-550-2583.

After services have been received, submit an out-of-network claim form along with copies of the provider's bills to:

FEP BlueVision

P.O. Box 2010

Latham, New York 12110-2010

Deadline for Filing Your Claim

Participating providers will file your claim for you.

For international claims, those incurred in limited access areas and out-of-network claims*, the standard time limit for filing a claim is up to one year from the date of service.

* High Option Only

Disputed Claims Process

Follow this disputed claims process if you disagree with our decision on your claim or request for services. **The FEDVIP law does not provide a role for OPM to review disputed claims.**

Disputed Claim Steps:

1. The provider, member or patient may appeal any decision to deny services before, during or after the service is provided. Ask us in writing to reconsider our initial decision. You must send written notice of disputed claims via U.S. Mail to:

Quality Assurance/Patient Advocate Department

FEP BlueVision

P.O. Box 791

Latham, New York 12110-0791

2. We will acknowledge receipt of your request within five business days from the date we receive it and will give you a decision within 30 days.

3. If the dispute is not resolved through the reconsideration process, you may request a review of the denial. We will make a decision within 35 days of the date we receive your request in writing.

4. If you do not agree with our final decision, you may request an independent third party, mutually agreed upon by us and OPM, review the decision. The decision of the independent third party is binding on us and is the final administrative review of your claim. This decision is not subject to judicial review.

Section 9 Definitions of Terms We Use in This Brochure

Annual Benefit Maximum	The maximum annual benefit that you can receive, per person, under this plan.
Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Enrollee	The Federal employee or annuitant enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Plan Allowance	The maximum benefit payment for services received. Please refer to Section 4, Your Cost for Covered Services, for the maximum benefit payment for services received in limited access areas or out-of-network and Section 6, International Services and Supplies, for services received outside the United States or Puerto Rico.
Pre-Authorization	This is the procedure used by the plan to pre-approve services and the amount that the plan will cover.
We/Us	FEP BlueVision.
You	Enrollee or eligible family member.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Dental and Vision Insurance Program premium.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-888-550-BLUE (2583) and explain the situation.
- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self-support).

If you have any questions about the eligibility of a dependent, please contact BENEFEDS.

Be sure to review Section 1, Eligibility, of this brochure, prior to submitting your enrollment or obtaining benefits.

Fraud or intentional misrepresentation of material fact is prohibited under the plan. You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the plan, or enroll in the plan when you are no longer eligible.

Notes

Summary of Benefits

- **Do not rely on this chart alone.** This page summarizes specific expenses we cover; for more detail, please review the individual sections of this brochure.
- If you want to enroll or change your enrollment in this plan, please visit www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680.

Covered Services In-Network	High Option You Pay	Standard Option You Pay	Page
Routine Eye Exams (including dilation, if professionally indicated)	Nothing	Nothing	12
Standard Eyeglass Lenses (Contact lenses may be obtained in lieu of glasses)	Nothing	Nothing	12
Optional Lens Treatments	Some additional copays	Some additional copays	
Frames			
Collection Frames	Nothing	Nothing	12-13
Non-Collection Frame	Any amount over the \$150 Plan allowance after a 20% discount	Any amount over the \$130 Plan allowance after a 20% discount	12-13
Contact Lenses	Any amount over the \$150 plan allowance after a 15% discount	Any amount over the \$130 plan allowance after a 15% discount	13
Laser Vision Correction	The provider's charge after the negotiated discount	The provider's charge after the negotiated discount	14

See Section 4, Your Cost for Covered Services, for the Out-of-Network benefits available under High Option.

Rate Information

These rates apply nationwide and internationally.

Monthly Rates

High Option Self Only	High Option Self Plus One	High Option Self and Family	Standard Option Self Only	Standard Option Self Plus One	Standard Option Self and Family
\$10.29	\$20.56	\$30.88	\$8.17	\$16.29	\$24.46

Bi-Weekly Rates

High Option Self Only	High Option Self Plus One	High Option Self and Family	Standard Option Self Only	Standard Option Self Plus One	Standard Option Self and Family
\$4.75	\$9.49	\$14.25	\$3.77	\$7.52	\$11.29