

Qualified Health Plan Submission Guide

West Virginia Offices of the Insurance Commissioner
April 2013

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Versioning Table		
Version	Date	Update Reason
Working Draft v1.0	February 12, 2013	Initial release
Working Draft v2.0	April 2013	Updates after release of final rules related to Market Rules, Rate Review, EHB's, Actuarial Value and Accreditation in February 2013 and CMS's Letter to Issuers on April 5, 2013

Section I. General Information and Background

1.1 Purpose

The purpose of this document is to provide guidance to health insurance issuers regarding the certification standards for individual and/or Small Business Health Options Program (SHOP) Qualified Health Plans (QHPs) offered through the federal Health Insurance Marketplace¹ (“Exchange”). This document is for informational purposes and has no legal force or effect; issuers should refer to applicable West Virginia State Code and federal statute, rules, and regulations for a more comprehensive and thorough understanding of requirements related to qualified health plans offered in the Exchange. Federal statute and regulations referenced in this document may not be final, and the citations to the same will be updated in future versions of this document when such regulations are made final.

1.2 Context

The Patient Protection and Affordable Care Act of 2010 (ACA) provides the regulatory framework for the establishment of an Affordable Insurance Exchange (Exchange) and the certified qualified health plans that will be made available to consumers through them. Effective January 1, 2014, the Exchange will offer issuers a state-wide marketplace to make it easier for individuals and small employers and their employees to compare plans and buy health insurance. The Exchange is the only distributional channel through which individuals and small employers will be able to purchase coverage that will be eligible for certain affordability subsidies, including:

- Advanced premium tax credits and/or cost-sharing reductions available to households purchasing coverage in the individual market
- Affordability tax credits available to eligible employers offering coverage in the small group market

To be certified as a QHP, the issuer and its health plans must meet all pertinent federal and state statutory requirements. Operating in partnership with the US Department of Health and Human Services’ (HHS) Center for Medicare and Medicaid Services (CMS), the West Virginia Offices of the Insurance Commissioner (OIC) will review and recommend certification of QHPs to CMS for ratification of the certification recommendation, allowing for participation in the Federally-Facilitated Exchange (FFE). The Affordable Care Act authorizes QHP certification as well as other operational standards for the Exchange in following sections: 1301-1304, 1311-1312, 1321-1322, 1324, 1334, 1401-1402, 1411, and 1412. Standards for QHP issuers are codified in 45 CFR 155 and 156.

An Exchange will need to collect data from issuers as part of QHP certification and recertification and to monitor compliance with QHP certification standards on an ongoing basis. QHP issuer and plan data will also support additional operational

¹Please note that in January 2013 HHS rebranded and began referring to “Exchanges” as “Marketplaces”.

activities, including the calculation of each individual's advance payment of the premium tax credit, the display of plan information on the Exchange web site, and managing the ongoing relationships between QHP issuers, the OIC, and the Exchange. Much of the information collected for QHP certification purposes will support these operational activities on an ongoing basis.

An individual or SHOP health insurance plan certified as a QHP in 2013 will be offered through the Exchange beginning October 1 to any eligible consumer wanting to purchase coverage, with an effective date of coverage beginning no sooner than January 1, 2014. Health insurance issuers will offer certified QHPs for a term of one year beginning January 1, 2014 and ending December 31, 2014. Only OIC-approved health plans certified by CMS may be offered as QHPs through the Exchange during this period.

1.3 General Exchange Participation Requirements

To be certified for participation in the Exchange, a QHP must:

- Meet the legal requirements of offering health insurance in West Virginia
- Satisfy the certification criteria as established by the State
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR Parts 155 and 156
- Receive a recommendation for certification by the OIC, have the recommendation ratified by CMS, and enter into a Certification Agreement with CMS

In addition, to participate in the Exchange an issuer must:

- Submit at least one silver plan and one gold plan (45 CFR 156.200(c)(1))
- Provide a child-only plan at the same level of coverage as any QHP offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21² (45 CFR 156.200(c)(2), 45 CFR 147.150)
- Submit three variations to each silver plan reflecting reduced cost-sharing on the essential health benefits (45 CFR 156.420(a))

Please note that although not reflected in this Guide in their entirety, the Health Insurance Market Rules and Rate Review provisions of 45 CFR Parts 144, 147, 150, 154, and 146³ –released in final form by HHS in February 2013- also apply to plans offered within the Exchange.

²Please note that the OIC has requested clarity from CMS regarding if a child-only plan needs to be made available for each QHP offered or at every metal level for which a QHP is offered.

³E.g., guaranteed availability and guaranteed renewability of coverage.

1.4 Timetable

The following table provides estimated dates for QHP certification process in 2013. Please note that dates are subject to change based on several factors, including many beyond the control of the OIC such as delays in federal guidance, federal timelines, and SERFF enhancements. Issuers will be kept informed of delays through monthly OIC stakeholder meetings and other existing communication mechanisms.

Table 1. Estimated Dates for 2013 QHP Certification Process	
Action	Dates
Issuers request HIOS Product ID and Standard Component Plan IDs in HIOS ⁴	February-March 2013
Issuers submit medical QHPs	April 1 – May 31, 2013
Issuers complete data templates and submit stand-alone dental QHPs ⁵	May 15-June 15, 2013
OIC reviews QHP submissions, requests additional information and works through any concerns with issuers, and submits certification recommendations to CMS for approval/disapproval	April 1 – July 31, 2013
CMS reviews and ratifies OIC certification recommendations	August 2013
Carriers preview plan data and confirm it is correctly uploaded ⁶	August 22-26, 2013
CMS Notifies all Issuers of QHP Certification Decisions for the FFEs	September 4, 2013
Issuer enters into certification agreement with CMS ⁷	September 5 -9, 2013
Consumer open enrollment period	October 1, 2013 – March 31, 2014
2014 plan year	January 1 – December 31, 2014

1.5 Contact Information

For questions, please contact Jeremiah Samples, Director, Health Policy Division, at the West Virginia Offices of the Insurance Commissioner, as follows:

E-mail: jeremiah.samples@wvinsurance.gov

Phone: 304-558-6279 ext. 1131

Mailing Address: 1124 Smith St, Charleston, WV 25301

⁴Issuers must also have a HIOS Issuer ID issued by HHS.

⁵The stand-alone dental plan submission window is delayed due to CCIIO data templates not being finalized; dates are tentative and dependent on CCIIO release of final templates. Please note that although data templates are expected to be available on May 15, 2013 and issuers may begin to complete them immediately, SERFF is not expected to be ready to accept submissions until May 24.

⁶Dates are only estimates as they will be established by CCIIO. Please see Chapter 2 of CCIIO's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013 for more details on the approach to plan preview by issuers.

⁷Same as preceding footnote.

Section II. Specifications for QHP Certification

This section outlines the various issuer- and plan-level components that the OIC will require in the QHP submission. *Please note that prior to completing a “Plans and Benefits Data Template,” issuers must register their HIOS Product IDs and receive Standard Component Plan IDs via CMS’s Health Insurance Oversight System (HIOS)*⁸.

QHP data and information will be submitted by issuers to the OIC in SERFF using the methods numbered below. For each QHP certification requirement included in this section, the primary proposed method issuers will use to submit supporting data information is listed. However, this may change prior to the opening of the QHP submission window subject to new guidance and information from CMS and the NAIC. As permitted by the ACA, issuer and plan data and information required for initial QHP certification and ongoing monitoring will be forwarded by the OIC securely and directly to CMS through SERFF.

At the time of drafting this Guide, the CMS MS Excel Data Templates referenced below are in final form⁹ and can be found at the following location under “Documentation – Business”: <http://www.serff.com/hix.htm>

1. Built-in Onscreen SERFF Data Entry Fields
 - E.g., Plan Binder Name, Plan Year, Market Type
2. CMS Standard MS Excel Data Templates (as attachments)
 - E.g., Administrative Data, Plan and Benefit Data, Rate Data, Formulary Data
3. Supporting Documents (as attachments)
 - E.g., Certification of Compliance, Actuarial Memorandum, and Certificate of Readability
4. Attestations (as a PDF attachment)
 - E.g., “Issuer will adhere to all requirements contained in 45 CFR 156, applicable law and applicable guidance”

2.1 Issuer Administrative Information

This information will be issuer-specific and will only need to be submitted once, per issuer, for all related initial QHP application submissions. This section does apply to stand-alone dental plans.

⁸Issuers must also have a HIOS Issuer ID issued by HHS.

⁹Please note that external testing of the templates will occur through the month of March, the results of which may lead to minor changes in the templates to be used for final QHP submission. The plans and benefits template will be released with the latest add-in file versions of the state-specific benchmark data and AV calculator.

Statutory/Regulatory Standard

Not applicable

OIC/CMS Approach to Certification

The QHP filing process requires submission of certain general administrative data that will be utilized for operational purposes. This basic information is required to identify issuers and the Exchange markets they intend to serve, and to facilitate communications with and payment to issuers. The data elements may include issuer contact information and banking information¹⁰.

Please see the “Administrative Data Template” for detail on the data elements to be collected.

Primary data submission method(s): CMS MS Excel Data Templates

2.2 Licensure, Solvency, and Standing

This information will be issuer-specific and will only need to be submitted once, per issuer, for all related initial QHP application submissions. This section does apply to stand-alone dental plans.

Statutory/Regulatory Standard

An issuer must be licensed, meet State solvency requirements, and have unrestricted authority to write its authorized lines of business in West Virginia State in order to be considered “in good standing” and to offer a QHP through the Exchange. Good standing means that the issuer has no outstanding sanctions imposed by the OIC (45 CFR 156.200(b)(4)).

OIC/CMS Approach to Certification

Financial Conditions Division will review and confirm issuers submitting QHPs meet these standards, leveraging existing information and data sources to review the status of an issuer’s license, solvency, and standing. Consequently, issuers licensed in West Virginia will not be required to submit supporting documentation for this certification standard initially unless concerns are identified and additional review is required. Issuers that are not currently licensed will be required to complete the WV licensing process, which is handled by the OIC’s Financial Conditions Division. West Virginia is a NAIC Uniform Certificate of Authority Application (UCAA) participant state; therefore, West Virginia accepts the UCAA Primary and Expansion Applications. To obtain a

¹⁰ See 508 Appendices A1 and A4 of Paperwork Reduction Act package, CMS Form Number CMS-10433, for additional information.

license in West Virginia, insurers and stand-alone dental plans must follow the procedures outlined in the UCAA Primary and Expansion Applications.

Primary data submission method(s): Attestations

2.3 Benefit Standards and Product Offerings

This information will be QHP-specific and will need to be included for each submitted QHP in the issuer's application. With the exception of 2.3.5 and 2.3.6, this section does apply to stand-alone dental plans.

Plan-specific information not captured in other sections will be collected, including data elements such as Plan ID, whether or not the plan is offered in the individual or SHOP Exchange market and/or off of the Exchange, and plan effective date.

Additionally, issuers must submit benefits information for each QHP. QHP issuers must ensure that each QHP complies with the benefit design standards (specified in section 1302(b) of the ACA and all subsequent related rules, including:

- Federally approved state-specific essential health benefits (EHB) (45 CFR 156.100, 156.110, 156.115, 156.122)
- Cost-sharing limits (45 CFR 156.130)
- Actuarial value (AV) requirements (45 CFR 156.135, §156.140)
- Non-discriminatory benefit design (45 CFR 156.130)
- Mental health parity (45 CFR 156.115)

QHP offerings¹¹ must also reflect meaningful differences amongst products to ensure that a manageable number of distinct plan options are offered.

Sections 2.3.1 – 2.3.6 provide additional requirements related to benefit design standards.

2.3.1 Essential Health Benefits

Statutory/Regulatory Standard

Non-grandfathered small group and individual health benefit plans sold inside and outside of the Exchange must cover a core set of “essential health benefits” as defined by CMS. Coverage must be substantially equal to the coverage offered by a benchmark plan, and the plan must cover at least the greater of one drug in every USP category and class or the same number of drugs in each category and class as benchmark plan (45 CFR 156.110, 156.115, 156.120). In West Virginia, the benchmark plan is Highmark Blue Cross Blue Shield West Virginia Super Blue Plus 2000 1000 Ded. Pediatric dental

¹¹Stand-alone dental plans will not be reviewed for meaningful difference, per CCIIO's “Letter to Issuers on Federally-Facilitated and State Partnership Exchanges” from April 5, 2013.

benefits are supplemented using the State's separate Children's Health Insurance Program (CHIP) program, and pediatric vision benefits are supplemented using the Federal Employees Dental and Vision Insurance Program. Please see Appendix C for a copy of West Virginia's EHB benchmark plan policies. West Virginia Informational Letter 186, located in Appendix D and on the OIC website, provides additional information regarding requirements related to providing coverage that is substantially equal to the benchmark plan.

West Virginia will require that an issuer "provides parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services." Please see Informational Letter No. 184, located in Appendix D and on the OIC website, for additional information regarding habilitative services requirements in West Virginia.

In addition, as a state-required benefit (W. Va. Code § 33-25A-2(1)) enacted on or before December 31, 2011, infertility services are considered an essential health benefit for HMO plans only. Please see Informational Letter No. 185 in Appendix D and on the OIC website for additional information regarding HMO infertility services requirements.

OIC/CMS Approach to Certification

In its review, the OIC will confirm the following:

- Issuer offers coverage that is substantially equal to the benchmark plan
- Issuer has demonstrated actuarial equivalence of substituted benefits if the issuer is substituting benefits
- Issuer provides habilitative services at parity with rehabilitative services
- Issuer provides required number of drugs per category and class
- Issuer provides infertility services (HMO only)

EHB substitutions will require an actuarial certification to support that the substitutions are compliant and actuarially equivalent substitutions (45 CFR 156.115(b)(2)). CMS is working on an actuarial tool to determine actuarially-equivalent EHB substitutions, and further CMS guidance is expected. Data will be collected on health benefits, including covered drugs, and issuers will submit Summary of Benefits and Coverage (SBC) Scenario results.

Issuers will submit their formulary to the OIC using the standard Prescription Drug Data Template (in Microsoft Excel). Prior to doing so, issuers have the option to use CMS' United States Pharmacopeia (USP) Category Class Count Tool¹² to submit a list of RxNorm Count Unique Identifiers (RxCUI's) and receive a report of the category, class, and count of unique drugs applicable to the submitted RxCUI's. Issuers may then manually compare this report with the benchmark standard to assess whether or not the

¹² For more information on this tool, please see the User Guide released by CMS on January 2, 2013.

formulary is in compliance. Similarly, the OIC will use a separate and independent tool created by CMS to compare the issuer's formulary submitted in the Prescription Drug Data Template against West Virginia's benchmark plan to assess areas of non-compliance.

Please see the "Plans and Benefits Data Template" and "Prescription Drug Data Template" for additional detail on the data elements to be collected. Stand-alone dental plan data templates are currently under development by CCIIO and are expected to be made available to issuers by May 15.

Primary data submission method(s): CMS MS Excel Data Templates, Attestations, Supporting Documents

2.3.2 Cost-Sharing Requirements

Statutory/Regulatory Standard

Annual Limitation on Enrollee Out-of-Pocket Costs

Non-grandfathered small group and individual health benefit plans sold inside and outside of the Exchange must meet out-of-pocket limits for annual cost-sharing in 2014 (45 CFR 156.130). The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year shall not exceed the out-of-pocket limit for high deductible health plans (HDHP), adjusted by the Consumer Price Index (CPI-U), and set by the Internal Revenue Service (IRS) pursuant to section 223(c)(2)(A)(ii) of the Internal Revenue Code¹³. CMS anticipates that the IRS will publish the HDHP limit for 2014 in the spring of 2013. To assist issuers in designing health plans for the 2014 plan year, CMS has estimated that the annual limitation on cost sharing for the 2014 plan year will be approximately \$6,400 for self-only coverage and \$12,800 for family coverage¹⁴

Annual Limitation on Deductibles

Employer-sponsored plans may not have a deductible in excess of \$2,000 for a plan covering a single individual or \$4,000 for other coverage. The deductible limit may be increased by the maximum amount of reimbursement reasonably available to an employee under a flexible spending arrangement.

Coverage of Out-of-Network Emergency Services

In addition, emergency department services must be provided as follows:

- Without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency department services received in network; and

¹³As provided in 45 C.F.R. § 156.130(c), cost sharing for benefits provided outside of a health plan's network do not count towards the annual limitation on cost sharing when the health plan uses a provider network.

¹⁴Please see CCIIO's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013 for more details.

- If such services are provided out-of-network, cost-sharing must be limited as provided in §147.138(b)(3).

Please see the provisions of 45 CFR 156.130 for the full complement of requirements related to cost-sharing for medical QHPs.

Cost-Sharing for Stand-Alone Dental Plans

While the annual limitation on cost-sharing for a QHP must be consistent with 45 CFR 156.130, 45 CFR 156.150 indicates the annual limitation on cost-sharing for a stand-alone dental plan would be considered separately from QHPs covering the remaining EHBs. A stand-alone dental plan must demonstrate the annual limitation on cost-sharing for coverage of the pediatric dental EHB is “reasonable”, as determined by the Exchange. CMS’s “Letter to Issuers on Federally-Facilitated and State Partnership Exchanges” from April 5, 2013¹⁵ clarified that for the 2014 coverage year in the FFE, CMS interprets the word “reasonable” to mean any annual limit on cost sharing that is at or below \$700 for a plan with one child enrollee or \$1,400 for a plan with two or more child enrollees.

OIC/CMS Approach to Certification

The OIC will review plan data for compliance with ACA cost-sharing limitations. Benefit cost-sharing (e.g., quantitative limits, co-payments, and co-insurance by benefit), plan cost-sharing (e.g., in-network and out-of-network deductibles), and pharmacy benefit cost-sharing data elements will be collected; please see the “Plans and Benefits Data Template” and “Prescription Drug Data Template” for additional detail on required data elements.

Primary data submission method(s): CMS MS Excel Data Templates, Attestations

2.3.3 Actuarial Value

Statutory/Regulatory Standard

Except for the impact of cost-sharing reduction subsidies and a *de minimis* variation of +/- 2 percentage points, each plan in a metal tier must meet the specified AV requirements based on the cost-sharing features of the plan (45 CFR 156.140):

- Bronze plan – AV of 60 percent
- Silver plan – AV of 70 percent
- Gold plan – AV of 80 percent
- Platinum plan – AV of 90 percent
- Catastrophic plan – N/A¹⁶

¹⁵Chapter 4, Section 2i

¹⁶Please see ACA §1302(e) for details on catastrophic plans and individuals eligible for them.

With exceptions for unique plan designs, issuers must use an actuarial value calculator, provided by CMS for use within the SERFF application, to produce computations of a QHP's metallic level based upon benefit design features. The AV calculator *may* also be used by issuers informally for plan design. For unique plan designs for which the calculator does not provide an accurate summary of plan generosity, an actuarial certification is required from the issuer indicating compliance with one of the calculation methods described in 45 CFR 156.135(b)(2).

Per 45 CFR 156.150, standalone dental plans may not use the CMS-developed AV calculator. Instead, any stand-alone dental plan certified to meet a 70 percent AV, with a *de minimis* range of +/- 2 percentage points, be considered a "low" plan and anything with an AV of 85 percent, with a *de minimis* range of +/- 2 percentage points, be considered a "high" plan. The level of coverage must be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles. The "high/low" actuarial value standard would apply to the pediatric dental EHB only in a stand-alone dental plan; when the pediatric dental EHB is included in a health plan, the AV calculator would apply to the pediatric dental EHB.

OIC/CMS Approach to Certification

The OIC will review and confirm that the AV for each QHP meets specified levels and review unique plan designs and the accompanying actuarial certification, if applicable.

Primary data submission method(s): CMS MS Excel Data Templates, Attestations, Supporting Documents

2.3.4 Non-Discrimination

Statutory/Regulatory Standard

An issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (45 CFR 156.125). In addition, QHPs must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR 156.200(e)) and must not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs (45 CFR 156.225(b)).

OIC/CMS Approach to Certification

To ensure non-discrimination in benefit design, the OIC will perform an outlier analysis on QHP cost sharing (e.g., co-payments and co-insurance) using an Excel-based tool provided by CMS as part of QHP certification reviews. In 2014, the analysis will identify cost-sharing outliers for specific benefits, including:

- Inpatient hospital stays
- Inpatient mental/behavioral health stays
- Specialist visits

- Pregnancy and newborn care
- Specific conditions including behavioral health conditions such as mental health disorders and substance abuse
- Prescription drugs

In addition, information contained in the “explanations” and “exclusions” sections of the plans and benefits template will be performed with the objective of identifying discriminatory practices or wording. Lastly, issuers will be required to attest to non-discrimination on these factors.

Please see Chapter 1, Section 4i of CMS’s “Letter to Issuers on Federally-Facilitated and State Partnership Exchanges” from April 5, 2013 for additional information related to review of non-discrimination in benefit design.

Primary data submission method(s): CMS MS Excel Data Templates, Attestations

2.3.5 Mental Health Parity and Addiction Equity Act

Statutory/Regulatory Standard

Non-grandfathered individual and small group plans sold inside and outside of the Exchange are required to comply with the Mental Health Parity and Addiction Equity Act (45 CFR 156.115).

OIC/CMS Approach to Certification

The OIC will review benefits and cost-sharing for compliance with this standard, including ensuring that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Primary data submission method(s): CMS MS Excel Data Templates, Attestations

2.3.6 Meaningful Difference

Statutory/Regulatory Standard

Per Chapter 1, Section 4ii of CMS’s “Letter to Issuers on Federally-Facilitated and State Partnership Exchanges” from April 5, 2013, “CMS wishes to ensure that consumers can make an informed selection among plan choices that the consumer can readily differentiate and compare, and that one issuer does not impede competition by submitting a number of very similar QHPs that monopolize virtual ‘shelf space’”.

OIC/CMS Approach to Certification

The OIC will perform a review of benefit packages for all QHPs offered by an issuer using an Excel-based tool provided by CMS. The goal of this review will be to identify QHPs that are not meaningfully different from other QHPs offered by the same issuer and with the same plan characteristics. As in other areas, the OIC and CMS will use this review to target QHPs for additional review and discussion with the issuer. Based on CMS guidance, the OIC expects the review to consist of two parts.

First, an issuer's plans will be organized into subgroups based on plan type, metal level and overlapping counties/service areas. Second, the OIC will review each subgroup to determine whether the potential QHPs in that subgroup differ from each other on least any one of the following criteria:

- Different network
- Different formulary
- \$50 or more difference in both individual and family in-network deductibles;
- \$100 or more difference in both individual and family in-network maximum-out-of-pocket; and
- Difference in covered EHB

If the OIC finds that two or more plans within a subgroup do not differ based on any of the above criteria (that is, the two or more QHPs are of the same plan type and metal level; have overlapping service areas; have the same provider network, formulary, and EHB coverage; and have less than a \$50 difference in deductibles and less than a \$100 difference in maximum out-of-pocket), then those QHPs will be flagged for follow-up.

If the OIC flags a potential QHP for follow-up based on this review, we anticipate that the issuer will be given the opportunity to amend or withdraw its submission for one of the identified health plans. Alternatively, the issuer may submit supporting documentation explaining how the potential QHP is substantially different from others offered by the issuer for QHP certification and, thus, is in the interest of consumers to certify as a QHP.

Please see Chapter 1, Section 4ii of CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013 for additional information related to supporting informed consumer choice and meaningful difference.

Primary data submission method(s): CMS MS Excel Data Templates

2.4 Rates

This information will be QHP-specific and will need to be included for each submitted QHP in the issuer's application. Due to their excepted benefit status, stand-alone dental plans are not required to meet the rating rules of PHS Act section 2701(a) that underlie the QHP Rating Tables and Business Rules template, therefore sections 2.4.1 and 2.4.2 do not apply. However, section 2.4.3 does apply uniquely to stand-alone dental plans.

2.4.1 Rating Factors

Statutory/Regulatory Standard

Issuers offering non-grandfathered health insurance coverage in the individual and small group markets starting in 2014, and the large group market if such coverage is available through an Exchange starting in 2017, must limit variation in plan premiums to age, tobacco use (subject to wellness program requirements in the small group market), family size, and geography (45 CFR 147.102; 45 CFR 156.255). The federal rule prohibits the use of other rating factors such as health status, medical history, gender, and industry of employment to set premium rates.

The following rules related to rate-setting apply within West Virginia:

- *Tobacco Use.* Rates based on tobacco use may vary by up to 1.5:1.
- *Family Composition.* Issuers must add up the premium rate of each family member to arrive at a family rate. However, the rates of no more than the three oldest covered children who are under age 21 would be used in computing the family premium.
- *Age.* Issuers must use a uniform age rating curve that specifies the distribution of relative rates across all age bands and is applicable to the entire market. The federal government's age curve anchors the premium amount to age 21, and is expressed as a ratio, for all ages between ages 0 and 64, inclusive, subject to the following:
 - Children: single age band covering children 0 to 20 years of age, where all premium rates are the same
 - Adults: one-year age bands starting at age 21 and ending at age 63
 - Older adults: a single age band covering individuals 64 years of age and older, where all premium rates are the same
 - Rates for adults age 21 and older may vary within a ratio of 3:1.

The maximum annual increase based on age is:

- Annual age band: 4.7%
- 3-year age band: 15.9%
- 5-year age band: 24.5%

In both the individual and small group market, the State is proceeding with eleven geographic rating areas based on provider catchment areas, population health and utilization experience factors; to a large degree, these rating areas match regional breakdowns in the market today. For additional details on the eleven rating areas, please refer to the State Rating Requirements Disclosure Form released by the OIC in February 2013.

Issuers must set rates for an entire benefit year, or for the SHOP, plan year and must submit rate information to the Exchange at least annually (45 CFR 156.210 (a) and (b)). In addition, they must charge the same premium rate without regard to whether the plan

is offered through the FFE or directly from the issuer through an agent and is sold inside or outside of the Exchange (156.255).

OIC/CMS Approach to Certification

The OIC will review rates for compliance with rating standards, as well as issuer attestations. Please see the “Rates” and “Business Rules” Data Templates for detail on the data elements to be collected.

Primary data submission method(s): CMS MS Excel Data Templates, Attestation, Supporting Documents

2.4.2 Rate Increases

Statutory/Regulatory Standard

A QHP issuer must submit to the Exchange a justification for a rate increase prior to the implementation of the increase and must prominently post the justification on its Web site (45 CFR 156.210(c)). In addition, rate increases for QHPs are subject to the reporting and review requirements in 45 CFR 154.215 related to the submission of a Rate Filing Justification, inclusive of:

- An CMS standardized Unified Rate Review data template (Part I)
- Written description justifying the rate increase for increases subject to the review threshold (Part II)
- Rate filing documentation (Part III), including an actuarial memorandum providing the reasoning and assumptions that support the data submitted in Part I

OIC/CMS Approach to Certification

The OIC will review the Rate Filing Justification, including actuarial memorandum, for rate increases. Please see the “Uniform Rate Review” Data Template for detail on the data elements to be collected.

Primary data submission method(s): CMS MS Excel Data Templates, Attestation, Supporting Documents

2.4.3 Display of Stand-Alone Dental Plan Rates

Statutory/Regulatory Standard

The Exchange is required to collect and display premium rate information for all QHPs, including stand-alone dental plans, in a standardized and comparable way (45 CFR 155.205(b)). In addition, 45 CFR 156.210 requires QHP and stand-alone dental plan issuers to submit rate and benefit information to the Exchange as a standard for certification by the Exchange.

OIC/CMS Approach to Certification

Stand-alone dental plans will need to complete the rating tables provided in CMS's Excel data templates, and based on that information, CMS will display basic, comparable rate information for stand-alone dental plans on the web portal. CMS will also calculate the advance payment of the premium tax credit for stand-alone dental plans using the pediatric dental EHB premium allocation.

Per CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013, when a consumer is directed to the stand-alone dental plan issuer to make the initial premium payment to effectuate enrollment, the stand-alone dental plan issuers will have the ability to make any premium adjustments beyond those accounted for in the Rating Tables and based on additional rating factors available to issuers of stand-alone dental plans.

In order to provide the maximum amount of information to consumers during plan selection, stand-alone dental plans will need to indicate whether they are committing to the rates reported in the Rating Tables or if they are reserving the option to charge additional premium amounts. Issuers of stand-alone dental plans would indicate in the templates included in the issuer application for QHP certification whether they are guaranteeing the rate that is completed in the templates. If the issuer indicates that the rates are guaranteed, then the issuer would not charge additional rates beyond what is reported in the rating templates. If the issuer indicates that the rates are not guaranteed, the issuer could charge additional premiums to the consumer. The plan compare function of the FFE website will inform consumers what the different indications mean. If an issuer of stand-alone dental plans elects to charge an additional premium, CMS would collect that information for the individual market from the issuer during the transmission of enrollment information and acknowledgement process. As with QHPs in the individual market, the enrollee will be billed by and make payments directly to the stand-alone dental plan issuer.

Primary data submission method(s): CMS MS Excel Data Templates

2.5 Accreditation Standards

This information will be issuer-specific and will only need to be submitted once, per issuer, for all related initial QHP application submissions. This section does not apply to stand-alone dental plans.

Statutory/Regulatory Standard

During an issuer's initial year of QHP certification (e.g., in 2013 for the 2014 coverage year), a QHP issuer must have an existing commercial, Medicaid, or Exchange health plan accreditation in West Virginia granted by a CMS recognized accrediting entity¹⁷ or must have scheduled, or plan to schedule, a review of QHP policies and procedures

¹⁷Accrediting entities approved by HHS as defined in 45 CFR Parts 156.275.

with a recognized accrediting entity (45 CFR 155.1045).¹⁸ Accreditation must be on the basis of local performance in the following categories (45 CFR 156.275):

- Clinical quality measures, such as the HEDIS
- Patient experience ratings on a standardized CAHPS survey
- Consumer access
- Utilization management
- Quality assurance
- Provider credentialing
- Complaints and appeals
- Network adequacy and access
- Patient information programs

OIC/CMS Approach to Certification

In 2013, data verifying accreditation status is expected to be received directly in SERFF from the NCQA and URAC. Issuers meeting accreditation standards in the initial year must authorize the release of accreditation survey data to the OIC and Exchange. An accreditation data file will be received by the NAIC from accrediting entities, loaded into SERFF, and made available for display as part of the plan submission (data will also be sent to CMS). In addition, issuers, regardless of accreditation status, must provide attestations including acknowledgment that, prior to 2016, CAHPS[®] data may be used on the Exchange Internet website and the website may display that a QHP issuer is accredited if that issuer is accredited on its commercial, Medicaid or Exchange product lines¹⁹.

Please see Chapter 1, Section 2, of CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013 for additional information related to accreditation standards and review process.

Primary data submission method(s): Built-in SERFF Fields, Attestations

2.6 Network Adequacy and Provider Data

This information may be issuer or QHP-specific. If the provider network within the service area is consistent across all products and plans sold by the issuer, the issuer

¹⁸ Per 45 CFR 155.1045, prior to a QHP issuer's second and third year of QHP certification (e.g. in 2014 for the 2015 coverage year), a QHP issuer must be accredited by a recognized accrediting entity on the policies and procedures that are applicable to their Exchange products or must have commercial or Medicaid plan accreditation granted by a recognized accrediting entity for the same state in which the issuer is offering Exchange coverage and the administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHP. Prior to a QHP issuer's fourth year of QHP certification and in every subsequent year of certification, an issuer must be accredited in accordance with 45 CFR 156.275.

¹⁹Please see CCIIO's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013 for more details.

may provide required information and attestations only once. If there is any variation in the provider networks across QHPs, information will need to be provided for each product and/or plan. With the exception of 2.6.3, Mental Health and Substance Abuse providers, this section does apply to stand-alone dental plans.

2.6.1 General

Statutory/Regulatory Standard

Per 45 CFR 155.1050, the Exchange must ensure that enrollees of QHPs have a sufficient choice of providers. A QHP's provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be available without unreasonable delay (45 CFR 156.230(a)(2)).

OIC/CMS Approach to Certification

To fulfill the network adequacy requirement, an issuer must be accredited with respect to network adequacy by a CMS-recognized accrediting entity and attest to complying with the following standards to demonstrate it has an adequate range of providers for the intended service areas:

1. Issuer will maintain a provider network that is sufficient in number and types of providers to assure that all services are accessible without unreasonable delay, as specified in 45 CFR 156.230(a)(2)
2. Issuer's network meets applicable WV network adequacy requirements as defined in West Virginia Informational Letter No. 112
3. Issuer's network reflects executed contracts for the year in which the issuer is applying

If the issuer is not accredited or is accredited but cannot respond affirmatively to each of the attestations, a network access plan must be submitted. In general, the access plan may include, but is not limited to, the following types of information based on the NAIC Model Act #74 Managed Care Plan Network Adequacy requirements:

1. Standards for network composition
2. Referral policy
3. Needs of special populations
4. Health needs assessment
5. Communication with members.
6. Coordination activities
7. Continuity of care

Primary data submission method(s): Attestations, Supporting Documents

2.6.2 Essential Community Providers

Statutory/Regulatory Standard

Issuers must ensure that the provider network for a QHP has a sufficient number and geographic distribution of Essential Community Providers (ECPs)²⁰, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area (45 CFR 156.235).

OIC/CMS Approach to Certification

In this section, issuers must denote the ECP's with which they have contracts for each network in which they plan to provide coverage. This must be provided for each service area to which the applicant is applying for QHP certification.

Based on a CMS-developed ECP list²¹, the OIC will verify one of the following using an Excel-based tool provided by CMS:

- Issuer achieves at least 20% ECP participation in network in the service area, agrees to offer contracts to at least one ECP of each type available by county, and agrees to offer contracts to all available Indian providers
- Issuer achieves at least 10% ECP participation in network in the service area, and submits a satisfactory narrative justification as part of its QHP submission
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission.

Justifications submitted by issuers that fail to achieve either standard will undergo stricter review by the OIC.

Issuers that provide a majority of covered services through employed physicians or a single contracted medical group must comply with the alternate standard established by the Exchange (45 CFR 156.235(b)), as follows:

- Issuer has at least the same number of providers located in designated low-income areas²²
- Issuer has at least the same number of providers located in designated low-income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its QHP submission

²⁰ECPs are defined in section 340B(a)(4) of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act. ECPs are provider organizations that by legal obligation, organizational mission, or geographic location serve a patient population that has been at risk for inadequate access to care.

²¹CCIIO's non-exhaustive ECP list is available at: <http://cciio.cms.gov/programs/exchanges/ghp.html>; ECP standards outlined in this document are transitional policies to accommodate first year timeframes.

²²HHS will consider a low-income area a Health Professional Shortage Area (HPSA) or a zip code in which at least 30 percent of the population have incomes below 200 percent of the federal poverty limit.

- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission

Data elements requested may include Essential Community Provider name, an in-network indicator, or alternative documentation for non-standard essential community providers. Please see the “Essential Community Providers Data Template” for more detail on the data elements to be collected.

Please see Chapter 1, Section 1ii of CMS’s “Letter to Issuers on Federally-Facilitated and State Partnership Exchanges” from April 5, 2013 for additional information related to Essential Community Providers.

Primary data submission method(s): Attestation, CMS MS Excel Data Templates, Supporting Documents

2.6.3 Mental Health and Substance Abuse Services

Statutory/Regulatory Standard

Issuers must ensure that the provider network for the QHP has a sufficient number and type of providers that specialize in mental health and substance abuse services to assure that mental health and substance abuse services will be accessible without unreasonable delay (45 CFR 156.230(a)(2)).

OIC/CMS Approach to Certification

Issuers must establish a standard to assure that the QHP network complies with the Federal standard. A copy of this standard must be included in this application, and the issuer must certify that the provider network for this QHP meets this standard.

Primary data submission method(s): Attestation, Supporting Documents

2.6.4 Service Area

This information will be QHP-specific and will need to be included for each QHP in the issuer’s submission. This section does apply to stand-alone dental plans.

Statutory/Regulatory Standard

The QHP service area must be at minimum an entire county, or a group of counties, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, in the best interest of the qualified individuals and employers, and was established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high-utilizing, high-cost, or medically-underserved populations (45 CFR 155.1055).

OIC/CMS Approach to Certification

QHP service areas will be set by county in WV.²³

Data elements such as service area ID and name will be collected from issuers using the CMS standard data template. Please see the “Service Area Data Template” for additional detail on the data elements to be collected.

Primary data submission method(s): CMS MS Excel Data Template, Attestation

2.6.5 Provider Directory

Statutory/Regulatory Standard

A QHP issuer must make its health plan provider directory available to the Exchange electronically and to potential enrollees and current enrollees in hard copy upon request (45 CFR 156.230 (b)).

OIC/CMS Approach to Certification

For benefit year 2014, issuers will be asked to provide their network names, IDs, and URL in a Network Template (included as part of the “Plans and Benefits Data Templates”).

Primary data submission method(s): CMS MS Excel Data Templates

2.7 Marketing, Applications, and Notices

This information may be issuer-specific or QHP-specific. This section does apply to stand-alone dental plans.

Statutory/Regulatory Standard

Issuers must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in their QHP (45 CFR 156.225). In addition, all QHP enrollee applications and notices must comply with Federal standards in 45 CFR 155.230 and 156.250, including being provided in plain language and language that is accessible to people with Limited English Proficiency and disabilities. Issuers must also comply with existing standards related to advertising and marketing in WV based on the NAIC Model Act for Advertisement of Accident and Sickness Insurance (“WV Legislative Rules Title 114 Series 10”).

²³Please note that the standard SERFF template used includes a field to indicate whether or not the service area is a partial county; this does not apply in West Virginia.

OIC/CMS Approach to Certification

Issuers will be asked to attest to compliance with the ACA requirements related to non-discrimination in marketing practices. Issuers must also submit a copy of all marketing materials, application, and notices for approval and provide a Certificate of Readability per WV 33-29-5.

Primary data submission method(s): Attestation; Supporting Documents

2.8 Quality Standards

This information may be issuer-specific or QHP-specific. This section does apply to stand-alone dental plans.

Statutory/Regulatory Standard

By 2016, CMS will develop a rating system that will rate QHPs offered through an Exchange in each benefits level on the basis of the relative quality and price (ACA § 1311(c)(3)) and an enrollee satisfaction survey system (ACA § 1311(c)(4)). In addition, issuers must implement a Quality Improvement Strategy (QIS) that complies with the description in ACA § 1311(g)(1), i.e., uses provider reimbursement or other incentives to improve health outcomes, prevent hospital readmissions, improve patient safety, and implement wellness programs.

CMS intends to propose in future rulemaking that quality reporting requirements related to all QHP issuers (other than accreditation reporting) become a condition of QHP certification, beginning in 2016, based on the 2015 coverage year; such regulatory proposals would be part of the implementation of Affordable Care Act § 1311(c)(1)(E), 1311(c)(3), 1311(c)(4), 1311(g), and 1311(h).

OIC/CMS Approach to Certification

Issuers will be required attest to compliance with various Federal quality requirements (see section 3.2 for details). Future quality and quality improvement standards will be developed for 2016.

Primary data submission method(s): Attestation

2.9 Segregation of Funds for Abortion Services

This information is QHP-specific. This section does not apply to stand-alone dental plans.

Statutory/Regulatory Standard

In the case of issuers that cover abortions for which federal funding is prohibited, the ACA bars the use of federal funds "attributable" to either the advance refundable tax

credit or cost-sharing reduction under the Act for those abortions. The ACA requires issuers to create allocation accounts that separate the portion of premiums/tax credits/cost-sharing subsidies for covered services *other* than non-excepted abortions from the premium amount equal to the actuarial value of the coverage of abortion services. Issuers must exclusively use funds from these separate accounts to pay for the services for which the funds were allocated (e.g., funds for services other than non-excepted abortions cannot be used to pay for non-excepted abortions).

Additionally, the ACA requires issuers to provide a notice to enrollees of abortion coverage as part of the summary of benefits and coverage explanation at the time of enrollment; specifies that notices provided to enrollees, advertisements about qualified plans, information provided by Exchanges, and any other information specified by the Secretary, must provide information with respect to the total amount of the combined premium/tax credit/cost sharing subsidy payments for services covered by the plan and in connection with abortions for which federal funding is prohibited; and prohibits qualified health plans from discriminating against any health care provider or any health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortion.

Issuers offering coverage for non-excepted abortion services²⁴ must submit a segregation plan that details its process and methodology for meeting the requirements of Section 1303(b)(2)(C), (D), and (E) of the ACA. The segregation plan must describe the health plan's financial accounting systems, including appropriate accounting documentation and internal controls²⁵, which would ensure the segregation of funds required by the ACA. The plan should address items including the following:

- The financial accounting systems, including accounting documentation and internal controls, that would ensure the appropriate segregation of payments received for coverage of non-excepted abortion services from those received for coverage of all other services, which may be supported by Federal premium tax credits and cost-sharing reduction payments
- The financial accounting systems, including accounting documentation and internal controls, that would ensure that all expenditures for non-excepted abortion services are reimbursed from the appropriate account
- An explanation of how the health plan's systems, accounting documentation, and controls meet the requirements for segregation accounts under the law

²⁴“Non-excepted services and other requirements are enumerated in “Pre-Regulatory Model Guidelines Under Section 1303 of the Affordable Care Act (PL-111- 148): Issued Pursuant to Executive Order 13535 (March 24, 2010)” and finalized in 45 CFR 156.280.

²⁵ For more information on internal control standards, please refer to the following Federal guidance: OMB Circular A-123, *Management's Responsibilities for Internal Controls*, located at http://www.whitehouse.gov/omb/circulars_a123_rev/ and the Government Accountability Office's *Standards for Internal Control in the Federal Government*, more commonly known as the “Green Book,” located at <http://www.gao.gov/products/AIMD-00-21.3.1>.

OIC/CMS Approach to Certification

Issuers will be asked to annually attest that they will comply with Federal requirements related to segregation of funds for abortion services, as well as provide a segregation plan. The OIC will perform periodic financial audits of each QHP to assure compliance with Section 1303 of the ACA.

Primary data submission method(s): Attestation, Supporting Documents

2.10 Other Issuer and QHP Requirements

In addition to the initial QHP certification requirements listed in the preceding sections 2.1-2.9, QHP issuers must comply with several other requirements in the ACA and associated Federal rules initially and on an ongoing basis as a condition of participation in the Exchange. These requirements are summarized below, and additional information is provided in the QHP certification checklist in Appendix A. Issuers will be required to attest to compliance with several of these requirements; please see section 3.2 for a full list of CMS-required attestations.

1. Transparency requirements (45 CFR 155.1040; 45 CFR 156.220)
2. Enrollment period (45 CFR 155.410; 45 CFR 155.410)
3. Enrollment process for qualified individuals (45 CFR 156.265; 45 CFR 156.400 (d))
4. Termination of coverage of qualified individuals (45 CFR 155.430; 45 CFR 156.270)
5. SHOP-specific requirements (45 CFR 156.285)
6. Recertification and decertification (45 CFR 156.290)
7. Other substantive and reporting requirements (45 CFR 156.200(b); 45 CFR 156.200(e); 45 CFR 155.1000(c)(2); 45 CFR 147.136; 45 CFR 156.245; 45 CFR 156.295)

2.11 Summary of Required Attachments

Documents listed in this section may or may not apply to stand-alone dental plans, as indicated in previous sections.

The following required documentation should be submitted as attachments in SERFF.

- A. Actuarial certification for EHB substitutions (*if applicable*)
- B. Actuarial certification for unique plan designs using approved calculation methodology to determine plan actuarial value as an alternative to the AV calculator (*if applicable*)
- C. Actuarial memorandum and rate abstract for the review of rates

- D. Network access plan for issuers not accredited by an CMS-approved accrediting entity on network adequacy (*if applicable*)
- E. Network adequacy standard regarding mental health and substance abuse providers
- F. Narrative justification for not meeting ECP standards (*if applicable*)
- G. Marketing materials, enrollee applications and notices, and associated Certificate(s) of Readability
- H. Segregation plan for funds used for abortion services
- I. Compliance plan, in or ready for implementation, consisting of:
 - a. Written policies, procedures, and standards of conduct
 - b. Designated Compliance Officer and a compliance committee
 - c. Compliance training and education
 - d. Effective lines of communication
 - e. Well-publicized disciplinary standards
 - f. A system for routine monitoring and the identification of compliance risks
 - g. Procedures and a system for prompt responses to compliance issues
- J. Organization chart

Section III. Attestations

Documents including all attestations will be available for download by issuers in SERFF. Issuers will review, complete, provide an electronic signature, and upload back into SERFF.

3.1 West Virginia Requirements

3.1.1 Network Adequacy

1. Issuer attests that it will maintain a provider network that is sufficient in number and types of providers to assure that all services are accessible without unreasonable delay, as specified in 45 CFR 156.230(a)(2).
2. Issuer attests that its provider network meets applicable WV network adequacy requirements in defined in West Virginia Informational Letter No. 112.
3. Applicant attests that its provider network reflects executed contracts for the year in which the issuer is applying.
4. Issuer attests that the provider network for this QHP has a sufficient number and geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area.
5. Issuer attests that the provider network for this QHP has a sufficient number and type of providers that specialize in mental health and substance abuse services (MHSAPs) to assure that mental health and substance abuse services will be accessible without unreasonable delay.

3.2 CMS Requirements

The following attestations were developed by CMS and are proposed therefore are subject to change. CMS and the NAIC have indicated issuers will be able to download a PDF document with the attestations in SERFF, provide an electronic signature, and upload back into SERFF for submission to the State and CMS.

3.2.1 General

1. As a QHP issuer, applicant will adhere to all requirements contained in 45 CFR 156, applicable law, and applicable guidance.
2. Applicant attests that it has a compliance plan that adheres to all applicable laws, regulations, and guidance and that the compliance plan is ready for implementation.
3. If yes, upload a copy of the applicant's compliance plan.
4. Applicant agrees to adhere to the compliance plan provided.
5. Applicant attests that it will inform CMS of any significant changes to the organizational chart submitted that occur after the submission of this application.
6. If yes, upload a copy of the applicant's organizational chart.

7. As a QHP issuer, applicant attests that it will notify and obtain CMS approval prior to making any change in ownership that impact the entity(ies) that directly impact the QHP issuer.
8. As a QHP issuer, applicant will:
 - (1) Comply with all QHP requirements on an ongoing basis
 - (2) Comply with Exchange processes, procedures, and requirements
 - (3) Comply with all benefit design standards
 - (4) Have a license, be in good standing, and be authorized to offer each specific type of insurance coverage offered in each State in which the issuer offers a QHP
9. Applicant has in place an effective internal claims and appeals process, and agrees to comply with all requirements for an external review process with respect to QHP enrollees, consistent with 45 CFR 147.
10. The applicant (under a current or former name) attests that there are no Federal or State Government past (within 3 years of this submission), current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration against the applicant, its principals, or any of its subcontractors.
11. The applicant (under current or former name) attests that none of its principals, nor any of its affiliates is presently debarred, suspended, proposed for debarment, or declared ineligible to participate in Federal programs under 2 CFR 180.970 or any other applicable statute or regulation.
12. Applicant, Applicant staff, and its affiliated companies, subsidiaries, or subcontractors (first tier, downstream, and related entities), and subcontractor staff agree that they are bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. Please note that this attestation includes any member of the board of directors, key management or executive staff, or major stockholder of the Applicant and its affiliated companies, subsidiaries, or subcontractors (first tier, downstream, and related entities).
13. The applicant agrees that as a QHP issuer it will adhere to all applicable state and federal law.
14. As a QHP issuer, applicant will provide updated rate and benefit information for QHPs offered in the SHOP, if applicable, on a quarterly basis consistent with 45 CFR 156.285(a)(2) and all applicable guidance.
15. As a QHP issuer, applicant will adhere to requirements related to the segregation of funds for abortion services consistent with 45 CFR 156.280 and all applicable guidance.
16. Applicant agrees to use of FFE systems and tools for communication with CMS.

17. Applicant agrees to technical requirements related to the use of FFE Plan Management system.
18. As a QHP issuer, applicant agrees to make available the amount of enrollee cost-sharing under an individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of an individual, consistent with 45 CFR 156.220. At a minimum, such information must be made available to such individuals through an Internet website and such other means for individuals without access to the Internet.
19. As a QHP issuer, applicant will set rates for the rates for an entire benefit year and will submit the rate information to the Exchange, including a justification for a rate increase prior to implementation consistent with 45 CFR 156.210.
20. As a QHP issuer, applicant agrees to prominently post rate increase justifications on its website.
21. As a QHP, applicant agrees to adhere to all rating variation requirements pursuant to 45 CFR 156.255.
22. As a QHP issuer, applicant agrees to adhere to provisions addressing payment of federally-qualified health centers in 45 CFR 156.235(e).
23. As a QHP issuer, applicant agrees to offer through the Exchange a minimum of one silver and one gold coverage plans, one child-only plan, and a QHP at the same premium rate in accordance with the requirement of 45 CFR 156.200(c).
24. As a QHP issuer, applicant will not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.
25. As a QHP issuer, applicant will provide transparency in coverage in accordance with 45 CFR 156.220.
26. As a QHP issuer, applicant will market its QHPs in accordance with all applicable state laws and regulations and will not employ discriminatory marketing practices in accordance with 45 CFR 156.225.
27. As a QHP issuer, applicant agrees to pay all users fees in accordance with 45 CFR 156.200(b)(6).
28. As a QHP issuer, applicant agrees to adhere with all non-renewal and decertification requirements in accordance with 45 CFR 156.290.
29. As a QHP issuer, applicant attests that the premium rates for its QHPs comply with federal rating requirements or the state's more restrictive rating requirements.
30. As a QHP issuer, applicant attests that its QHPs provide coverage for each of the 10 statutory categories of EHB in accordance with the applicable EHB benchmark plan and federal law.

31. As a QHP issuer, applicant attests that its QHPs provide benefits that are substantially equal to those covered by the EHB-benchmark plan.
32. As a QHP issuer, applicant attests that any benefits substituted in designing QHP plan benefits are actuarially equivalent to those offered by the EHB benchmark plan.
33. As a QHP issuer, applicant attests that its QHPs' benefits reflect an appropriate balance among the EHB categories, so that benefits are not unduly weighted toward any category.
34. As a QHP issuer, applicant attests that its QHPs include all applicable state required benefits.
35. As a QHP issuer, applicant attests that its QHPs comply with preventive services requirements.
36. As a QHP issuer, applicant attests that it will not employ benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs in QHPs in accordance with 45 CFR 156.225.
37. As a QHP issuer, applicant attests that its drug list will be in compliance with federal regulations.
38. As a QHP issuer, applicant agrees to abide by all cost-sharing limits.
39. As a QHP issuer, applicant attests that each QHP complies with benefit design standards in accordance with 156.200(b)(3).
40. As a QHP issuer, applicant attests that its QHPs provide coverage for emergency department services without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan.
41. As a QHP issuer, applicant attests that the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement for in-network and out-of-network providers for emergency department services.
42. As a QHP issuer, applicant attests to follow all Actuarial Value requirements and meet the metal tiers, as appropriate.
43. As a QHP issuer, applicant attests that its catastrophic QHPs will only enroll individuals under the age of 30.
44. Issuer attests that its stand-alone dental plans are limited scope dental plans.
45. Issuer attests that its stand-alone dental plans meet AV requirements.

3.2.2 Quality

1. As a QHP issuer, applicant will comply with the specific quality disclosure, reporting and implementation requirements of 45 CFR §156.200(b)(5) as will be detailed in future guidance.

2. Issuer Accreditation attestation

a. Issuers with accreditation will attest to the following statements:

1. The QHP issuer authorizes the release of its accreditation data from the accrediting entity to the FFE (if applicable).

2. The QHP issuer understands and acknowledges that for issuers with accreditation, prior to 2016, the Exchange Internet website may display data gathered using the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) measures, which correspond to the commercial market. If commercial market data is unavailable but data corresponding to Medicaid accreditation is available, the latter may be displayed. This data will be displayed if the following conditions are met:

- The QHP issuer has authorized the release of its accreditation data as required for QHP certification
- CAHPS[®] data was considered as part of the QHP issuer's accreditation on Medicaid or commercial lines of business and was submitted to the Exchange by the accrediting entity
- CAHPS[®] data that was submitted to the Exchange by the accrediting entity is available for the same product type as the QHP that is being offered in the Exchange (e.g., HMO Adult CAHPS[®] data for HMO QHP, PPO Adult CAHPS[®] data for PPO QHP, HMO Child CAHPS[®] data for Child-Only QHP HMO, PPO Child CAHPS[®] data for Child-Only QHP PPO)

3. The QHP issuer understands and acknowledges that prior to 2016, the Exchange Internet website may display that a QHP issuer is accredited if that issuer is accredited on its commercial, Medicaid, or Exchange product lines by one of the recognized accrediting entities. An accredited status for a QHP issuer will not be displayed if the issuer does not have any products that have achieved at least "provisional" or "interim" status (i.e., an issuer will not be displayed as "accredited" if the accreditation review is scheduled or in process).

b. Issuers who indicate that they are not accredited will attest to the following statements:

1. The QHP issuer understands and acknowledges that for issuers with accreditation, prior to 2016, the Exchange internet website may display data gathered using the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) measures, which correspond to the commercial market. If commercial market data is unavailable but data corresponding to Medicaid accreditation is

available, the latter may be displayed. This data will be displayed if the following conditions are met:

- The QHP issuer has authorized the release of its accreditation data as required for QHP certification
- CAHPS[®] data was considered as part of the QHP issuer's accreditation on Medicaid or commercial lines of business and was submitted to the Exchange by the accrediting entity
- CAHPS[®] data that was submitted to the Exchange by the accrediting entity is available for the same product type as the QHP that is being offered in the Exchange (e.g., HMO Adult CAHPS[®] data for HMO QHP, PPO Adult CAHPS[®] data for PPO QHP, HMO Child CAHPS[®] data for Child-Only QHP HMO, PPO Child CAHPS[®] data for Child-Only QHP PPO)

2. The QHP issuer understands and acknowledges that prior to 2016, the Exchange Internet website may display that a QHP issuer is accredited if that issuer is accredited on its commercial, Medicaid, or Exchange product lines by one of the recognized accrediting entities. An accredited status for a QHP issuer will not be displayed if the issuer does not have any products that have achieved at least "provisional" or "interim" status (i.e., an issuer will not be displayed as "accredited" if the accreditation review is scheduled or in process).

3.2.3 Enrollment

1. As a QHP issuer, the applicant will meet the individual market requirement to enroll a qualified individual during the initial and annual open enrollment periods; abide by the effective dates of coverage; make available, at a minimum, special enrollment periods; and abide by the effective dates of coverage established by the Exchange.
2. As a QHP issuer, the applicant will maintain termination records in accordance with Exchange standards.
3. As a QHP issuer, the applicant will abide by the termination of coverage effective dates requirements.
4. As a QHP issuer, the applicant will notify the qualified individual of his or her effective date of coverage in coordination with the standards.
5. As a QHP issuer, the applicant will adhere to enrollment information collection and transmission and will:
 - Collect enrollment information using the application adopted
 - Transmit the enrollment information to the Exchange consistent with the standards to facilitate the eligibility determination process

- Enroll an individual only after receiving confirmation that the eligibility process is complete and the individual has been determined eligible for enrollment in a QHP, in accordance with the standards
6. As an issuer of a QHP, the applicant will accept enrollment information in an electronic format from the Exchange that is consistent with requirements.
 7. As an issuer of a QHP, the applicant will provide new enrollees an enrollment information package.
 8. As an issuer of a QHP, the applicant will reconcile enrollment files with the Exchange no less than once a month.
 9. As an issuer of a QHP, the applicant will acknowledge receipt of enrollment information in accordance with Exchange standards.
 10. As a QHP issuer, the applicant will only terminate coverage as permitted by the Exchange.
 11. As a QHP issuer, if an enrollee's coverage with a QHP is terminated for any reason, the applicant will provide the Exchange and the enrollee with a notice of termination of coverage that is consistent with the effective date established by the Exchange.
 12. As a QHP issuer, the applicant will establish a standard policy for the termination of coverage of enrollees due to non-payment of premium as permitted by the Exchange.
 13. As a QHP issuer, the applicant will provide a grace period of at least three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one month's premium.
 14. As a QHP issuer, if an enrollee is delinquent on premium payments, the applicant will provide the enrollee with notice of such payment delinquency.
 15. As a QHP issuer, if an enrollee receiving advance payments of the premium tax credit exhausts the grace period without submitting any premium payments, the applicant will terminate the enrollee's coverage effective at the end of the payment grace period.
 16. As a QHP issuer within an FFE, applicant agrees to develop, operate, and maintain viable systems, processes, and procedures for the timely, accurate, and valid enrollment and termination of enrollees' coverage within the exchange.
 17. As a QHP issuer within an FFE, applicant agrees to establish business processes and communication protocols for the prompt resolution of urgent issues affecting enrollees, such as changes in enrollment.
 18. As a QHP issuer within an FFE, applicant acknowledges that enrollees can make enrollment changes during open and special enrollment periods for which they are eligible.

19. As a QHP issuer within an FFE, applicant will comply with all Exchange requirements regarding involuntary termination of an enrollee initiated by the QHP for the following reasons: 1) Monthly premiums are not paid on a timely basis and is subject to the grace period for late payments, or 2) enrollee provides fraudulent information on his or her application form or permits abuse of his or her benefit cards.
20. As a QHP issuer, applicant agrees to provide required notices to enrollees, including enrollment materials consistent with CMS rules, including but not limited to summary of benefits, evidence of coverage, provider directories, enrollment/disenrollment notices, coverage denials, ID cards, and other standardized mandated notices.
21. As a QHP issuer within an FFE, applicant will give the enrollee written notice(s) of involuntary termination with an explanation of why the QHP is terminating the enrollee. Notices and reason must include an explanation of the enrollee's right to appeal.
22. As a QHP issuer within an FFE, applicant agrees to accurately and thoroughly process and submit the necessary data to validate enrollment and APTC credits on a monthly basis.
23. As a QHP issuer, applicant accepts that the FFE will calculate individuals' premiums and make determinations of individuals' eligibility for the premium tax credit and cost-sharing reduction.
24. As a QHP issuer, applicant approves of the use of the following information for display on the FFE Web site for consumer education purposes:
 - Information on rates and premiums
 - Information on benefits
 - The provider network URL(s) provided in this application
 - The URL(s) for the Summary of Benefits and Coverage provided in this application
 - The URL(s) for payment provided by this application
 - Information on whether the issuer is a Medicaid managed care organization
 - Quality information derived from the accreditation survey, including accreditation status and CAHPS data

3.2.4 Financial Management

1. As a QHP issuer, applicant acknowledges and agrees they are bound by Federal statutes and requirements that govern Federal funds. Federal funds include but are not limited to advance payments of the premium tax credit, cost-sharing reductions, and Federal payments related to the risk adjustment, reinsurance, and risk corridor programs.

2. As a QHP issuer, applicant agrees to make reinsurance contributions at the national contribution rate for the reinsurance program for all reinsurance contribution enrollees who reside in a State, in a frequency and manner determined by CMS as applicable.
3. As a QHP issuer, applicant agrees to make reinsurance contributions to each applicable reinsurance entity for the reinsurance contribution enrollees who reside in the applicable geographic area, if the State establishes or contracts with more than one applicable reinsurance entity.
4. QHP applicant agrees to submit contributions to CMS on a quarterly basis beginning January 15, 2014.
5. As a QHP issuer, applicant agrees to submit to CMS data required to substantiate the contribution amounts for the contributing entity in the manner and timeframe specified by the State or CMS.
6. As a QHP issuer, applicant acknowledges that only issuers of reinsurance-eligible plans may make a request for payment when an enrollee of that reinsurance-eligible plan has met the criteria for reinsurance payment set forth in annual CMS notice of benefit and payment parameters for the applicable year.
7. As a QHP issuer, applicant agrees that they will adhere to the risk adjustment issuer requirements set by CMS in 45 CFR 153.610.
8. As a QHP issuer, applicant agrees to adhere to the risk adjustment compliance standards set by CMS in 45 CFR 153.620.
9. As a QHP issuer, applicant agrees to adhere to the requirements set by CMS in 45 CFR 153.510 and the annual CMS notice of benefit and payment parameters for the establishment and administration of a program risk corridors for calendar years 2014, 2015, and 2016.
10. As a QHP issuer, applicant agrees to remit charges to CMS under the circumstances described in 45 CFR 153.510(c)
11. As a QHP issuer, applicant agrees to adhere to the risk corridor standards set by CMS in 45 CFR 153.520.
12. As a QHP issuer, applicant agrees to adhere to the risk corridor data requirements set by CMS in 45 CFR 153.530
13. As a QHP issuer, applicant agrees to adhere to the standards set forth by CMS for the administration of advance payments of the premium tax credit, including the provisions at 45 CFR 156.460, 156.440, and 156.470.
14. As a QHP issuer, applicant agrees to adhere to the standards set forth by CMS for the administration of cost-sharing reductions, including the provisions at 45 CFR 156.410, 156.425, 156.430, 156.440, and 156.470.

15. As a QHP issuer, applicant agrees to submit to CMS the applicable plan variations that adhere to the standards set forth by CMS at 45 CFR 156.420.

3.2.5 SHOP

1. I attest that I will adhere to any current or future regulation and guidance with respect to conditioning a QHP issuer's ability to offer QHPs in the individual market Exchange with the offering of QHPs in the SHOP.
2. I attest that I understand QHP premiums in the SHOP may not vary based on the method of plan offering chosen by an employer; OR I attest that I understand QHP premiums in the SHOP may not vary based on method of offering (i.e., employee or employer choice).
3. I attest that I will adhere to any current or future regulation and guidance with respect to agent and broker appointments and commissions in the SHOP.
4. I attest that I will adhere to any current or future regulation and guidance with respect to the holder of a QHP policy, including the understanding that the qualified employer is considered the holder of the QHP policies sold to its employees through the SHOP.

3.2.6 Reporting Requirements

1. As a QHP issuer, the applicant agrees to provide to the Exchange the following "transparency" information in the manner identified by CMS:
 - Claims payment policies and practices
 - Periodic financial disclosures
 - Data on enrollment
 - Data on disenrollment
 - Data on the number of claims that are denied
 - Data on rating practices
 - Information on cost-sharing and payments with respect to any out-of-network coverage
 - Information on enrollee rights under title I of the Affordable Care Act
2. As a QHP issuer, applicant will report required data on prescription drug distribution and costs consistent with 45 CFR 156.295 and all applicable guidance.

Section IV. Appendices

Appendix A. QHP Certification Checklists

The following checklists of QHP certification requirements in the individual and small group markets are intended to serve as a guide to issuers as they prepare their QHP submissions for benefit year 2014. For ease of reference, the existing State of West Virginia review checklists have been merged with the Federal QHP-related requirements. Please note that additional requirements that have not been captured in the checklist may apply.

Please note that the order of the requirements in the checklist does not necessarily imply the order in which an issuer must submit the QHP data and information in SERFF. Prior to submitting plan-level “Plans and Benefits Data Templates,” issuers must register their Product IDs and receive Standard Component Plan IDs via HIOS²⁶.

General Exchange Participation Requirements

In addition to the requirements included in the table below, to be certified for participation in the Exchange, a QHP must:

- Meet the legal requirements of offering health insurance in West Virginia
- Satisfy the certification criteria as established by the State
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR Parts §155 and §156
- Receive a recommendation for certification by the OIC, have the recommendation ratified by CMS, and enter into a Certification Agreement with CMS

To participate in the Exchange, an issuer must also:

- Submit at least one silver plan and one gold plan (45 CFR 156.200(c)(1))
- Provide a child-only plan at the same level of coverage as any QHP offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21²⁷ (45 CFR 156.200(c)(2), 45 CFR 147.150)
- Submit three variations to each silver plan reflecting reduced cost-sharing on the essential health benefits (45 CFR 156.420(a))
- Comply with all applicable provisions of the Health Insurance Market Rules and Rate Review provisions of 45 CFR Parts 144, 147, 150, 154, and 146²⁸ – released in final form by HHS in February 2013

²⁶ Issuers must also have a HIOS Issuer ID issued by HHS.

²⁷ Please note that the OIC has requested clarity from CMS regarding if a child-only plan needs to be made available for each QHP offered or at every metal level for which a QHP is offered.

Appendix B. Reference Table for Federal Requirements

Requirement Category	Federal Requirement	Reference
Licensing and Standing	State Licensure	45 CFR §156.200(b)(4)
QHP Certification Process	Timing of QHP Certification	45 CFR §155.1010(a)
	Frequency of QHP Certification	45 CFR §155.1075
Continued Compliance with Certification Criteria	Exchange monitoring of QHP for compliance	45 CFR §155.1010(d)
Actuarial Value	Actuarial Value Standards	45 CFR 156.135, 156.40, 156.50
	Catastrophic Plans	45 CFR 156.155
Abortion Services	Compliance with State Abortion Laws	45 CFR §156.280(a)
	Abortion Funds Segregation	45 CFR §156.280
Premium Rate and Benefit Information	Rate Plan Year	45 CFR §156.210(a)
	Rate Submission	45 CFR §156.210 (b)
	Rate Increase Justification	45 CFR §156.210(c), 45 CFR §155.1020(a)
	Rate Increase Consideration	45 CFR §155.1020 (b)
	Benefit and Rate Information	45 CFR §155.1020(c)
Plan Benefits	QHP Requirement to Cover	45 CFR §156.200(b)(3)
	EHB Benchmark Plan Standards	45 CFR 156.110
	EHB Standards (including Mental Health Parity)	45 CFR 156.115
	EHB Formulary Review	45 CFR 156.120
	Cost-Sharing	45 CFR 156.130
Rating Variations	Product Pricing	45 CFR §156.255(b)
	Allowable Variability	45 CFR §156.255(a)
Plan Offering Requirements	Actuarial Value Tiers	45 CFR §156.200(c)(1)
	Child-only Plan	45 CFR §156.200(c)(2)
Accreditation	General requirement	45 CFR §156.275(a)

²⁸E.g., guaranteed availability and guaranteed renewability of coverage.

Requirement Category	Federal Requirement	Reference
	Timeframe for Accreditation	45 CFR §155.1045
Health Care Quality Requirements	Quality Improvement Initiative	45 CFR §156.200(b)(5), Section 1311(g) of the ACA
	Quality and Outcomes Reporting	45 CFR §156.200(b)(5), Section 1311(c)(1)(I) of the ACA
	Enrollee Satisfaction Surveys	45 CFR §156.200(b)(5), Section 1311(c)(4) of the ACA
Transparency in Coverage	Required Information Related to Coverage Transparency	45 CFR §156.220(a)
	Reporting Requirement	45 CFR §156.220(b), 45 CFR §156.220(c)
	Enrollee Cost-sharing	45 CFR §156.220(d)
Service Area	Minimum Service Area	45 CFR §155.1050(a)
	Non-Discriminatory Service Area	45 CFR §155.1050(b)
Network Adequacy	Network Adequacy Standards	45 CFR §156.230
	Provider Directory	45 CFR §156.230(b)
	Essential Community Providers	45 CFR §156.235
User Fees	Issuer Payment of Fees	45 CFR §156.200(b)(6)
Marketing	Marketing Rule Compliance	45 CFR §156.225(a)
	Non-discrimination	45 CFR §156.225(b)
Enrollment Processes and Periods	Enrollment Periods and Processes	45 CFR §156.260, §156.265 (small employer: 45 CFR §155.725)
	Termination	45 CFR §156.270
Risk Adjustment	Participation in Risk Adjustment Programs	45 CFR §156.200(b)(7)
Non-Discrimination	Non-Discrimination	45 CFR §156.200(e), 45 CFR §156.125, 45 CFR 156.225(b)
Cost-Sharing Reduction	Cost-Sharing Reductions	45 CFR §155.340, 45 CFR §156.410, §156.420, §156.425, §156.430, §156.440

Appendix C. West Virginia EHB Benchmark Plan Policies

Appendix D. Informational Letters

Appendix A:
QHP Certification Checklists

**West Virginia Offices of the Insurance Commissioner
QHP REVIEW REQUIREMENTS CHECKLIST**

INDIVIDUAL MARKET

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
State Requirements		
<i>All references are State of West Virginia statute and regulations, unless otherwise noted</i>		
FORMS		
General Requirements		SERFF filings are submitted in accordance with SERFF filing requirements.
Fees	§33-6-34 §33-6-34	The fee for a Form Filing is \$50.00 per filing The fee for a Rate Filing is \$75 per filing
Submission	Informational Letter No 163 §33-3-7	All filings must be submitted through SERFF (System for Electronic Rate and Form Filing). Filing fees must be remitted via EFT (Electronic Funds Transfer) through SERFF. Review within 60 days. The company transacting insurance in this State must be licensed by the Insurance Commissioner and authorized to conduct the appropriate lines of business for the filing submitted.
Prohibited Provision Or Practice	§33-6-14 §33-4-20(b)(3)	The policy must be construed under the laws of this state. No entity providing life or health insurance may deny, refuse to issue, refuse to reissue, cancel or otherwise terminate an insurance policy or restrict coverage on any individual because that individual is, has been or may be the victim of abuse.
Policy Contents	§ 33-6-11	The policy shall specify the names of the parties to the contract, the insurer's name, the subject of the insurance, the risks insured against, the time the insurance coverage becomes effective and the term during which such coverage continues, the premium (or sufficient information to determine the premium), and the conditions pertaining to the insurance.
Readability	§33-29-5 (a)(1)	The Certification of Readability must show a Test Score of 40 or better according to the Flesch Score reading ease method or by any other comparable method.
Execution of Policies	§33-6-15	Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney-in-fact, employee, or representative duly authorized by the insurer. A facsimile signature of any such executing individual may be used in lieu of an original signature, except that in all policies other than those approved for machine vending the countersignature shall be in original handwriting.
Compliance	§33-15 §33-15A Reg. 114-10 Reg. 114-17	<u>The Certification of Compliance</u> should reference the Chapter and Article for Individual Accident and Sickness policies. <u>Individual Accident and Sickness</u> policy forms must comply with Chapter 33, Article 15 of the WV Code. <u>Advertising</u> - Department policy to require advertising filing on all Accident & Sickness products. <u>AIDS Regulation</u>
Applications		The Application, when attached to the policy, and all its attachments become part of the Entire Contract. Statements Are binding only if an application is attached. Only the applicant can alter statements on the application. This Division does not permit a box on the Application , For Company Use Only, because no changes are to be made to the Entire Contract after the application has been signed by the applicant. False statements may bar recovery.
Required Disclosure Provisions		
Insuring Clause	§33-6-11	<u>On the First Page</u> of the health policy, there should be a broad statement stipulating the conditions under which benefits are to be paid for losses resulting from sickness or accidents. This is the <u>insuring agreement</u> .
Free Look Provision (Right of Return)	Reg. §114-12-6.6.8	<u>On the First Page</u> of all policies, there must be a prominently displayed notice, stating that the policyholder has the <u>right to return the policy within 10 days</u> of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason.
Definition of Special Terms	Reg. §114-12-6.6.4	A policy which provides for the payment of benefits based on standards described as usual and customary, reasonable and

**West Virginia Offices of the Insurance Commissioner
QHP REVIEW REQUIREMENTS CHECKLIST**

INDIVIDUAL MARKET

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
		customary, or similar words must include a definition of those terms in both the policy and the Outline of Coverage.
Summary of Benefit Coverage (SBC)	PHSA 2715 (PPACA)	No policy or certificate for individual health insurance may be delivered or issued for delivery in West Virginia unless an <u>Summary of Benefit Coverage (SBC)</u> is completed for that policy. The SBC and glossary will be provided with enrollment materials or generally 30 days prior to the start of coverage if enrollment materials are not distributed. Consumers in all markets may request a copy of their SBC at any time, and plans and issuers will be required to provide it within 7 business days. The SBC will contain a link to the uniform glossary, but plans and issuers will be required to provide paper copies within 7 business days of requests. Plans and issuers will also provide a notice of material modifications 60 days prior to the effective date of such modifications.
Form and Content Requirements For Accident & Sickness Policies	§33-15-2	<u>Form and Content Requirements</u> - (a) The entire money and considerations must be expressed; (b) The effective date and the termination date of the policy must be expressed; (c) The policy purports to insure only one person, except for family members of the adult policyholder; (d) The policy is guaranteed renewable at the option of the insured; (e) Specifications for style, arrangement, over-all appearance, print size must be met; (f) Each policy form, including riders and endorsements must be identified by a form number in the lower left hand corner of the first part. . .(each page preferably); (g) There must be no provision purporting to make any portion of the insurer's charter, rules, constitution, by-laws a part of the policy. . . (h) The insurer must offer and accept for enrollment every eligible individual who applies for coverage within 63 days after termination of the individual's prior creditable coverage.
Required Policy Provisions		
(1) Entire Contract	§33-15-4(a)	<u>Entire Contract</u> – The Entire Contract includes the policy, all endorsements and any attached papers, such as the application and any riders. Nothing outside of the contract and its attachments is considered part of the entire contract. This Entire Contract assures the policy owner that no changes will be made to the contract after it has been issued. Only an executive Officer of the insurance company and not the agent can make changes to the policy.
(2) Time Limit on Certain Defenses	§33-15-4(b)	<u>Time Limit on Certain Defenses</u> – There is a limit to the period of time in which an insurer may challenge the contract or deny a claim on grounds of material misrepresentation in the application. There are two provisions: 1) After two (2) years has expired from the policy date of issue, no material non disclosures or misstatements made by the applicant may be used to void the policy or deny a claim except in case of fraudulent misstatements. 2) After two (2) years has expired, the insurer cannot deny a claim on the basis of preexisting conditions, unless the condition was excluded from coverage under the policy by name or specific description.
(3) Grace Period	§33-15-4(c)	<u>Grace Period</u> – A certain number of days are allowed after the premium due date during which a premium may be paid without penalty or lapse of the policy for non-payment of premium. The number of days depends on how the premiums are paid: a) 7 days if premiums are paid weekly; b) 10 days if premiums are paid monthly; c) 31 days for all other modes of premium payment.
(5) Reinstatement	§33-15-4(d)	<u>Reinstatement</u> – A policy which has lapsed due to non payment of premium may be put back in force. a) If an application is required, and a conditional receipt for the premium is issued, the policy will be reinstated upon the insurer's approval of the application, or lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the applicant in writing of the disapproval of such application.
(6) Notice of Claim	§33-15-4(e)	<u>Notice of Claim</u> – A Policyholder must give the insurer written notice of claim within 20 days or as soon as reasonably possible. This notice can be given to either the agent or directly to the insurance company. In loss of time contracts, notice of continuation of disability is required at least every six months except in the absence of legal incapacity.
(7) Claim Forms	§33-15-4(f)	<u>Claim Forms</u> - Upon receipt of a notice of claim, the insurer will furnish the claimant within fifteen (15) days the appropriate forms upon which the claimant is to file proofs of loss. The proof of loss must cover the occurrence, the character and the extent of the loss for which claim is made.

**West Virginia Offices of the Insurance Commissioner
QHP REVIEW REQUIREMENTS CHECKLIST**

INDIVIDUAL MARKET

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
(8) Proof of Loss	§33-15-4(g)	<u>Proof of Loss</u> – The claimant must provide the insurer with the written proof of loss within 90 days of the loss or, in the case of a continuing loss, within 90 days after the end of a period for which the insurer is liable. A proof of loss is a formal statement given to the carrier regarding the loss. If the claimant is unable to file within 90 days, the proof of loss must be filed within a reasonable time not exceeding one year, except in the case of legal incapacity.
(10) Payment of Claims	§33-15-4(l)	<u>Payment of Claims</u> – Death benefits from any group policy or individual accident policy are paid to a named beneficiary otherwise to the estate of the insured. If the beneficiary is a minor or legally incapable of receiving proceeds, a facility of payment provision may be included for payments up to one thousand dollars (\$1,000.00). All other benefits are payable to the insured unless assigned to a healthcare provider. The insurer may have the option of making payments directly to the person or hospital rendering services.
(11) Physical Exams & Autopsy	§33-15-4(j)	<u>Physical Examinations and Autopsy</u> – The insurer at its own expense has the right to examine the person insured when and as often as it is reasonably required while a claim under the policy is pending and to make an autopsy in case of death where it is not prohibited by law.
(12) Legal Actions	§33-15-4(k)	<u>Legal Actions</u> – No legal action shall be brought against the company prior to sixty (60) days after proof of loss has been submitted and not later than three years after proof of loss has been submitted.
(13) Change of Beneficiary	§33-15-4(l)	<u>Change of Beneficiary</u> – Unless the insured makes an irrevocable designation of beneficiary, the insured has the right to change the beneficiary and the consent of the beneficiary is not required for the surrender or assignment or other changes in this policy.
AIDS Regulation	Reg. §114-27-2.2.1 Reg. §114-27-4.4.1 b -4.4.2 a -4.4.2 b -4.4.2 c	All insurers who deliver or issue for delivery in this state any policies for life or accident and sickness insurance are subject to this regulation. Sexual orientation may not be used in the underwriting process or in the determination of insurability. No question shall be used which is designed to establish the sexual orientation of the proposed insured. Questions relating to the proposed insured having or having been diagnosed as having AIDS or ARC are permissible if they are factual and designed to establish the existence of the condition. Questions inquiring as to whether the proposed insured has ever tested positive for the presence of the HIV virus or HIV virus antibodies are permissible; however, questions inquiring as to whether the proposed insured has ever been tested for the presence of the HIV virus or HIV antibodies are prohibited.
Mandatory Benefits		
Mental Illness Coverage	45 CFR §156.115	<u>Mental Illness Coverage</u> – EHB covered under Mental health and substance use disorder services, including behavioral health treatment.
Nursing Services	§33-15-4b	<u>Nursing Services</u> – Any insurer issuing policies of accident and sickness insurance shall make available to all subscribers and member’s coverage for primary health care nursing services as described in Article 4b (a), (b) and (c).
Women’s Preventive Coverage	45 CFR §156.115	<u>Women’s Preventive Coverage</u> – EHB covered under Preventive and wellness services and chronic disease management.
Rehabilitation Therapy Benefits	§33-15-4d	<u>Rehabilitation Therapy Benefits</u> – Any entity regulated by Article 15 of Chapter 33 shall provide benefits to all subscribers and members for coverage for rehabilitation services. “Rehabilitation Services” includes those services designed to remediate patient’s condition or restore patients to their optimal physical, medical, psychological, social, emotional, vocational and economic status. These services include, but are not limited to, diagnostic testing, assessment, monitoring or treatment of conditions as described in 33-15-4d (b), (c) and (d). . . Stroke; Spinal cord injury; Amputation; Brain injury. . .
Postpartum Hospital Stay Coverage	§33-15-4e	An insurer offering accident and sickness coverage under Article 15 may not restrict the mother or her newborn child to less than forty-eight hours following a normal vaginal delivery, or to less than ninety-six hours following a cesarean section. . . The mother and her newborn child may be discharged prior to the expiration of the minimum length of stay in those cases in which the decision to discharge is made by an attending provider in consultation with the mother.
Colorectal Cancer Screening Coverage	§33-15-4f	When reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed by qualified and medical board certified physicians, reimbursement or indemnification for colorectal cancer examinations and

**West Virginia Offices of the Insurance Commissioner
QHP REVIEW REQUIREMENTS CHECKLIST**

INDIVIDUAL MARKET

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
		laboratory testing may not be denied for any nonsymptomatic person fifty years of age or older, or a symptomatic person under fifty years of age.
TMJ / CMD	§33-16-3f Reg. §114-29-4	All insurers who issue for delivery in this state accident and sickness insurance policies shall provide benefits for the diagnosis and treatment of temporomandibular disorders (TMD) and craniomandibular disorders. This applies to both renewed coverage and new coverage. An insured shall be given the option of declining coverage for temporomandibular disorders (TMD) and craniomandibular disorders (CMD) and the insurer must provide an appropriate waiver form or incorporate such waiver form into the insurance policy or other evidence of coverage.
Reconstructive Surgery Following Mastectomy	§33-15-4g	Any policy of insurance which provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy
Clinical Trials under §33-25F-1	§33-15-4h	The provisions relating to clinical trials established in article twenty-five-f of Chapter 33 shall apply to the health benefit plans regulated by Article 15 of Chapter 33.
Third-party reimbursement for kidney disease screening	§33-15-4i	Reimbursement or indemnification for annual kidney disease screening and laboratory testing as recommended by the National Kidney Foundation may not be denied for any person when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for kidney disease screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the board of medicine. The tests are as follows: Any combination of blood pressure testing, urine albumin or urine protein testing and serum creatinine testing. The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person may apply to kidney disease screening and laboratory testing.
Required coverage for dental anesthesia services	§33-15-4j	Required coverage for dental anesthesia services. (a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 2009, provide as benefits to all subscribers and members coverage for dental anesthesia services as hereinafter set forth. (b) For purposes of this article and section, "dental anesthesia services" means general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care provided to an enrollee or insured if the enrollee or insured is: (1) Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the enrollee or insured and for whom a superior result can be expected from dental care provided under general anesthesia; or (2) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia. (c) Prior authorization. -- An entity subject to this section may require prior authorization for general anesthesia and associated outpatient hospital or ambulatory facility charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care. (d) An entity subject to this section may restrict coverage for general anesthesia and associated outpatient hospital or ambulatory facility charges unless the dental care is provided by: (1) A fully accredited specialist in pediatric dentistry; (2) A fully accredited specialist in oral and maxillofacial surgery; and (3) A dentist to whom hospital privileges have been granted. (e) Dental care coverage not required. -- The provisions of this section

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		<p>may not be construed to require coverage for the dental care for which the general anesthesia is provided.</p> <p>(f) Temporal mandibular joint disorders. -- The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders.</p> <p>(g) A policy, provision, contract, plan or agreement may apply to dental anesthesia services the same deductibles, coinsurance and other limitations as apply to other covered services.</p>
Child Immunization Services Coverage	§33-15-17	All policies shall cover the cost of child immunization services as described in W. Va. Code §16-3-5, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration. These services shall be exempt from any deductible, per-visit charge and/or copayment provisions which may be in force in these policies or contracts. This does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.
Emergency Services	§33-15-21	<p>Insurers shall provide as benefits coverage for emergency services. A policy, provision, contract, plan or agreement may apply to emergency services the same deductibles, coinsurance and other limitations as apply to other covered services, provided that preauthorization or precertification shall not be required.</p> <p>Every insurer shall provide coverage for emergency medical services to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.</p> <p>An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation.</p> <p>Coverage of emergency services shall be subject to coinsurance, copayments and deductibles applicable under the health benefit plan. The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite post-evaluation or post-stabilization services in order to avoid material deterioration of the covered person's condition.</p>
Contraceptive Coverage (Applies to policies which include a prescription drug plan)	§33-16E-3	Health insurance plans that provide benefits for prescription drugs or prescription devices in prescription drug plans may not exclude or restrict benefits to covered persons for any prescription contraceptive drug or prescription contraceptive device approved by the federal Food and Drug Administration.
Diabetes Coverage	§33-15C-1	<p>Except as provided in W. Va. Code §33-15-6, any policy shall include coverage for equipment and supplies listed in W. Va. Code §33-16-16(a) for treatment and/or management of diabetes for both insulin dependent and noninsulin dependent persons with diabetes and those with gestational diabetes, if medically necessary and prescribed by a licensed physician.</p> <p>All policies shall also include coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for this education shall be limited to visits medically necessary upon diagnosis, visits under circumstances whereby a physician diagnoses a significant change in symptoms or conditions that necessitate changes in self-management, and where a new medication or therapeutic process has been identified as medically necessary by a licensed physician.</p> <p>The education may be provided by the physician as part of an office visit, or by a certified diabetes educator certified by a national diabetes educator certification program, or registered dietitian registered by a nationally recognized professional association of dietitians upon the referral of a physician. Provided that such national program has been certified to the commissioner by the commissioner of the bureau of public health.</p> <p>Any deductible or coinsurance billed for any service shall apply on an equal basis with all other coverages provided by the insurer.</p>
Newly Born Children	§33-6-32	All health insurance policies shall provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer within 31 days after the date of birth in order to have the coverage continue beyond such 31 day period.

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Newborn Screenings (Applies to policies that cover pregnancy benefits)	§16-22-3(c)	Newborn screenings shall be considered a covered benefit reimbursed to the birthing facilities by Public Employees Insurance Agency, the State Children's Health Insurance Program, the Medicaid program and all health insurers whose benefit package includes pregnancy coverage and who are licensed under chapter thirty-three of this code.
Optional Policy Provisions Individual Accident and Sickness Policies		
Misstatement of Age	§33-15-5(b)	" <u>Misstatement of Age</u> " – Caption the provision. "If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age."
Other Insurance with this Insurer	§33-15-5(c)	" <u>Other Insurance With This Insurer</u> " – Caption the provision. This provision is designed to limit the problems of over-insurance. 1) If a policy or policies concurrently in force, issued by and insurer to an insured, make(s) the aggregate indemnity for the accident and sickness coverages excess of a maximum stated limit, the excess insurance shall be void and all premiums paid shall be returned to the insured. 2) The Liability of the insurer is limited to one policy selected by the insured and premiums for all others shall be refunded.
Insurance with Other Insurers	§33-15-5(d)	" <u>Insurance With Other Insurers</u> " – Caption the provision. The essence of this provision: If an insured person has two or more policies that cover the same expenses with more than one insurer and the insurers were not notified that the other coverage existed, then each company shall pay a proportionate share of any claim. Each insurer's share of the claim shall be in proportion to the amount of the insurer's coverage involved in the claim. (This prevents the insured from receiving benefits greater than the loss.) The insurer may include in this provision a definition for "other valid coverage". Provision shall be made for the return of such portion of the premium paid as shall exceed the amount needed to pay for the company's portion of prorated benefits.
Unpaid Premiums	§33-15-5(f)	" <u>Unpaid Premiums</u> " – Caption the provision. If there is an unpaid premium or a premium is covered by a note at the time a claim becomes payable, the amount of the premium shall be deducted from the sum payable to the insured or to the beneficiary.
Return of Premium on Cancellation	§33-15-5(g)	" <u>Return of Premium on Cancellation</u> " - After the initial term, the insured may cancel at any time with written notice to the company. If the insured cancels this policy, the earned premium shall be computed by the use of the short-rate table last filed with the Insurance Commission. Cancellation is effective upon the company's receipt of the written notice, but does not affect claims pending to the effective date of cancellation. The insurer is allowed to cancel the policy with written notice to the insured during the initial term. If the insurer cancels the policy, any unearned premium is refunded on a pro rata basis. The insurer must give the insured (7) days notice if the premium is paid weekly; (10) days notice if the premium is paid monthly; (31) days notice for any other mode of payment.
Conformity with State Statutes	§33-15-5(h)	" <u>Conformity with State Statutes</u> " – Caption the provision. "Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes."
(9) Illegal Occupation	§33-15-5(l)	" <u>Illegal Occupation</u> " – Caption the provision. "The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation."
(10) Intoxicants and Narcotics	§33-15-5(j)	" <u>Intoxicants and Narcotics</u> " – Caption the provision. "The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician."
Advertising	Reg. 114-10 (1-20) §114-10-5 Reg. §114-10-6	Standards – (- 5.1 a) - The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. (-5.1 b) – Advertisements shall be truthful and not misleading in fact or implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used. Advertisements of Benefits Payable, Losses Covered or Premiums Payable - (a) No advertisement shall omit information or use words, phrases, statements references or illustrations if the omission of such information or use of such words,

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		phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. (b) No advertisement shall contain or use words or phrases such as, "All," "Full," "Complete," "Comprehensive;" "Unlimited;" "Up To;" "As High As;" . . . or similar words or phrases, in a manner which exaggerates any benefits beyond the terms of the policy.
Unique Characteristics of Health Insurance Contracts		
Conditional		The contract is Conditional in that the obligation of the insurance company to pay a claim depends on the insure performing certain acts such as, payment of premiums, notifying the company of a claim (within 20 days), filing claim reports (proof of loss), etc.
Unilateral		The contract is Unilateral because it involves the enforceable promises of only one party, the insurer. In order for the contract to perform, the insured must pay the premium, although the contract does not obligate him to do so. If the insured does pay the premiums as required, the company must accept them and meet its full obligation under the contract.
Adhesion		The health insurance contract is a contract of Adhesion because all the provision are determined by the insurance company. The applicant has a right to accept or reject the contract; it is not the result of negotiation between the two parties. Since the insured accepts the contract, any ambiguities are usually interpreted in favor of the insured by the courts.
Common Exclusions or Restrictions		
Policy Exclusions		Some common exclusions found in health insurance policies include: injuries due to war or an act of war, self-inflicted injuries, injuries incurred while the insured serves as a pilot or crew member of an aircraft. Other exclusions are losses resulting from suicide, riots or the use of drugs or narcotics. (This department does not permit the exclusion of hernia, as an accidental injury.) Losses due to injuries sustained while committing or attempting to commit a felony, may be excluded. Foreign travel may not be excluded in every instance and extended stays may cause a loss of benefits. If travel to specific countries is excluded, a list of the countries must be provided the insured, prior to purchase. Terrorism is excluded.
Replacement of Health Insurance	Reg. §114-12-7	
The Application	Reg. §114-12-7.7.1	The Application forms must include a question designed to elicit information as to whether the policy to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application to be signed by the applicant containing such question may be used.
Rights of Renewability		
Newly Born Children	§33-6-32	All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or subscriber shall, as to such family members coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. For the newly born child there shall be coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the policy may require that notice of the newborn child's birth and payment of the required premium must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days in order to have the coverage continue beyond the 31-day period.
Service Corporations		
Hospital Service Corporation	§33-24-2 (b)	<u>Hospital Service Corporation</u> is a non-profit, non-stock corporation, organized for the sole purpose of contracting with the public and with hospitals and other health agencies for hospital or other health services to be furnished to subscribers

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		under terms of their contract with the corporation. The corporation must have a controlling board of directors (not more than 20% of whom, or whose spouse, parent, child, brother or sister by blood or marriage) who are engaged in the providing of health care, and at least 80% of whom must be chosen as representatives of the interests of consumers, elderly persons, organized labor and business subscribers.
Medical Service Corporation	§33-24-2 (d)	<u>Medical Service Corporation</u> is a nonprofit, non-stock corporation, organized for the sole purpose of contracting with the public and with licensed physicians, dentists and podiatrists for medical or surgical services and with licensed chiropractors and other health agencies for other health services to be furnished to subscribers under terms of their contract with the corporation. The corporation must have a controlling board of directors (not more than 20% of whom, or whose spouse, parent, child, brother or sister by blood or marriage) who are engaged in the providing of health care, and at least 80% of whom must be chosen as representatives of the interest of consumers, elderly persons, organized labor and business subscribers.
Dental Service Corporation	§33-24-2 (f)	<u>A Dental Service Corporation</u> is a nonprofit, non-stock corporation, organized for the sole purpose of contracting with the public and with licensed dentists for dental services to be furnished to subscribers under terms of their contracts with the corporations. The corporation must have a board of directors as discussed with the previous corporation forms.
Health Service Corporation	§33-24-2 (h)	<u>A Health Service Corporation</u> is a nonprofit, non-stock corporation, organized for the sole purpose of contracting with the public and with hospitals and other health agencies for hospital or other health services to be furnished to subscribers, or for the purpose of contracting with the public and with licensed physicians, dentists and chiropodists-podiatrists for medical or surgical services and with chiropractors and other health agencies for other health services or for the purpose of contracting with the public and with duly licensed dentists for dental services to be furnished to subscribers, all under terms of their contract or contracts with the corporation. Must have a board of directors as previously described. Hospital Service, Medical Service and Dental Service Corporations may merge to form a Health Service Corporation. However, no merger may be made unless the plan, agreement and other supporting documents have been filed in advance and approved by the Insurance Commissioner. Examinations of such corporations are conducted by the Commissioner once every four years.
PPACA FILINGS		Please refer to documentation in SERFF's Online Help section for instructions on completing the required PPACA fields. West Virginia <u>does</u> accept grandfathered and non-grandfathered related filings in one submission.
Federal Requirements		
<i>All references are Federal statute and regulations, unless otherwise noted</i>		
Issuer Administrative Information	N/A	Please see Administrative Data Template for details on information requested.
Licensure, Solvency, and Standing		
Licensure and Solvency	45 CFR § 156.200(b)(4)	<input type="checkbox"/> Is licensed or authorized in WV to offer health insurance; or <input type="checkbox"/> Is licenses or authorized by WV OIC to offer dental insurance. OIC Financial Conditions Division will review and confirm issuers submitting QHPs meet these standards, leveraging existing information and data sources to review the status of an issuer's license, solvency, and standing. Issuers licensed in West Virginia are not required to submit supporting documentation unless concerns are identified and additional review is required. Issuers not currently licensed are required to complete the WV licensing process; West Virginia is a NAIC Uniform Certificate of Authority Application (UCAA) participant state and accepts the UCAA Primary and Expansion Applications.
Standing		<input type="checkbox"/> Is in good standing (no outstanding sanctions imposed by the OIC).
Benefit Standards and Product Offerings		

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Essential Health Benefits	45 CFR §156.110 §156.115 §156.120 §156.122	<input type="checkbox"/> Covers the Essential Health Benefit Package. <ul style="list-style-type: none"> <input type="checkbox"/> Ambulatory patient services <input type="checkbox"/> Emergency services <input type="checkbox"/> Hospitalization <input type="checkbox"/> Maternity and newborn care <input type="checkbox"/> Mental health and substance use disorder services, including behavioral health treatment <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Rehabilitative and habilitative services and devices <input type="checkbox"/> Laboratory services <input type="checkbox"/> Preventive and wellness services and chronic disease management <input type="checkbox"/> Pediatric services, including oral and vision care. <input type="checkbox"/> Offers coverage that is substantially equal to the benchmark plan. <input type="checkbox"/> Demonstrates actuarial equivalence of substituted benefits if substituting benefits. <input type="checkbox"/> Provides required number of drugs per category and class. <input type="checkbox"/> Provides habilitative benefits that are similar in scope, amount, and duration to benefits covered for habilitative services. In West Virginia, benchmark plan is Highmark Blue Cross Blue Shield West Virginia Super Blue Plus 2000 1000 Ded.; pediatric dental benefits are supplemented using the State's separate Children's Health Insurance Program (CHIP) program; pediatric vision benefits are supplemented using the Federal Employees Dental and Vision Insurance Program.
Cost-Sharing Requirements	45 CFR §156.130 45 CFR §156.150 (for SADPs)	<input type="checkbox"/> Complies with annual limitation on cost-sharing. <input type="checkbox"/> Cost-sharing shall not exceed the dollar amounts in effect under §223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage. <input type="checkbox"/> Complies with requirements related to coverage of out-of-network emergency services. FOR SHOP ONLY: <input type="checkbox"/> Complies with annual limitations on deductibles for employer-sponsored plans. FOR STAND-ALONE DENTAL ONLY: <input type="checkbox"/> Cost-sharing is "reasonable" for coverage of the pediatric dental EHB. CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013 clarified that for the 2014 coverage year in the FFE, CMS interprets the word "reasonable" to mean any annual limit on cost sharing that is at or below \$700 for a plan with one child enrollee or \$1,400 for a plan with two or more child enrollees.
Actuarial Value	45 CFR §156.135 §156.140 45 CFR §156.150 (for SADPs)	<input type="checkbox"/> If health insurance, offers a plan that provides one of the following actuarial values (± 2%): <ul style="list-style-type: none"> <input type="checkbox"/> Bronze plan (AV 60%) <input type="checkbox"/> Silver plan (AV 70%) <input type="checkbox"/> Gold plan (AV 80%) <input type="checkbox"/> Platinum plan (AV 90%) <input type="checkbox"/> Catastrophic plan

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		FOR STAND-ALONE DENTAL ONLY <input type="checkbox"/> Offers a plan that provides one of the following actuarial values(± 2%) : <input type="checkbox"/> Low plan (AV 70%) <input type="checkbox"/> High plan (AV 85%)
Catastrophic Plans	45 CFR §156.155	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> If offers a catastrophic plan, it is only offered to eligible individuals eligible to enroll in a catastrophic plan. Eligible individuals: <input type="checkbox"/> Individuals that have not attained the age of 30 before the beginning of the plan year <input type="checkbox"/> Individual has a certification in effect for any plan year exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. <input type="checkbox"/> If offered, catastrophic plans are offered only in the individual exchange and not in the SHOP. <input type="checkbox"/> If offered, catastrophic plan complies with specific requirements for benefits.
Non-Discrimination	45 CFR §156.125 §156.225(b) §156.200(e)	<input type="checkbox"/> Does not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs. <input type="checkbox"/> Does not discriminate based on individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, other health conditions, race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Passes outlier analysis of QHP cost sharing; information contained in the "explanations" and "exclusions" sections of the plans and benefits template does not include discriminatory practices or wording; issuers have attested to non-discrimination (per Chapter 1, Section 4i of CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013).
Mental Health Parity and Addiction Equity Act	45 CFR §156.115	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> Complies with the Mental Health Parity and Addiction Equity Act.
Meaningful Difference	N/A	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> Reflects meaningful difference across product offerings. Chapter 1, Section 4ii of CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013 clarifies CMS' intent related to this requirement.
Rates		
Rating Factors	45 CFR §147.102 §156.255	<input type="checkbox"/> Varies rates only based on: <input type="checkbox"/> Geographic area <input type="checkbox"/> Age (3 to 1) <input type="checkbox"/> Tobacco use (1.5 to 1) <input type="checkbox"/> Family composition: <input type="checkbox"/> Individual <input type="checkbox"/> Two-adult families <input type="checkbox"/> One-adult family with child(ren) <input type="checkbox"/> All other families Due to their excepted benefit status, stand-alone dental plans are not required to meet the rating rules of PHS Act section 2701(a) that underlie the QHP Rating Tables and Business Rules template, therefore sections 2.4.1 and 2.4.2 do not apply.

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Other Rating Provisions	45 CFR §156.210(a)	<input type="checkbox"/> Sets rates for an entire benefit year, or for the SHOP, plan year.
Other Rating Provisions	45 CFR §156.255(b)	<input type="checkbox"/> Rates must be the same for a QHP offered inside and outside Exchange and without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent.
Other Rating Provisions	45 CFR §155.1020 §156.210(b)	<input type="checkbox"/> Submits rate information to the Exchange at least annually.
Rate Increases	45 CFR §155.1020 §156.210(c) §154.215	<input type="checkbox"/> Submits to the Exchange a justification for a rate increase prior to the implementation of the increase Submits Rate Filing Justification, including: <ul style="list-style-type: none"> • An CMS standardized Unified Rate Review data template (Part I) • Written description justifying the rate increase for increases subject to the review threshold (Part II) Rate filing documentation (Part III), including an actuarial memorandum providing the reasoning and assumptions that support the data submitted in Part I
Rate Increase Posting	45 CFR §155.1020 §156.210(c)	<input type="checkbox"/> Prominently posts the rate increase justification on issuer Web site prior to the implementation of the increase.
Display of Stand-Alone Dental Plan Rates		FOR STAND-ALONE DENTAL ONLY: <input type="checkbox"/> Provides rates and indicates whether they are committing to rates reported or if they are reserving the option to charge additional premium amounts. CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013.
Accreditation Standards		
Accreditation	45 CFR §156.275(a)(1)	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> Accredited on the basis of local performance in the following categories by an accrediting entity recognized by CMS: <input type="checkbox"/> Clinical quality measures, such as the HEDIS <input type="checkbox"/> Patient experience ratings on a standardized CAHPS survey <input type="checkbox"/> Consumer access <input type="checkbox"/> Utilization management <input type="checkbox"/> Quality assurance <input type="checkbox"/> Provider credentialing <input type="checkbox"/> Complaints and appeals <input type="checkbox"/> Network adequacy and access <input type="checkbox"/> Patient information programs
Accreditation Survey Results	45 CFR §156.275(a)(2)	<input type="checkbox"/> Authorizes the accrediting entity to release to the Exchange and CMS a copy of its most recent accreditation survey and survey-related information.
Accreditation Timeline	45 CFR §155.1045 45 CFR §156.275(b)	<input type="checkbox"/> Accredited within the timeframe established by the Exchange. <input type="checkbox"/> Maintains accreditation. During initial year of certification, issuer must have an existing commercial, Medicaid, or Exchange health plan accreditation in WV granted by an accrediting entity or must have scheduled, or plan to schedule, a review of QHP policies and procedures with the accrediting entity.
Network Adequacy and Provider		

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Directory		
General	45 CFR §156.230	<input type="checkbox"/> Complies with WV network adequacy laws and regulations in addition to the specific requirements listed below. <input type="checkbox"/> Has a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay. WV Informational Letter No. 112 provides standards related to distance/time and provider to enrollee ratios. Is accredited on network adequacy and attests to compliance or provides and access plan based on NAIC Model Act #74 Managed Care Plan Network Adequacy.
Essential Community Providers	45 CFR §156.230(a)(1) 45 CFR §156.235	<input type="checkbox"/> Has sufficient number and geographic distribution of Essential Community Providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the service area. <ul style="list-style-type: none"> • Issuer achieves at least 20% ECP participation in network in the service area, agrees to offer contracts to at least one ECP of each type available by county, and agrees to offer contracts to all available Indian providers; or • Issuer achieves at least 10% ECP participation in network in the service area, and submits a satisfactory narrative justification as part of its QHP submission; or • Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission.
Mental Health and Substance Abuse Providers	45 CFR §156.230	<input type="checkbox"/> Network must include providers that specialize in mental health and substance abuse services. Issuers establish a standard to assure that the QHP network complies with the Federal standard; a copy of this standard is included in application and issuer certifies that the network meets the standard. Standard does NOT apply to stand-alone dental plans.
Service Area	45 CFR §155.1055	<input type="checkbox"/> Has a minimum service area of an entire county.
Provider Directory	45 CFR §156.230(b)	<input type="checkbox"/> Makes its provider directory available: <input type="checkbox"/> To the Exchange for publication online in accordance with guidance from the Exchange <input type="checkbox"/> To potential enrollees in hard copy upon request. <input type="checkbox"/> Provider directory identifies providers that are not accepting new patients. Provides network names, IDs, and URL in a Network Template.
Marketing, Applications, and Notices		
WV Laws	45 CFR §156.225(a)	<input type="checkbox"/> Complies with all WV marketing laws & regulations. <input type="checkbox"/> Certificate of Readability provided WV Legislative Rules Title 114 Series 10; WV 33-29-5
Non-discrimination	45 CFR §156.225(b)	<input type="checkbox"/> Marketing practices do not discourage the enrollment of individuals with significant health needs.
Readability/Accessibility	45 CFR §155.230(b)	<input type="checkbox"/> Provides applications and notices to applicants and enrollees all applications and other material: <input type="checkbox"/> In plain language <input type="checkbox"/> In a manner that is accessible and timely to:

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		<input type="checkbox"/> Individuals living with disabilities <input type="checkbox"/> Individuals with limited English proficiency through the provision of language services at no cost to the individual.
Quality Standards		
Quality	45 CFR §156.200 (b)(5) ACA § 1311(c)(1), 1311(c)(3), 1311(c)(4), and 1311(g)	<input type="checkbox"/> Attests to comply with future Federal rule-making related to 45 CFR §156.200(b)(5). CMS indicates they intend to address specific requirements in future rulemaking related to quality data reporting, quality improvement strategies, and enrollee satisfaction surveys described in these statutory provisions.
Segregation of Funds for Abortion Services		
Abortion Services	45 CFR §156.280 ACA §1303	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> Does not use federal funds for abortion. <input type="checkbox"/> Complies with procedures to ensure Federal funds are not misused, depositing payments into separate allocation accounts. <input type="checkbox"/> Submits segregation plan. <input type="checkbox"/> Provides annual assurance statement. <input type="checkbox"/> If provides for coverage of abortion services, provides a notice to enrollees as part of the summary of benefits and coverage explanation at the time of enrollment. <input type="checkbox"/> Does not discriminate against any health care provider or any health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortion.
<ul style="list-style-type: none"> • Issuers will be required to attest to the Federal requirements included in the following sections. 		
Transparency Requirements		
Coverage Transparency	45 CFR §155.1040 45 CFR §156.220	<input type="checkbox"/> Makes available to the public, Exchange, CMS, and the WV Insurance Commissioner in an accurate and timely manner, and in plain language: <input type="checkbox"/> Claims payment policies and practices <input type="checkbox"/> Periodic financial disclosures <input type="checkbox"/> Data on enrollment <input type="checkbox"/> Data on disenrollment <input type="checkbox"/> Data on the number of claims that are denied <input type="checkbox"/> Data on rating practices <input type="checkbox"/> Information on cost-sharing and payments for out-of network coverage <input type="checkbox"/> Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights)
Enrollee Cost-Sharing	45 CFR § 156.220(d)	<input type="checkbox"/> Makes available the amount of enrollee cost-sharing for a specific item or service by a participating provider in a timely manner upon the request of the individual. <input type="checkbox"/> Makes available such information through: <input type="checkbox"/> Internet website <input type="checkbox"/> Other means for individuals without access to the Internet
Appeals Notices	45 CFR §147.136(e)	<input type="checkbox"/> Provides required notices on internal and external appeals in a culturally and linguistically appropriate manner.
Enrollment Periods		
Initial	45 CFR §155.410(b)	<input type="checkbox"/> Provides an initial open enrollment period October 1, 2013 to March 31, 2014.
Annual	45 CFR §155.410(e)	<input type="checkbox"/> Provides an annual open enrollment period October 15 to December 7.

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INDIVIDUAL MARKET

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Special	45 CFR §155.420	<input type="checkbox"/> Provides special enrollment periods for qualified enrollees. <input type="checkbox"/> Provides notice to individuals eligible to enroll during a special enrollment period.
Enrollment Process for Qualified Individuals		
Enrollment	45 CFR §156.265 (b)(1) 45 CFR §156.265 (b)(2) 45 CFR §156.265 (c) 45 CFR §156.265 (d) 45 CFR §156.265 (e) 45 CFR §156.265 (f)45 CFR §156.400 (d) 45 CFR §156.265 (g)	<input type="checkbox"/> Enrolls a qualified individual when Exchange notifies the issuer that the individual is a qualified individual and transmits information to the issuer. <input type="checkbox"/> If an applicant initiates enrollment directly with the issuer for enrollment through the Exchange, the issuer either: <input type="checkbox"/> Directs the individual to file an application with the Exchange <input type="checkbox"/> Ensures that the individual received an eligibility determination for coverage through the Exchange via the Exchange Internet website. <input type="checkbox"/> Accepts enrollment information consistent with the privacy and security requirements established by the Exchange. <input type="checkbox"/> Uses the premium payment process established by the Exchange. <input type="checkbox"/> Provides new enrollees an enrollment information package that is compliant with accessibility and readability standards. <input type="checkbox"/> Reconciles enrollment files with CMS and the Exchange no less than once a month. <input type="checkbox"/> Acknowledges receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards.
Termination of Coverage of Qualified Individuals		
Termination Allowances	45 CFR §155.430(b) 45 CFR §156.270	Terminates coverage only if: <input type="checkbox"/> Enrollee is no longer eligible for coverage through the Exchange <input type="checkbox"/> Enrollee's coverage is rescinded <input type="checkbox"/> QHP terminates or is decertified <input type="checkbox"/> Enrollee switches coverage: <input type="checkbox"/> During an annual open enrollment period <input type="checkbox"/> Special enrollment period <input type="checkbox"/> Obtains other minimum essential coverage <input type="checkbox"/> For non-payment of premium only if: <input type="checkbox"/> Applies termination policy for non-payment of premium uniformly to enrollees in similar circumstances <input type="checkbox"/> Enrollee is delinquent on premium payment <input type="checkbox"/> Provides the enrollee with notice of such payment delinquency <input type="checkbox"/> Provides a grace period of at least three consecutive months if an enrollee is receiving advance payments of the premium tax credit and has previously paid at least one month's premium
Notice	45 CFR §155.430 (d)45 CFR §156.270 (b)	<input type="checkbox"/> Provides reasonable notice of termination of coverage to the Exchange and enrollee (this includes effective date of termination).
Records	45 CFR §155.430(c) 45 CFR §156.270(h)	<input type="checkbox"/> Maintains records of terminations of coverage for auditing.
Recertification and Decertification		
Recertification	45 CFR §156.290	<input type="checkbox"/> If elects not to seek recertification with the FFE: <input type="checkbox"/> Notifies the FFE of its decision prior to the beginning of the recertification process and procedures adopted by the FFE <input type="checkbox"/> Fulfills its obligation to cover benefits for each enrollee through the end of the plan or benefit year <input type="checkbox"/> Fulfills data reporting obligations from the last plan or benefit year of the certification

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		<input type="checkbox"/> Provides written notice to enrollees <input type="checkbox"/> Terminates coverage for enrollees in the QHP.
Decertification	45 CFR §156.290	<input type="checkbox"/> If decertified by the FFE, terminates coverage for enrollees only after: <input type="checkbox"/> The FFE has made notification <input type="checkbox"/> Enrollees have an opportunity to enroll in other coverage
Other Substantive and Reporting Requirements		
General Compliance	45 CFR §156.200(b)(2)	<input type="checkbox"/> Complies with all Exchange processes, procedures, requirements.
User Fee	45 CFR §156.200(b)(6)	<input type="checkbox"/> Pays the Exchange user fee.
Risk Adjustment	45 CFR §156.200(b)(7)	<input type="checkbox"/> Complies with risk adjustment program.
Non-Discrimination	45 CFR §156.200(e)	<input type="checkbox"/> Does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.
Consumer Interest	45 CFR §155.1000(c)(2)	<input type="checkbox"/> Is in the interest of qualified individuals.
Claims, Appeals, and External Review	45 CFR §147.136	<input type="checkbox"/> Complies with internal claims and appeals and external review process.
Direct Primary Medical Home	45 CFR §156.245	<input type="checkbox"/> If provides coverage through a direct primary care medical home: <input type="checkbox"/> Medical home meets criteria established by CMS <input type="checkbox"/> Issuer meets all requirements otherwise required <input type="checkbox"/> Issuer coordinates the services covered by the direct primary care medical home
Data-Sharing		<input type="checkbox"/> Collects and transmits data to and from Exchanges, CMS, Treasury, and reinsurance entities. <input type="checkbox"/> Provides a description of system infrastructure's capacity to securely interface with these entities for data transfers, including enrollment, reconciliation, claims encounter data, and reports.
Prescription Drug Distribution and Cost Reporting	45 CFR §156.295	<input type="checkbox"/> Reports to U.S. DCMS on prescription drug distribution and cost the following information (paid by PBM or issuer): <input type="checkbox"/> Percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies <input type="checkbox"/> Percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type: <input type="checkbox"/> Independent pharmacy <input type="checkbox"/> Supermarket pharmacy <input type="checkbox"/> Mass merchandiser pharmacy <input type="checkbox"/> Aggregate amount and type of rebates, discounts, or price concessions that the issuer or its contracted PBM negotiates that are: <input type="checkbox"/> Attributable to patient utilization <input type="checkbox"/> Passed through to the issuer <input type="checkbox"/> Total number of prescriptions that were dispensed. <input type="checkbox"/> Aggregate amount of the difference between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.

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GROUP MARKET

REVIEW REQUIREMENTS	REFERENCE	COMMENTS
FORMS		
State Requirements		
<i>All references are State of West Virginia statute and regulations, unless otherwise noted</i>		
General Requirements		SERFF filings are submitted in accordance with SERFF procedures.
Fees	§33-6-34 §33-6-34	The fee for a Form Filing is \$50.00 per Filing. The fee for a Rate Filing is \$75 per Filing.
Submission	Informational Letter No 163 §33-3-7	All filings must be submitted through SERFF (System for Electronic Rate and Form Filing). Filing fees must be remitted via EFT (Electronic Funds Transfer) through SERFF. The company transacting insurance in this State must be licensed by the Insurance Commissioner and authorized to conduct the appropriate lines of business for the filing submitted.
Certifications		
Readability	§33-29-5 (a)(1)	The Certification of Readability must show a Test Score of 40 or better according to the Flesch Score reading ease Method or by any other comparable method.
Compliance	33-16 114-10 114-26 114-27 114-28 114-29	<u>Group Accident and Sickness</u> policy forms must comply with Chapter 16 of the WV Code. The Required provisions are found in 33-16-3. <u>Advertising</u> – Department policy to require advertising filing on all Accident & Sickness products. <u>Rate Filing Accident and Sickness</u> <u>AIDS Regulation</u> <u>Coordination of Benefits</u> <u>Temporo/Craniomandibular Disorders</u>
Applications		
		The Application, when attached to the policy, and all its attachments become part of the Entire Contract. Statements are binding only if an application is attached. Only the applicant can alter statements on the application. This Division does not permit a box on the Application, For Company Use Only , because no changes are to be made to the Entire Contract after the application has been signed by the applicant. False statements may bar recovery.
General Characteristics		
Group Acceptance		Acceptance of all members of the group, regardless of any individual's physical condition.
Master Contract		Issuance of a master contract to the administrator of the group and individual certificates of insurance (outlines of coverage) to the members.
Coordination of Benefits		Coordination of benefits with other available coverages (such as workers compensation benefits)
Benefits		Benefits are automatically determined by some preset formula which excludes individual benefit selection and thereby precludes adverse selection by not allowing poor risks to purchase higher amounts of insurance.
Legal Requirements		

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REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Eligible Groups	§33-16-2	Group policies must come within any of the following classifications: (1) A policy issued to an employer, who shall be considered the policyholder, insuring at least two employees of the employer, for the benefit of persons other than the employer, and conforming to the following requirements: (A) If the premium is paid by the employer the group shall comprise all employees or all of any class or classes thereof determined by conditions pertaining to the employment; or (B) If the premium is paid by the employer and the employees jointly, or by the employees, there shall be no employee participation requirement. The term "employee" as used herein is considered to include the officers, managers and employees of the employer, the partners, if the employer is a partnership, the officers, managers and employees of subsidiary or affiliated corporations of a corporate employer, and the individual proprietors, partners and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract or otherwise. The term "employer" as used herein may include any municipal or governmental corporation, unit, agency or department and the proper officers of any unincorporated municipality or department, as well as private individuals, partnerships and corporations.
Required Policy Provisions		Group policies must contain the following:
Entire Contract	§33-16-3(a)	A provision that the policy, application of the policyholder, and the individual applications submitted shall constitute the entire contract between the parties, and that all statements made by any applicant(s) shall be deemed representations and not warranties, and that no such statement shall void the insurance or reduce benefits thereunder unless contained in a written application.
Individual Certificates	§33-16-3(b)	A provision that the insurer will provide an individual certificate for each member of the group setting forth in substance the essential features of the coverage and to whom benefits are payable. If dependents are included, only one certificate need be issued for each family unit.
New Members	§33-16-3(c)	A provision that all new employees or members, in the groups or classes eligible for insurance, shall from time to time be added to such groups or classes eligible to obtain such insurance in accordance with the terms of the policy.
Prohibited Provisions	§33-16-3(d)	No provision relative to notice or proof of loss or the time for paying benefits or the time within which suit may be brought upon the policy shall be less favorable to the insured than would be permitted in the case of an individual policy by the provisions set forth in §§33-15-1 et seq.
Layoff Provision	§33-16-3(e)	A provision that all members shall be permitted to pay the premiums at the same group rate and receive the same coverages for a period not to exceed 18 months when they are involuntarily laid off from work.
Other Provisions	§33-16-3(f)	Further provisions as the commissioner shall promulgate by rule.
Mandatory Benefits		
Mental Health	45 CFR §156.115	<u>Mental Illness Coverage</u> – EHB covered under Mental health and substance use disorder services, including behavioral health treatment.
Home Health Care Coverage	§33-16-3b	Any insurer who delivers or issues for delivery in West Virginia group basic hospital expense or major medical expense coverage shall make available to the policyholder home health care coverage consistent with the provisions of this section. Home health care coverage offered shall include: 1. Services provided by a registered nurse or a licensed practical nurse. 2. Health services provided by a physical, occupational, respiratory and speech therapists. 3. Health services provided by a home health aide to the extent that such services would be covered if provided on an inpatient basis. 4. Medical supplies, drugs, medicines and laboratory services to the extent that they would be covered if provided on an inpatient basis.

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		<p>5. Services provided by a licensed midwife or a licensed nurse midwife.</p> <p>Home health care coverage may be limited to:</p> <ol style="list-style-type: none"> 1. Services provided on the written order of a licensed physician, provided such order is renewed at least every sixty days. 2. Services provided by a home health agency certified in the state in which the services are rendered or under Title XVIII [42 U.S.C. §§ 1395 et seq.] of the Social Security Act. 3. Services as set forth above without which the insured would have to be hospitalized. <p>Coverage shall be provided for at least 100 home visits per insured per policy year, with each home visit by a member of a home health care team to be considered as one visit including up to four hours of home health care services.</p> <p style="padding-left: 20px;">A. No such policy need provide such coverage to persons eligible for Medicare.</p>
Policies to Cover Nursing Services	§33-16-3e	Group policies must make available as benefits coverage for primary health care nursing services if such services are currently being reimbursed when rendered by any other duly licensed health care practitioner. No insurer may be required to pay for duplicative health care services actually provided by both a nurse and other health providers.
TMD/CMD	§33-16-3f, §114-29-4	All accident and sickness coverage which provides hospital, surgical, or major medical coverage must provide benefits for the diagnosis and treatment of temporomandibular disorders (TMD) and craniomandibular disorders (CMD). An insured shall be given the option of declining coverage for temporomandibular disorders (TMD) and craniomandibular disorders (CMD) and the insurer must provide an appropriate waiver form or incorporate such waiver form or incorporate such waiver form into the insurance policy or other evidence of coverage.
Women's Preventive Coverage	45 CFR §156.115	<u>Women's Preventive Coverage</u> – EHB covered under Preventive and wellness services and chronic disease management.
Rehabilitation Services	§33-16-3h	Insurers shall provide as benefits coverage for rehabilitation services (as defined in §33-16-3h), unless rejected by the insured.
Emergency Services	§33-16-3i	<p>Insurers shall provide as benefits coverage for emergency services. A policy, provision, contract, plan or agreement may apply to emergency services the same deductibles, coinsurance and other limitations as apply to other covered services, provided that preauthorization or precertification shall not be required.</p> <p>Every insurer shall provide coverage for emergency medical services to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.</p> <p>An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation.</p> <p>Coverage of emergency services shall be subject to coinsurance, copayments and deductibles applicable under the health benefit plan.</p> <p>The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite post-evaluation or post-stabilization services in order to avoid material deterioration of the covered person's condition.</p>
Postpartum Hospital Stay 48 Hours Normal Delivery 96 Hours C-Section	§33-16-3j	<p>If a health plan provides inpatient benefits in connection with child birth for a mother or her newborn child:</p> <p>The plan may not restrict benefits for any hospital stay following a normal vaginal delivery to less than forty-eight hours or following a cesarean section to less than ninety-six hours, or require a provider to obtain authorization for such length hospital stays.</p>
Colorectal Cancer Examination and Laboratory Testing	§33-16-3o	Reimbursement or indemnification for colorectal cancer examinations and laboratory testing may not be denied for any nonsymptomatic person 50 years of age or older, or a symptomatic person under 50 years of age, when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for colorectal cancer screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery.
Reconstructive Surgery Following Mastectomy	§33-16-3p	Any policy of insurance which provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy
Clinical Trials under §33-25F-1	§33-16-3r	The provisions relating to clinical trials established in article twenty-five-f of Chapter 33 shall apply to the health benefit plans regulated by Article 16 of Chapter 33.

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Third-party reimbursement for kidney disease screening	§33-16-3s	Reimbursement or indemnification for annual kidney disease screening and laboratory testing as recommended by the National Kidney Foundation may not be denied for any person when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for kidney disease screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the board of medicine. The tests are as follows: Any combination of blood pressure testing, urine albumin or urine protein testing and serum creatinine testing. The same deductibles, coinsurance, network restrictions and other limitations for covered services found in the policy, provision, contract, plan or agreement of the covered person may apply to kidney disease screening and laboratory testing.
Required coverage for dental anesthesia services	§33-16-3t	Required coverage for dental anesthesia services. (a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall, on or after July 1, 2009, provide as benefits to all subscribers and members coverage for dental anesthesia services as hereinafter set forth. (b) For purposes of this article and section, "dental anesthesia services" means general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care provided to an enrollee or insured if the enrollee or insured is: (1) Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the enrollee or insured and for whom a superior result can be expected from dental care provided under general anesthesia; or (2) A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia. (c) Prior authorization. -- An entity subject to this section may require prior authorization for general anesthesia and associated outpatient hospital or ambulatory facility charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care. (d) An entity subject to this section may restrict coverage for general anesthesia and associated outpatient hospital or ambulatory facility charges unless the dental care is provided by: (1) A fully accredited specialist in pediatric dentistry; (2) A fully accredited specialist in oral and maxillofacial surgery; and (3) A dentist to whom hospital privileges have been granted. (e) Dental care coverage not required. -- The provisions of this section may not be construed to require coverage for the dental care for which the general anesthesia is provided. (f) Temporal mandibular joint disorders. -- The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders. (g) A policy, provision, contract, plan or agreement may apply to dental anesthesia services the same deductibles, coinsurance and other limitations as apply to other covered services.
AIDS Regulation	§33-16-9, §114-27	No insurer may cancel or nonrenew a policy of any insured because of diagnosis or treatment of acquired immune deficiency syndrome. See West Virginia Regulation §114-27 for more details.
Women's Preventive Coverage	45 CFR §156.115	<u>Women's Preventive Coverage</u> – EHB covered under Preventive and wellness services – and chronic disease management.
Newly Born Children	§33-6-32	All health insurance policies shall provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer within 31 days

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		after the date of birth in order to have the coverage continue beyond such 31 day period.
Newborn Screenings (Applies to policies that cover pregnancy benefits)	§16-22-3(c)	Newborn screenings shall be considered a covered benefit reimbursed to the birthing facilities by Public Employees Insurance Agency, the State Children's Health Insurance Program, the Medicaid program and all health insurers whose benefit package includes pregnancy coverage and who are licensed under chapter thirty-three of this code.
Child Immunization Services Coverage	§33-16-12	All policies shall cover the cost of child immunization services as described in W. Va. Code §16-3-5, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration. These services shall be exempt from any deductible, per-visit charge and/or copayment provisions which may be in force in these policies or contracts. This does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.
Diabetes Coverage	§33-16-16 §33-15C-1	Except as provided in W. Va. Code §33-15-6, any policy shall include coverage for equipment and supplies listed in W. Va. Code §33-16-16(a) for treatment and/or management of diabetes for both insulin dependent and noninsulin dependent persons with diabetes and those with gestational diabetes, if medically necessary and prescribed by a licensed physician. All policies shall also include coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for this education shall be limited to visits medically necessary upon diagnosis, visits under circumstances whereby a physician diagnoses a significant change in symptoms or conditions that necessitate changes in self-management, and where a new medication or therapeutic process has been identified as medically necessary by a licensed physician. The education may be provided by the physician as part of an office visit, or by a certified diabetes educator certified by a national diabetes educator certification program, or registered dietitian registered by a nationally recognized professional association of dietitians upon the referral of a physician. Provided that such national program has been certified to the commissioner by the commissioner of the bureau of public health. Any deductible or coinsurance billed for any service shall apply on an equal basis with all other coverages provided by the insurer.
Contraceptive Coverage	45 CFR §156.115	<u>Contraceptive Coverage</u> – EHB covered under Preventive and wellness services and chronic disease management (Women's Preventive Services)
Autism Spectrum Disorders (Applies to policies delivered or renewed on or after January 1, 2012)	§33-16-3v	Groups with more than twenty-five eligible employees shall include coverage for diagnosis and treatment of autism spectrum disorder in individuals ages eighteen months through eighteen years. To be eligible for coverage and benefits under this section, the individual must be diagnosed with autism spectrum disorder at age 8 or younger. Such policy shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist for an individual diagnosed with autism spectrum disorder, in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual, subject to review by the agency every six months.
Coordination of Benefits		
COB Contract Provision	§114-28-3.1	Appendix A of §114-28 contains a model COB provision.
Flexibility	§114-28-3.2	A group contract's COB provision does not have to use the words and format of the model. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference amount plans which provide services, which pay benefits for expenses incurred, and which indemnify. No other substantive changes are allowed.
Cost Containment Provisions		
Mandatory Second Surgical Opinion		Company won't pay 100% of scheduled charges unless another physician's opinion is sought – emergencies excepted.
Pre-Admission Certification		1. Company approves the admission to the hospital (emergencies excepted).

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Concurrent Review		A review of an insured's medical care while that care is being administered. The purpose of concurrent review is to assure that the required care is being provided.
Retrospective Review		Company reviews all charges by the hospital and the physician and looks for duplicate or unreasonable fees.
Ambulatory Outpatient Services		Deductible waived and at 100%.
COBRA		
Basic Requirements		The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers with 20 employees or more on at least 50% or the working days in the previous calendar year to provide for continuation of health coverage at group rates (except group disability income benefits) for the dependents of all eligible employees with evidence of insurability.
		<ol style="list-style-type: none"> 1. Qualified beneficiaries may elect to continue coverage identical to that covered under the original health plan. 2. Employers have an obligation to determine the specific rights of the beneficiaries and inform them of same through an initial general notice known as a summary plan description. 3. Employers must notify plan administrators within 30 days of an employee's death, termination, reduced hours, and/or Medicare entitlement. 4. Multi-employer plans may be given a longer period of time than 30 days. 5. Employees, retirees and family members must notify the plan administrator within 60 days of such qualifying events as divorce or legal separation or an individual losing "dependent child" status. 6. Once notified of a "qualifying event," plan administrators must notify employees and/or family members of their rights to elect benefits identical to those received immediately before the qualifying event. 7. Qualified beneficiaries have a 60 day period to elect whether or not to continue coverage. 8. Employer Penalties – Employers who fail to comply with COBRA regulations are subject to a fine of \$100 per day per eligible insured. <p>Premiums – COBRA allows employers to charge those who elect to continue coverage 102% of the premiums the employer (company) pays for each employee. The excess 2% covers administrative duties and paperwork required of the employer. A grace period exists for the failure to pay premiums. The grace period is the longest of 30 days, the period the plan allows employees for failure to pay premiums, and the period the insurance company allows the plan or the employer for failure to pay premiums.</p>
PPACA FILINGS		Please refer to documentation in SERFF's Online Help section for instructions on completing the required PPACA fields. West Virginia does accept grandfathered and non-grandfathered related filings in one submission.
Federal Requirements <i>All references are Federal statute and regulations, unless otherwise noted</i>		
Issuer Administrative Information	N/A	Please see Administrative Data Template for details on information requested.
Licensure, Solvency, and Standing		
Licensure and Solvency	45 CFR § 156.200(b)(4)	<input type="checkbox"/> Is licensed or authorized in WV to offer health insurance; or <input type="checkbox"/> Is licenses or authorized by WV OIC to offer dental insurance.

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		<p>OIC Financial Conditions Division will review and confirm issuers submitting QHPs meet these standards, leveraging existing information and data sources to review the status of an issuer's license, solvency, and standing.</p> <p>Issuers licensed in West Virginia are not required to submit supporting documentation unless concerns are identified and additional review is required.</p> <p>Issuers not currently licensed are required to complete the WV licensing process; West Virginia is a NAIC Uniform Certificate of Authority Application (UCAA) participant state and accepts the UCAA Primary and Expansion Applications.</p>
Standing		<input type="checkbox"/> Is in good standing (no outstanding sanctions imposed by the OIC).
Benefit Standards and Product Offerings		9.
Essential Health Benefits	45 CFR §156.110 §156.115 §156.120 §156.122	<input type="checkbox"/> Covers the Essential Health Benefit Package. <ul style="list-style-type: none"> <input type="checkbox"/> Ambulatory patient services <input type="checkbox"/> Emergency services <input type="checkbox"/> Hospitalization <input type="checkbox"/> Maternity and newborn care <input type="checkbox"/> Mental health and substance use disorder services, including behavioral health treatment <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Rehabilitative and habilitative services and devices <input type="checkbox"/> Laboratory services <input type="checkbox"/> Preventive and wellness services and chronic disease management <input type="checkbox"/> Pediatric services, including oral and vision care. <input type="checkbox"/> Offers coverage that is substantially equal to the benchmark plan. <input type="checkbox"/> Demonstrates actuarial equivalence of substituted benefits if substituting benefits. <input type="checkbox"/> Provides required number of drugs per category and class. <input type="checkbox"/> Provides habilitative benefits that are similar in scope, amount, and duration to benefits covered for habilitative services. <p>In West Virginia, benchmark plan is Highmark Blue Cross Blue Shield West Virginia Super Blue Plus 2000 1000 Ded.; pediatric dental benefits are supplemented using the State's separate Children's Health Insurance Program (CHIP) program; pediatric vision benefits are supplemented using the Federal Employees Dental and Vision Insurance Program.</p>
Cost-Sharing Requirements	45 CFR §156.130 45 CFR §156.150 (for SADPs)	<input type="checkbox"/> Complies with annual limitation on cost-sharing. <input type="checkbox"/> Cost-sharing shall not exceed the dollar amounts in effect under §223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage. <input type="checkbox"/> Complies with requirements related to coverage of out-of-network emergency services. <p>FOR SHOP ONLY:</p> <input type="checkbox"/> Complies with annual limitations on deductibles for employer-sponsored plans. <p>FOR STAND-ALONE DENTAL ONLY:</p> <input type="checkbox"/> Cost-sharing is "reasonable" for coverage of the pediatric dental EHB. <p>CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013 clarified that for the 2014</p>

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REVIEW REQUIREMENTS	REFERENCE	COMMENTS
		coverage year in the FFE, CMS interprets the word “reasonable” to mean any annual limit on cost sharing that is at or below \$700 for a plan with one child enrollee or \$1,400 for a plan with two or more child enrollees.
Actuarial Value	45 CFR §156.135 §156.140 45 CFR §156.150 (for SADPs)	<input type="checkbox"/> If health insurance, offers a plan that provides one of the following actuarial values (± 2%): <input type="checkbox"/> Bronze plan (AV 60%) <input type="checkbox"/> Silver plan (AV 70%) <input type="checkbox"/> Gold plan (AV 80%) <input type="checkbox"/> Platinum plan (AV 90%) <input type="checkbox"/> Catastrophic plan FOR STAND-ALONE DENTAL ONLY <input type="checkbox"/> Offers a plan that provides one of the following actuarial values(± 2%) : <input type="checkbox"/> Low plan (AV 70%) <input type="checkbox"/> High plan (AV 85%)
Catastrophic Plans	45 CFR §156.155	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> If offers a catastrophic plan, it is only offered to eligible individuals eligible to enroll in a catastrophic plan. Eligible individuals: <input type="checkbox"/> Individuals that have not attained the age of 30 before the beginning of the plan year <input type="checkbox"/> Individual has a certification in effect for any plan year exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. <input type="checkbox"/> If offered, catastrophic plans are offered only in the individual exchange and not in the SHOP. <input type="checkbox"/> If offered, catastrophic plan complies with specific requirements for benefits.
Non-Discrimination	45 CFR §156.125 §156.225(b) §156.200(e)	<input type="checkbox"/> Does not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs. <input type="checkbox"/> Does not discriminate based on individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, other health conditions, race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Passes outlier analysis of QHP cost sharing; information contained in the “explanations” and “exclusions” sections of the plans and benefits template does not include discriminatory practices or wording; issuers have attested to non-discrimination (per Chapter 1, Section 4i of CMS’s “Letter to Issuers on Federally-Facilitated and State Partnership Exchanges” from April 5, 2013).
Mental Health Parity and Addiction Equity Act	45 CFR §156.115	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> Complies with the Mental Health Parity and Addiction Equity Act.
Meaningful Difference	N/A	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> Reflects meaningful difference across product offerings. Chapter 1, Section 4ii of CMS’s “Letter to Issuers on Federally-Facilitated and State Partnership Exchanges” from April 5, 2013 clarifies CMS’ intent related to this requirement.
Rates		
Rating Factors	45 CFR §147.102 §156.255	<input type="checkbox"/> Varies rates only based on:

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REVIEW REQUIREMENTS	REFERENCE	COMMENTS
		<input type="checkbox"/> Geographic area <input type="checkbox"/> Age (3 to 1) <input type="checkbox"/> Tobacco use (1.5 to 1) <input type="checkbox"/> Family composition: <input type="checkbox"/> Individual <input type="checkbox"/> Two-adult families <input type="checkbox"/> One-adult family with child(ren) <input type="checkbox"/> All other families Due to their excepted benefit status, stand-alone dental plans are not required to meet the rating rules of PHS Act section 2701(a) that underlie the QHP Rating Tables and Business Rules template, therefore sections 2.4.1 and 2.4.2 do not apply.
Other Rating Provisions	45 CFR §156.210(a)	<input type="checkbox"/> Sets rates for an entire benefit year, or for the SHOP, plan year.
Other Rating Provisions	45 CFR §156.255(b)	<input type="checkbox"/> Rates must be the same for a QHP offered inside and outside Exchange and without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent.
Other Rating Provisions	45 CFR §155.1020 §156.210(b)	<input type="checkbox"/> Submits rate information to the Exchange at least annually.
Rate Increases	45 CFR §155.1020 §156.210(c) §154.215	<input type="checkbox"/> Submits to the Exchange a justification for a rate increase prior to the implementation of the increase Submits Rate Filing Justification, including: <ul style="list-style-type: none"> • An CMS standardized Unified Rate Review data template (Part I) • Written description justifying the rate increase for increases subject to the review threshold (Part II) Rate filing documentation (Part III), including an actuarial memorandum providing the reasoning and assumptions that support the data submitted in Part I
Rate Increase Posting	45 CFR §155.1020 §156.210(c)	<input type="checkbox"/> Prominently posts the rate increase justification on issuer Web site prior to the implementation of the increase.
Display of Stand-Alone Dental Plan Rates		FOR STAND-ALONE DENTAL ONLY: <input type="checkbox"/> Provides rates and indicates whether they are committing to rates reported or if they are reserving the option to charge additional premium amounts. CMS's "Letter to Issuers on Federally-Facilitated and State Partnership Exchanges" from April 5, 2013.
Accreditation Standards		
Accreditation	45 CFR §156.275(a)(1)	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> Accredited on the basis of local performance in the following categories by an accrediting entity recognized by CMS: <input type="checkbox"/> Clinical quality measures, such as the HEDIS <input type="checkbox"/> Patient experience ratings on a standardized CAHPS survey <input type="checkbox"/> Consumer access <input type="checkbox"/> Utilization management <input type="checkbox"/> Quality assurance <input type="checkbox"/> Provider credentialing <input type="checkbox"/> Complaints and appeals

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REVIEW REQUIREMENTS	REFERENCE	COMMENTS
		<input type="checkbox"/> Network adequacy and access <input type="checkbox"/> Patient information programs
Accreditation Survey Results	45 CFR §156.275(a)(2)	<input type="checkbox"/> Authorizes the accrediting entity to release to the Exchange and CMS a copy of its most recent accreditation survey and survey-related information.
Accreditation Timeline	45 CFR §155.1045 45 CFR §156.275(b)	<input type="checkbox"/> Accredited within the timeframe established by the Exchange. <input type="checkbox"/> Maintains accreditation. During initial year of certification, issuer must have an existing commercial, Medicaid, or Exchange health plan accreditation in WV granted by an accrediting entity or must have scheduled, or plan to schedule, a review of QHP policies and procedures with the accrediting entity.
Network Adequacy and Provider Directory		•
General	45 CFR §156.230	<input type="checkbox"/> Complies with WV network adequacy laws and regulations in addition to the specific requirements listed below. <input type="checkbox"/> Has a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay. WV Informational Letter No. 112 provides standards related to distance/time and provider to enrollee ratios. Is accredited on network adequacy and attests to compliance or provides and access plan based on NAIC Model Act #74 Managed Care Plan Network Adequacy.
Essential Community Providers	45 CFR §156.230(a)(1) 45 CFR §156.235	<input type="checkbox"/> Has sufficient number and geographic distribution of Essential Community Providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the service area. <ul style="list-style-type: none"> • Issuer achieves at least 20% ECP participation in network in the service area, agrees to offer contracts to at least one ECP of each type available by county, and agrees to offer contracts to all available Indian providers; or • Issuer achieves at least 10% ECP participation in network in the service area, and submits a satisfactory narrative justification as part of its QHP submission; or • Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission.
Mental Health and Substance Abuse Providers	45 CFR §156.230	<input type="checkbox"/> Network must include providers that specialize in mental health and substance abuse services. Issuers establish a standard to assure that the QHP network complies with the Federal standard; a copy of this standard is included in application and issuer certifies that the network meets the standard. Standard does NOT apply to stand-alone dental plans.
Service Area	45 CFR §155.1055	<input type="checkbox"/> Has a minimum service area of an entire county.
Provider Directory	45 CFR §156.230(b)	<input type="checkbox"/> Makes its provider directory available: <input type="checkbox"/> To the Exchange for publication online in accordance with guidance from the Exchange <input type="checkbox"/> To potential enrollees in hard copy upon request. <input type="checkbox"/> Provider directory identifies providers that are not accepting new patients.

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REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Marketing, Applications, and Notices		Provides network names, IDs, and URL in a Network Template.
WV Laws	45 CFR §156.225(a)	<input type="checkbox"/> Complies with all WV marketing laws & regulations. <input type="checkbox"/> Certificate of Readability provided WV Legislative Rules Title 114 Series 10; WV 33-29-5
Non-discrimination	45 CFR §156.225(b)	<input type="checkbox"/> Marketing practices do not discourage the enrollment of individuals with significant health needs.
Readability/Accessibility	45 CFR §155.230(b)	<input type="checkbox"/> Provides applications and notices to applicants and enrollees all applications and other material: <input type="checkbox"/> In plain language <input type="checkbox"/> In a manner that is accessible and timely to: <input type="checkbox"/> Individuals living with disabilities <input type="checkbox"/> Individuals with limited English proficiency through the provision of language services at no cost to the individual.
Quality Standards		
Quality	45 CFR §156.200 (b)(5) ACA § 1311(c)(1), 1311(c)(3), 1311(c)(4), and 1311(g)	<input type="checkbox"/> Attests to comply with future Federal rule-making related to 45 CFR §156.200(b)(5). CMS indicates they intend to address specific requirements in future rulemaking related to quality data reporting, quality improvement strategies, and enrollee satisfaction surveys described in these statutory provisions.
Segregation of Funds for Abortion Services		
Abortion Services	45 CFR §156.280 ACA §1303	Standard does NOT apply to stand-alone dental plans. <input type="checkbox"/> Does not use federal funds for abortion. <input type="checkbox"/> Complies with procedures to ensure Federal funds are not misused, depositing payments into separate allocation accounts. <input type="checkbox"/> Submits segregation plan. <input type="checkbox"/> Provides annual assurance statement. <input type="checkbox"/> If provides for coverage of abortion services, provides a notice to enrollees as part of the summary of benefits and coverage explanation at the time of enrollment. <input type="checkbox"/> Does not discriminate against any health care provider or any health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortion.
<i>Issuers will be required to attest to the Federal requirements included in the following sections.</i>		
Transparency Requirements		
Coverage Transparency	45 CFR §155.1040 45 CFR §156.220	<input type="checkbox"/> Makes available to the public, Exchange, CMS, and the WV Insurance Commissioner in an accurate and timely manner, and in plain language: <input type="checkbox"/> Claims payment policies and practices <input type="checkbox"/> Periodic financial disclosures <input type="checkbox"/> Data on enrollment <input type="checkbox"/> Data on disenrollment <input type="checkbox"/> Data on the number of claims that are denied <input type="checkbox"/> Data on rating practices <input type="checkbox"/> Information on cost-sharing and payments for out-of network coverage <input type="checkbox"/> Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights)
Enrollee Cost-Sharing	45 CFR § 156.220(d)	<input type="checkbox"/> Makes available the amount of enrollee cost-sharing for a specific item or service by a participating provider in a timely manner upon

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REVIEW REQUIREMENTS	REFERENCE	COMMENTS
		<p>the request of the individual.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Makes available such information through: <ul style="list-style-type: none"> <input type="checkbox"/> Internet website <input type="checkbox"/> Other means for individuals without access to the Internet
Appeals Notices	45 CFR §147.136(e)	<input type="checkbox"/> Provides required notices on internal and external appeals in a culturally and linguistically appropriate manner.
Enrollment Periods		
Initial	45 CFR §155.410(b)	<input type="checkbox"/> Provides an initial open enrollment period October 1, 2013 to March 31, 2014.
Annual	45 CFR §155.410(e)	<input type="checkbox"/> Provides an annual open enrollment period October 15 to December 7.
Special	45 CFR §155.420	<input type="checkbox"/> Provides special enrollment periods for qualified enrollees. <input type="checkbox"/> Provides notice to individuals eligible to enroll during a special enrollment period.
Enrollment Process for Qualified Individuals		
Enrollment	45 CFR §156.265 (b)(1) 45 CFR §156.265 (b)(2) 45 CFR §156.265 (c) 45 CFR §156.265 (d) 45 CFR §156.265 (e) 45 CFR §156.265 (f)45 CFR §156.400 (d) 45 CFR §156.265 (g)	<input type="checkbox"/> Enrolls a qualified individual when Exchange notifies the issuer that the individual is a qualified individual and transmits information to the issuer. <input type="checkbox"/> If an applicant initiates enrollment directly with the issuer for enrollment through the Exchange, the issuer either: <input type="checkbox"/> Directs the individual to file an application with the Exchange <input type="checkbox"/> Ensures that the individual received an eligibility determination for coverage through the Exchange via the Exchange Internet website. <input type="checkbox"/> Accepts enrollment information consistent with the privacy and security requirements established by the Exchange. <input type="checkbox"/> Uses the premium payment process established by the Exchange. <input type="checkbox"/> Provides new enrollees an enrollment information package that is compliant with accessibility and readability standards. <input type="checkbox"/> Reconciles enrollment files with CMS and the Exchange no less than once a month. <input type="checkbox"/> Acknowledges receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards.
Termination of Coverage of Qualified Individuals		
Termination Allowances	45 CFR §155.430(b) 45 CFR §156.270	Terminates coverage only if: <input type="checkbox"/> Enrollee is no longer eligible for coverage through the Exchange <input type="checkbox"/> Enrollee's coverage is rescinded <input type="checkbox"/> QHP terminates or is decertified <input type="checkbox"/> Enrollee switches coverage: <input type="checkbox"/> During an annual open enrollment period <input type="checkbox"/> Special enrollment period <input type="checkbox"/> Obtains other minimum essential coverage <input type="checkbox"/> For non-payment of premium only if: <input type="checkbox"/> Applies termination policy for non-payment of premium uniformly to enrollees in similar circumstances <input type="checkbox"/> Enrollee is delinquent on premium payment <input type="checkbox"/> Provides the enrollee with notice of such payment delinquency <input type="checkbox"/> Provides a grace period of at least three consecutive months if an enrollee is receiving advance payments of the premium tax credit

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		and has previously paid at least one month's premium
Notice	45 CFR §155.430 (d)45 CFR §156.270 (b)	<input type="checkbox"/> Provides reasonable notice of termination of coverage to the Exchange and enrollee (this includes effective date of termination).
Records	45 CFR §155.430(c) 45 CFR §156.270(h)	<input type="checkbox"/> Maintains records of terminations of coverage for auditing.
SHOP-Specific Requirements		
	45 CFR §156.285	<input type="checkbox"/> Accepts payment from the SHOP on behalf of a qualified employer or employee. <input type="checkbox"/> Adheres to the SHOP timeline for rate setting. <input type="checkbox"/> Charges the same contact rate for a plan year.
		<input type="checkbox"/> Adheres to the SHOP enrollment timeline and process. <input type="checkbox"/> Receives enrollment information electronically. <input type="checkbox"/> Provides new enrollees with an enrollment information package. <input type="checkbox"/> Reconciles enrollment files with the SHOP at least monthly. <input type="checkbox"/> Acknowledges receipt of enrollment information in accordance with SHOP standards. <input type="checkbox"/> Enrolls all qualified employees consistent with the employer's plan year. <input type="checkbox"/> Enrolls a qualified employee in accordance with the qualified employer's annual open enrollment period. <input type="checkbox"/> Provides special enrollment periods. <input type="checkbox"/> Provides an enrollment period for an employee who becomes a qualified employee outside of the initial or annual open enrollment period. <input type="checkbox"/> Adheres to effective dates of coverage.
		<input type="checkbox"/> Complies with requirements with respect to termination of employees.
		<input type="checkbox"/> If a qualified employer withdraws from the SHOP, terminates coverage for all enrollees of the withdrawing employer.
Recertification and Decertification		
Recertification	45 CFR §156.290	<input type="checkbox"/> If elects not to seek recertification with the FFE: <input type="checkbox"/> Notifies the FFE of its decision prior to the beginning of the recertification process and procedures adopted by the FFE <input type="checkbox"/> Fulfills its obligation to cover benefits for each enrollee through the end of the plan or benefit year <input type="checkbox"/> Fulfills data reporting obligations from the last plan or benefit year of the certification <input type="checkbox"/> Provides written notice to enrollees <input type="checkbox"/> Terminates coverage for enrollees in the QHP.
Decertification	45 CFR §156.290	<input type="checkbox"/> If decertified by the FFE, terminates coverage for enrollees only after: <input type="checkbox"/> The FFE has made notification <input type="checkbox"/> Enrollees have an opportunity to enroll in other coverage
Other Substantive and Reporting Requirements		
General Compliance	45 CFR §156.200(b)(2)	<input type="checkbox"/> Complies with all Exchange processes, procedures, requirements.
User Fee	45 CFR §156.200(b)(6)	<input type="checkbox"/> Pays the Exchange user fee.
Risk Adjustment	45 CFR §156.200(b)(7)	<input type="checkbox"/> Complies with risk adjustment program.
Non-Discrimination	45 CFR §156.200(e)	<input type="checkbox"/> Does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.
Consumer Interest	45 CFR §155.1000(c)(2)	<input type="checkbox"/> Is in the interest of qualified individuals.
Claims, Appeals, and External Review	45 CFR §147.136	<input type="checkbox"/> Complies with internal claims and appeals and external review process.

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REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Direct Primary Medical Home	45 CFR §156.245	<input type="checkbox"/> If provides coverage through a direct primary care medical home: <input type="checkbox"/> Medical home meets criteria established by CMS <input type="checkbox"/> Issuer meets all requirements otherwise required <input type="checkbox"/> Issuer coordinates the services covered by the direct primary care medical home
Data-Sharing		<input type="checkbox"/> Collects and transmits data to and from Exchanges, CMS, Treasury, and reinsurance entities. <input type="checkbox"/> Provides a description of system infrastructure's capacity to securely interface with these entities for data transfers, including enrollment, reconciliation, claims encounter data, and reports.
Prescription Drug Distribution and Cost Reporting	45 CFR §156.295	<input type="checkbox"/> Reports to U.S. DCMS on prescription drug distribution and cost the following information (paid by PBM or issuer): <input type="checkbox"/> Percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies <input type="checkbox"/> Percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type: <input type="checkbox"/> Independent pharmacy <input type="checkbox"/> Supermarket pharmacy <input type="checkbox"/> Mass merchandiser pharmacy <input type="checkbox"/> Aggregate amount and type of rebates, discounts, or price concessions that the issuer or its contracted PBM negotiates that are: <input type="checkbox"/> Attributable to patient utilization <input type="checkbox"/> Passed through to the issuer <input type="checkbox"/> Total number of prescriptions that were dispensed. <input type="checkbox"/> Aggregate amount of the difference between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.

Appendix C:
WV EHB Benchmark Policies

HIGHMARK[®]
West Virginia



An Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross, Blue Shield and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

SUPERBLUE *Plus*SM
2000

**HEALTH CARE
CERTIFICATE**

\$1,000 DEDUCTIBLE

**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 Copay 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%
Birthing 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 carboxylase 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 hydroxyacyl-CpA dehydrogenase deficiency, trifunctional protein deficiency, carnitine uptake defect, 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/APPEAL 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.

Cranio-mandibular 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 women, 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



An Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross, Blue Shield and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

First Print November 2010

Dental Services

The WVCHIP Benefit Plan covers a full range of dental services. Most dental services require no copays. Procedures requiring copayments are noted below by *. Some services require precertification before the plan will cover them. Precertification requirements apply to **all** enrollment groups.

WVCHIP Gold Plan and WVCHIP Blue Plan Members have no copayments for dental services. **WVCHIP Premium** members have \$25.00 copayments for some non-preventive procedures, with a maximum copayment of \$100.00 per child or \$150.00 per family per benefit year. Please note the copayment is per procedure not per visit. If two procedures are performed then \$50.00 copay is required.

Preventive Dental and Other Services Requiring No Precertification:

Covered 100% - no copayment

- Dental examinations every six months
- Cleaning and fluoride treatments every six months
- 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
- 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
- Palliative Treatment
- Other x-rays (covered in connection with another service)
- Consultations
- Space Maintainers

Restorative: 100% after \$25 copay*

- Fillings as needed

Endodontics/Root Canals/Periodontics: 100% after \$25 copay*

- Pulpotomy
- Root Canals

Surgery/Extractions: 100% after \$25 copay*

- Simple extractions
- Extractions – impacted (Precertification required if performed in an outpatient facility or hospital)
- Extractions related to an abscess and root canal therapy
- Frenulectomy (frenectomy or frenotomy)

Dental Services (cont.)

- Removal of dental related cysts under a tooth or on a gum, including x-rays needed to diagnose the condition
- Biopsy of oral tissue

Dental Services Requiring Precertification:

The services listed below are covered when medically necessary as determined by precertification. Please call HealthSmart (formerly Wells Fargo, TPA) at 1-800-356-2392 prior to obtaining the service to assure it will be covered. **If the request for precertification is denied, WVCHIP will not cover the cost of the procedure.**

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 prior authorization **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, TPA) then the prior authorization request will be **DENIED** and the provider cannot be reimbursed for the service.

- Restorative/Periodontics
 - Dental crowns – 1 every 5 years
 - Gingivectomy or gingivoplasty – 1 per quad/per year
 - Osseous surgery – 1 per quad/per year
 - Periodontal scaling and root planning – 1 per quad/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 be provided within 72 hours of the accident. Biting and chewing accidents are not covered. Services provided more than six (6) months after the accident are not covered. **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 HealthSmart (formerly Wells Fargo, TPA).
- **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, TPA) for more information.

Dental Services (cont.)

- **Orthodontic Services:** Orthodontic services are covered if medically necessary for a WVCHIP member whose malocclusion creates a disability and impairs their physical development. Treatment is routinely accomplished through fixed appliance therapy and maintenance visits. All requests for treatment are subject to precertification by HealthSmart (formerly Wells Fargo, TPA) Dental Consultants. Precertification is dependent on diagnosis, degree of impairment and medical documentation submitted. Failure to obtain precertification before service is performed will result in the family being responsible for amounts above and beyond their copayment requirements.

If requested treatment is denied, follow the appeal process as outlined on pages 63 thru 64.

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

Precertification from HealthSmart (formerly Wells Fargo, TPA) assures that the claim will be paid when submitted unless the child disenrolls from the plan on or before the date of service. If the request for precertification is denied, the parent or guardian is responsible for paying for the procedure if the child has it done without a precertification approval.

Dental Services Not Covered

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
- Gold Restorations
- Precision Attachments
- Replacement of teeth extracted prior to coverage
- Replacements of crowns covered after 5 years
- Cosmetic Dentistry
- Dental implants and related services
- Experimental procedures
- Splinting
- Out of state providers unless prior approval is obtained
- Any other procedure not listed as covered

Timely 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.

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.BENEFEDES.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 BENEFEDES

You must use BENEFEDES to enroll or change enrollment in a FEDVIP plan. BENEFEDES is a secure enrollment website (www.BENEFEDES.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 BENEFEDES.

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 BENEFEDES 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 (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA), 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	
Diagnostic	Standard Option	High Option
<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: High Option: covered once every calendar year.</p> <p>Standard Option: 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: <table border="0"> <tr> <td>Select Progressive Lenses</td> <td>\$70</td> <td>\$70</td> </tr> <tr> <td>Ultra Progressive Lenses</td> <td>\$195</td> <td>\$195</td> </tr> </table> 	Select Progressive Lenses	\$70	\$70	Ultra Progressive Lenses	\$195	\$195		
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

Appendix D:
Informational Letters



STATE OF WEST VIRGINIA

Offices of the Insurance Commissioner

Earl Ray Tomblin
Governor

Michael D. Riley
Insurance Commissioner

MARCH 2013

WEST VIRGINIA INFORMATIONAL LETTER

NO. 184

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

RE: "Habilitative Benefit" Category of Essential Health Benefits

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). The ACA requires 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 US Department of Health and Human Resources which ultimately used a "benchmark" approach, permitting each state to select a "benchmark plan" from among 7 plans offered in the state and 3 federal plans. Because West Virginia did not select a benchmark, the largest small group plan offered in the state, the "Highmark Blue Cross BlueShield West Virginia Super Blue PPO Plus 2000 1000 Ded" became the benchmark plan. *See* 45 CFR §§147, 155 & 156.

One EHB category that traditionally has not been provided by most health insurance carriers in states is "habilitative benefits". Therefore, most states' benchmarks do not include habilitative benefits. Further, this category of EHB is not defined in federal statute, law or guidance. As such, the U.S. Department of Health and Human Services (HHS) has provided the states discretion to define this category for purposes of EHB. Specifically, 45 CFR §156.110(f) states:

(f) Determining habilitative services. If the base-benchmark plan does not include coverage for habilitative services, the State may determine which services are included in that category.

Additionally, language in the above-referenced federal rule indicates that one preferred approach is to make the habilitative benefits offered in the policy to be in parity with the rehabilitative benefits offered in the policy. *See* 45 CFR §156.110(f).

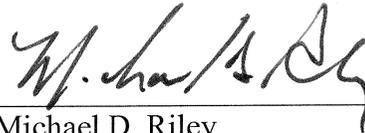


West Virginia defines “habilitative services” as follows:

Medically necessary services that help a person gain, keep, or improve skills for daily living. Some examples include physical and occupational therapy, speech-language pathology, and other needed services.

Therefore, to meet the requirement to provide habilitation services, carriers should provide them: (1) as defined above; and (2) in *parity* with the rehabilitative services offered under the plan.¹ For example, if the plan offers up to 50 physical therapy visits per year for rehabilitation benefits, the same amount would have to be offered for habilitative benefits pursuant to the definition above (“needed to help a person gain, keep, or improve skills for daily living”).

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

¹ Rehabilitative services are also an EHB “sub-category” under the ACA along with habilitative, so every plan that has to provide habilitative pursuant to EHB requirements will also provide rehabilitative. Further rehabilitative benefits *are* part of West Virginia’s benchmark plan so all EHB carriers will have a point of reference for purposes of establishing rehabilitative benefits in their plan.



STATE OF WEST VIRGINIA

Offices of the Insurance Commissioner

Earl Ray Tomblin
Governor

Michael D. Riley
Insurance Commissioner

MARCH 2013

WEST VIRGINIA INFORMATIONAL LETTER

NO. 185

TO: All Health Maintenance Organizations Licensed to do Business in the State of West Virginia and Interested Medical Providers

RE: Infertility Services – Minimum Benefits

This letter is intended to clarify minimum benefits that a health maintenance organization (“HMO”) is required to offer or otherwise make available to its enrollees with respect to infertility services. Clarification of the minimum benefits for infertility services is also expected to assist in the calculation of premium tax credits available pursuant to section 1401 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended.¹

West Virginia Code § 33-25A-2(11) defines an HMO as “a public or private organization which provides, or otherwise makes available to enrollees, health care services, including at a minimum basic health care services[.]”² Included among the mandated basic health care services, which are itemized at W. Va. Code § 33-25A-2(1), are “infertility services.”

For the purposes of this letter and W. Va. Code § 33-25A-2(1), infertility services mean diagnostic and/or exploratory procedures to establish a diagnosis of infertility and identify the cause. Infertility services do *not* include the treatment of infertility, which may consist of, but not be limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer.

¹ Section 1401 of the Patient Protection and Affordable Care Act created section 36B of the Internal Revenue Code (26 U.S.C. 36B), which provides for a premium tax credit that is available on an advanced basis to reduce the monthly insurance costs for eligible individuals who enroll in a qualified health plan through an approved health insurance exchange. Because infertility services mandated by W. Va. Code § 33-25A-2(1) are part of West Virginia’s “state-required benefits enacted on or before December 31, 2011,” an approved health insurance exchange must regard infertility services as an essential health benefit subject to the premium tax credit. *See* 45 CFR 155.

² W. Va. Code § 33-25A-18(1)(c) allows the Insurance Commissioner to suspend or revoke an HMO’s certificate of authority if the HMO fails to provide or arrange for basic health care services.



Nothing in this letter shall be construed to deny or restrict any existing right or benefit to coverage and treatment of infertility under an existing plan or policy. In addition, nothing in this letter shall be construed to prohibit an HMO from offering coverage for infertility services in excess of the required minimum benefits set forth herein.

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



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.

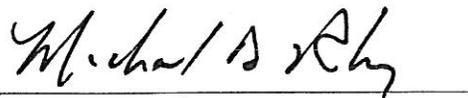


As such, the OIC directs all health insurance carriers required to provide EHB in West Virginia to use the benefits as outlined in the “Highmark Blue Cross BlueShield West Virginia \$1000 Deductible Super Blue Plus 2000 PPO Plan” Certificate of Coverage, attached to this letter as Appendix 1, as a starting 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.