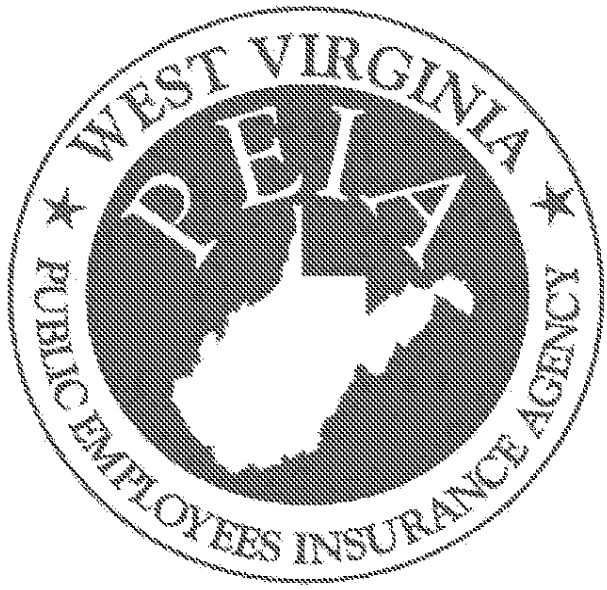

WEST VIRGINIA
PUBLIC EMPLOYEES INSURANCE AGENCY

PLAN DOCUMENT

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

Brian A. Cunningham, Director

July 1, 2024

I: GENERAL INFORMATION

I.1. Introduction

The West Virginia Public Employees Insurance Agency ("PEIA") was created by an Act of the West Virginia Legislature effective July 1, 1990, replacing the West Virginia Public Employees Insurance Board. The PEIA is the State Agency responsible for administering a health and life benefit plan and other benefit offerings to eligible employees and retirees of the State, county boards of education, local governmental entities as well as other persons as specifically authorized to participate by statute. The PEIA also provides coverage for eligible dependents of participating employees and retirees. As of July 1, 2007, retirees and their dependents are administered by PEIA on behalf of the West Virginia Retiree Health Benefits Trust Fund (RHBT).

The purpose of this Plan Document is to describe the various benefits offered by the PEIA to its covered insureds and how those benefits are administered. The PEIA also publishes a Summary Plan Description Booklet for its policyholders, a less technical explanation of Plan benefits and how to use them.

I.2. Mission Statement

Administer affordable insurance-oriented programs and quality services that protect, promote, and benefit the health and well-being of our members.

PEIA diligently works to achieve this by…

- improving benefits and choices for members.
- offering exceptional and caring customer service.
- providing education and awareness related to insurance and health care.
- advocating for members in matters that enhance being a PEIA member.
- implementing improved processes and updated documented policies.
- assisting members regarding insurance and health care benefits.
- administering effective and efficient programs and services.
- collaborating with others so as to improve PEIA programs and services.
- improving benefits and choices for members.
- ensuring that claims and other requests are processed promptly and accurately.
- working with providers to ensure ample access to medical services at reasonable cost.
- complying with applicable rules, regulations, and standards as they relate to ensuring the privacy, confidentiality, security, and integrity of the individually identifiable health information of our policyholders and dependents.

I.3. Organizational Overview

Director. The Director of the PEIA is appointed by the Governor with the advice and consent of the West Virginia Senate. He/she serves at the will and pleasure of the Governor and must have at least three years' experience in health insurance administration prior to appointment. The Director is responsible for the day-to-day administration and management of the PEIA, makes all rules and regulations, and enters into any contracts necessary to carry out the PEIA's mission.

PEIA Staff. The Director is authorized to employ such administrative, technical and clerical staff as is necessary to properly administer the Plan. All positions in the PEIA, except for the Director, Deputy Director, Chief Financial Officer and the Director's secretary will be included as classified personnel under the classification system of the Division of Personnel, of the Department of Administration.

Finance Board. The PEIA Finance Board consists of the Department Secretary and eight members appointed by the Governor with the advice and consent of the West Virginia senate for terms of four years and until the appointment of their successors.

The Finance Board is responsible for approving the Agency's and Retiree Health Benefit Trust's Annual Financial Plan, monitoring the implementation of the Financial Plan and insuring the financial stability of the Agency.

Actuaries. The Finance Board will employ an impartial, professional actuary with demonstrated experience in analysis of large group health insurance plans to estimate the total financial requirements of the Agency for each fiscal year and to review and render a written professional opinion as the fiscal soundness of any proposed financial plan or amendment to a financial plan. In addition, at the request of the Finance Board, the actuary shall develop alternative financing options and perform such other services as required.

Third-Party Administrators. The PEIA employs Third-party Administrators (TPAs) to administer the claims processing and utilization review procedures for the Medical Benefits plan, subrogation, the prescription Drug Plan and to administer the Mountaineer Flexible Benefits Plan. A current listing of TPAs is contained in Appendix A.

Consultants and Other Contractors. The Director may contract with such consultants and other contractors as is necessary to administer the Plan.

Technology. The Director or his/her designee(s) may employ or contract certain technologies, applications or systems to improve plan operations, allow employer and/or member access to management of their account(s), monitor health care trend(s), analyze data, or otherwise facilitate the safe and secure operation(s) of the Plan.

System(s) Access. Only authorized Users shall be allowed to access PEIA applications, platforms, and/or systems. PEIA Employee, member, Employer, Contractor, and/or vendor access to PEIA applications, platforms, and/or systems is a privilege and may be revoked if certain security provisions and/or procedures are violated, bypassed, tampered with, and/or otherwise compromised. PEIA reserves the right to conduct User and/or Access audits to authenticate users and verify compliance with security provisions and/or procedures.

Compliance. PEIA strives for compliance with any and/or all applicable State and/or federal laws, rules, and/or regulations that relate to the operations of the Plan. PEIA shall conduct an ongoing review of its operations, systems, applications, and processes to ensure said compliance.

I.4. Overview of Benefits

Medical Benefits Plan. The Medical Benefits Plan offers a board range of benefits including:

- Medically necessary services and supplies;

- Pre-admission review and case management;

- Wellness benefits; and

- An organ transplant network.

Medicare-Primary Members. For PEIA's Medicare-eligible retired employees and Medicare-eligible dependents of retired employees, the specific major medical and drug benefits described in this Plan Document do not apply, however, the eligibility, administrative, and fringe benefits (cafeteria plan) sections do apply. PEIA has contracted with Humana to provide the Medicare Advantage Prescription Drug Plan (MAPD). This plan provides both medical and prescription drug coverage for those Medicare-Primary members. Information in this Plan Document regarding the MAPD plan is very limited. Each eligible member has received detailed information about the plan from Humana and PEIA.

Prescription Drug Plan – PEIA PPB. The Prescription Drug Plan benefits generally include:

- Coverage of medically necessary prescription drugs and supplies;
- Discounts to the insured when using a Network pharmacy, a maintenance supply of medication and/ or generic drugs;
- Specialty medications;
- Utilization review to detect contraindicated prescriptions and improper utilization of prescription drugs; and
- Direct claims filing through Network pharmacies.

Basic and Optional Life and Accidental Death & Dismemberment (AD&D) Insurance. The PEIA's life insurance plan generally offers the following:

- Basic term life and AD&D coverage at no cost to the policyholder; and
- Optional term life insurance for the policyholder and qualified dependents that can be purchased by the policyholder.

Flexible Benefits Plan. The Mountaineer Flexible Benefits Plan generally includes the following:

- Dental, Vision, Hearing, Short- and Long-Term Disability Insurance;
- A Medical Flexible Spending Account;
- A Dependent Care Flexible Spending Account; and
- A *Legal Plan, *Hospital Indemnity Plan,*Critical Illness and *Accident Insurance.

*These are post-tax benefit options. Benefits for these plans are described in the open enrollment material mailed (annually) by the Plan Administrator.

I.5. Interpretation of Plan

The Director shall have ultimate authority to interpret the Plan for the PEIA. The Director may authorize others to interpret the Plan on the Agency's behalf, such as TPAs; however, such delegation shall not supersede the authority of the Director.

From time to time, this Plan may be superseded by legislation, enacted rules or regulations, court decisions, actions of the Finance Board or such other actions that may have a binding effect on the Agency. In such cases, the Plan Document will be amended, within a reasonable time, to reflect such actions.

In administering a medical and drug benefits plan it is necessary to follow certain medical and drug policies, procedures and protocols in determining whether a service, condition, treatment or item is medically necessary or otherwise appropriate and subject to coverage. It is not possible to include all these in this document. PEIA reserves the right to rely upon these in application to particular claims and or appeals.

As all actions conducted by PEIA are based on the tenets, premises of and/or covenants of contracts and/or agreements, and in accordance with West Virginia Code §5-16-12a(a), all parties to said contracts and/or agreements shall be truthful in any and/or all exchanges with the Agency related to the management of the Plan; the administration of claims; determinations of eligibility; and/or the provision of services either directly and/or indirectly to the Plan and its covered insureds. This truthful requirement shall apply to, but not be limited to: Business Associates, contractors, vendors, providers, participating employer agencies and their agents, employees, policyholder members, covered dependents, and authorized third-party representatives of policyholder members and/or dependents. The failure of a party to be truthful in its transactions with the Agency can and may result in the denial of claims and/or the loss of eligibility and/or the cancellation of contracts and/or agreements. The decision on penalties for untruthful submissions, conduct, or behavior shall rest with the Director or his/her assigned designee.

I.6. Amendments to Plan Document

The PEIA reserves the right to amend all or any portion of this Plan Document in order to reflect changes required by court decisions, legislation, actions by the Finance Board, actions by the Director and for any other matters as are appropriate. The Plan Document will be amended within a reasonable time of any such actions and notice will be provided no later than 60 days prior to the date on which the material modifications will become effective. All amendments to the Plan Document must be in writing, dated and approved by the Director. The Director or the Director's designee shall have sole authority to approve amendments to the Plan Document. The Plan Document, the Summary Plan Description, and all approved amendments will be filed with the State of West Virginia Secretary of State's Office.

I.7. Documentation

PEIA may require documentation from employers, employees, or retired employees to verify eligibility of insureds, eligibility events, or other relevant facts.

PEIA may require documentation from providers to verify the service(s) provided to its insureds and ensure the accuracy and validity of services provided and billed to the Plan.

PEIA may require documentation from its Business Associates, contractors and/or subcontractors to substantiate and verify that they have provided products, goods, and/or services in accordance with the terms, conditions and scope of their agreements and/or contract(s).

I.8. Appendices

The appendices to this Plan Document are incorporated into and made a part of this document.

I.9. HIPAA – Privacy Amendments – Information from Health Plans to Plan Sponsor

All health plans addressed in this Plan Document are amended consistent with the provisions contained in Appendix I and Appendix J hereto.

I.10. Definitions

The following definitions apply to all terms used in this Plan Document, except to the extent that the definitions may be contrary to definitions contained in Section IX (Medical Reimbursement Plan) and Section X (Dependent Care Reimbursement Plan), in which case the definitions contained in Sections IX and X will apply exclusively to those sections.

Active Employee – A person who is actively employed with a PEIA participating agency.

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

Annual Deductible - The amount an insured must pay each year before the Plan pays any portion of the cost.

Appeal - A formal request under defined procedures for the health insurance company or the Plan Sponsor to review a decision that denies a benefit or payment

Audit - A review of the insured's status and/or claims records to determine the eligibility for and validity of the service(s) paid for the coverage(s) furnished.

Authorized Individual: A person who has legal authority to make decisions related to health care for an individual. Examples are a spouse or other family member named in a health care power of attorney, a parent or legal guardian of a minor, a person appointed by a court to serve as custodian, guardian or conservator and an executor, administrator, or other person with authority to act on behalf of a deceased individual.

Beneficiary – The person who receives the proceeds of your PEIA life insurance policy. To view and/or change beneficiaries for your plan, please visit mybenefits.metlife.com/. All beneficiary changes must be made through MetLife. For more information, please contact MetLife at 1-888-466-8640.

Breach - Means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under 45 CFR 164.402, subpart E which compromises the security or privacy of the protected health information.

Coinsurance – The percentage of the allowed amount that the insured must pay after the deductible has been met. This is the amount applied to the insured's annual out-of-pocket maximum. The insured is responsible for paying the coinsurance and deductible amounts directly to the provider of service.

Common Specialty Medications: Self-administered specialty drugs that are provided through the Express Scripts Accredo Pharmacy and some local retail pharmacies participating in the Specialty Precision Network. All Specialty medications require prior authorization.

Complex Condition CARE: A program from UMR to identify catastrophic and complex illnesses, transplants, and trauma cases, and work with members to maximize their benefits.

Comprehensive Care Partnership (CCP) Program: The CCP program promotes the use of services to keep the patient well, identify health problems early, maintain control of chronic conditions and to promote efficient utilization of healthcare resources. The CCP provider is responsible for preventative services, routine sick care, and coordination of care with specialists when needed. Members that are in the CCP program pay less for specified services at their CCP provider. Insureds enrolled in PEIA PPB Plan C or who have Medicare are their primary coverage are not eligible in the CCP program.

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

Copayment - The set dollar amount an insured pays when using services, such as the flat dollar amount an insured pays for an office visit in the PEIA PPB Plan. Copayments are not applied to the annual deductible or out-of-pocket maximum.

Deductible – The amount of eligible expenses you are required to pay before the Plan begins to pay benefits for most services.

De-identified data – Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual in accordance with the HIPAA Privacy Rule 45 CFR 164.514.

Dependent - A person, other than a policyholder, who is eligible to participate in the Plan and who has been properly enrolled in the Plan by a policyholder. PEIA definition of a dependent differs from the definition used in the Internal Revenue Service rules. Being the Court appointed Guardian or Conservator of an adult "protected person" does not itself make that protected person eligible to be covered as a dependent. Certain other conditions may apply.

Diagnosis-Related Groups (DRGs) - System of classifying medical cases and surgical procedures for payment based on diagnoses; used under Medicare's prospective payment system (PPS) for inpatient hospital services.

Director - The Director of the West Virginia Public Employees Insurance Agency.

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

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

Emergency - A condition that manifests itself by 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 a bodily part or organ.

Employee - An active or retired employee as applicable.

Exclusions - Services, treatments, pharmaceuticals, supplies, conditions, or items or circumstances that are not covered under the PEIA Plan.

Experimental, Investigational, or Unproven Procedures - Medical, surgical, diagnostic, psychiatric, substance abuse or the other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan (at the time it makes a determination regarding coverage in a particular case) to be: (1) not approved by the United States Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Services, the United States Pharmacopoeia Dispensing Information, or the American Medical Association Drug Evaluations as appropriate for the proposed use; or (2) subject to review and approval by the Institutional review Board for the proposed use; or (3) the subject of an ongoing clinical trial that is subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which it is proposed. Phase 2 and 3 Clinical Trials for terminal cancer and other life-threatening conditions and which meet certain statutory criteria will be covered despite being experimental.

Explanation of Benefits (EOB) - A form sent to the policyholder after the claim has been evaluated or processed by the TPA-C or TPA-P. The EOB explains the action taken on the claim and includes information such as the PEIA allowed amount, the co-insurance amount, benefits available, reasons for denying payment, etc.

Express Scripts - PEIA's prescription drug benefit manager (PBM). Express Scripts processes and pays prescription drug claims and helps manage the prescription drug benefit.

Fringe Benefits Management Company (FBMC) - The flexible benefits TPA for PEIA.

GDPR – The General Data Protection Regulation - Designed to unify data privacy requirements across the European Union (EU). The regulation applies to entities who market to or process the information of EU Data Subjects – which include end users, customers and employees. Although PEIA may provide certain coverage(s) to members and/or their dependents who are citizens of the European Union, enrollment in a PEIA plan shall constitute a waiver of protection(s) under GDPR rule(s) and/or regulation(s). PEIA shall strive for full compliance with any and/or all applicable Federal and/or State of West Virginia law(s) rule(s) and/or regulation(s) as they relate to the privacy, security, confidentiality, and integrity of data that is created, used, stored, maintained, and/or transmitted by the Agency.

Handicap - A medical or physical impairment which substantially limits one or more of a person's major life activities. The term "major life activities" includes functions such as care for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

"Substantially limits" means interferes with or affects over a substantial period of time. Minor, temporary ailments or injuries shall not be considered physical or mental impairments which substantially limit a person's major life activities. "Physical or mental impairments" includes such diseases and conditions as orthopedic, visual, speech and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; autism; multiple sclerosis and diabetes. The term "handicap" does not include excessive use or abuse of alcohol, drugs or tobacco.

Health Maintenance Organization (HMO) - A managed care organization that provides a wide range of comprehensive health care services for a fixed periodic payment. PEIA contracts with HMOs to provide health coverage for policyholders and their dependents that choose this coverage. HMO participants receive general information about the plans in PEIA's Shopper's Guide, and specific information in the Evidence of Coverage (EOC) provided by their HMO.

Health Savings Account (HSA) - A health savings account (HSA) is a tax-exempt trust or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you incur. The HSA works in conjunction with a High Deductible Health Plan.

High Deductible Health Plan (HDHP) - A High Deductible Health Plan (HDHP) is a plan that includes a higher annual deductible than typical health plans, and an out-of-pocket maximum that includes amounts paid toward the annual deductible and any coinsurance that you must pay for covered expenses. The HDHP deductible includes both medical services and prescription drugs under a single deductible. Out-of-pocket expenses include copayments and other amounts, but do not include premiums.

HIPAA – the Health Insurance Portability and Accountability Act of 1996. This includes both the Privacy Rule(s) [45 CFR §164. Subpart E extends from §164.500 through §164.534] and the Security Rule(s) [45 CFR §164.302 through §164.318]

HITECH – the Health Information Technology for Economic and Clinical Health Act of 2009, enacted as part of the American Recovery and Reinvestment Act (ARRA)

IIHI - Protected Health Information as defined in Section 1171 of Part C of Subtitle F of Public Law 104-191 (August 21, 1996): Health Insurance Portability and Accountability Act of 1996: Administrative Simplification. These statutory definitions are of health information and individually identifiable health information. Also referred to as PHI.

Inpatient - An insured admitted as a bed patient to a hospital or other treatment facility for medical services.

Insureds - All persons who participate in the PEIA Plan, regardless of whether they are enrolled in the PPB Plan, a managed care plan or life insurance only. Insured refers to anyone who has coverage under any plan offered by PEIA.

Legal Guardianship - A legal relationship created when a person or institution is named by the Court to take care of minor children or certain "protected persons." Eligibility for guardianship requires an Order from a Court of record. Notarized documents signed by parents assigning "guardianship" are not sufficient to establish eligibility. The term "guardian" may also refer to someone who is Court-appointed to care for and/or handle the affairs of a person who is incompetent or incapable of administering his/her affairs and has been deemed a "protected

person" or similar in accordance with applicable law. Sometimes a separate person is appointed to handle the financial matters of the child(ren) or the adult and that relationship is called a conservatorship. Being the Court appointed Guardian or Conservator of a "protected person" does not itself make that protected person eligible to be covered as a dependent. Certain other conditions may apply.

Life Insurance Carrier - The life insurance company with which PEIA contracts to provide life insurance benefits to PEIA members.

Manage My Benefits (MMB) System: The PEIA online platform that allows policyholders to manage their health insurance benefits. Access to the Manage My Benefits (MMB) site is for policyholders ONLY and dependents, including spouses, and/or others (agents, guardians, etc.) are not permitted to access the site even with policyholder permission.

Managed Care Organization (MCO) - A generic term for HMO's or other similar models with which PEIA contracts. An MCO provides and/or pays for health care services.

Managed Allowable Charge (MAC) - A limitation on billed charges for prescription costs allowable by the PEIA.

Maternity CARE: A program from UMR that provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term.

Medical Out-of-Pocket Maximum: The amount you must spend in coinsurance in any plan year before your plan starts to pay 100% for most covered services. The out-of-pocket maximum is a running total of coinsurance you pay for services during the plan year. Amounts you pay toward your annual deductibles, for copayments, for precertification penalties, for prescription drugs, for amounts billed in excess of what PEIA pays to non-network providers, and for services that are not covered under the plan do not apply toward your annual medical out-of-pocket maximum. It includes only your medical charges; prescriptions are handled separately.

Medicare Advantage and Prescription Drug (MAPD) Plan - A type of Medicare benefit that combines Medicare Parts A, B and D into one comprehensive benefit package. PEIA provides benefits to Medicare-eligible retired employees and Medicare-eligible dependents of retired employees almost exclusively through the Humana MAPD plan offered by PEIA.

Medicare - The federal program of health benefits for retirees and other qualified individuals as established by Title XVII of the Social Security Act of 1965, as amended. Medicare consists of four parts, A, B, C and D. Parts A and B provide medical coverage to Medicare Beneficiaries. Retired, qualified Medicare Beneficiaries covered by PEIA are REQUIRED to enroll for both Medicare Part A and Part B. Medicare Part D (drug coverage) IS NOT required for members of the PEIA Plans.

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

Medicare Part A - The Medicare Hospital insurance program, which covers the cost of hospital and related post-hospital services. As an entitlement program, it is available to most individuals

without payment of a premium. Beneficiaries are responsible for an initial deductible per episode of illness, and coinsurance for some services.

Medicare Part B - The Medicare Supplementary Insurance Program (SMI); covers the costs of physician services, outpatient laboratory and X-ray test, durable medical equipment, outpatient hospital care, and certain other services. As a voluntary program, Part B requires payment of a monthly premium. Beneficiaries are responsible for a deductible and coinsurance payment for most covered services. PEIA Plan Medicare eligible retirees must participate in Part B.

Medicare Part D - Medicare Part D is prescription drug coverage offered through Medicare or a Medicare approved plan.

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

MetLife – Answers to questions about life insurance, to add or change a beneficiary, or to file a life insurance claim. To view and/or change beneficiaries for your plan, visit mybenefits.metlife.com/. For more information, contact MetLife at 1-888-466-8640.

Mountaineer Flexible Benefits - Flexible benefits plan offered by PEIA.

Non-Resident PPB Plan Participants - PEIA PPB Plan participants who reside outside West Virginia and beyond the bordering counties.

Notification: The required process for reporting an inpatient stay to UMR. This process is performed to screen for care planning, discharge planning, follow-up care and ancillary service requirements.

Organ Transplant Network - Network of providers through which the PEIA PPB Plan offers organ transplant services.

Ongoing Condition CARE: A program from UMR to identify individuals who have certain chronic diseases and would benefit from working with specially trained nurses to manage those chronic diseases and maintain quality of life.

Open Enrollment: A period held each year when policyholders can change their health plan, add, drop or change coverage without a qualifying event. Open enrollment for active members and non-Medicare retirees and survivors occurs annually from April 2-May 15. Open enrollment for Medicare retirees and survivors occurs annually October 1-31.

Out-of-Pocket Maximum: The amount you must spend for healthcare in any plan year before your plan starts to pay 100% for covered services. This limit includes deductibles (medical and prescription), coinsurance, and copayments. This limit does not include premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing.

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

OOSINNA: Out-of-state (beyond the contiguous counties), in-network, not approved. Services of an out-of-state, in-network provider, not approved in advance by UMR are covered at 60%.

The patient is also responsible for double the in-network deductible and double the in-network out-of-pocket maximum. OOSINNA does not apply to non-resident PPB Plan participants.

PEIA - The West Virginia Public Employees Insurance Agency.

PEIA Member - PEIA insureds who are participating in one of the managed care plans offered through the PEIA.

PEIA PPB Plan A - The standard PEIA PPB Plan offered to all eligible employees, regardless of employer. This plan is typically referred to as the PPB Plan.

PEIA PPB Plan B - An optional PPB Plan available to members. Plan B offers lower premiums with higher deductibles, higher out-of-pocket maximums, increased coinsurance, and higher copayments for prescription drugs. The medical coverage is the same as in Plan A. the differences in deductibles, out-of-pocket maximums, coinsurance, and drug copayments are noted in the tables in the "What You Pay with the PEIA PPB Plans, A, B and D" section and the "Prescription Drug Benefit" section of the Summary Plan Description (SPD). This plan is referred to as PPB Plan B.

PEIA PPB Plan C - The IRS-qualified High Deductible Health plan (HDHP) offered by PEIA. The plan offers lower premiums, but a high deductible that must be met before the plan begins to pay. The plan is designed to work with either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). The benefits are described in full in the section of the Summary Plan Description devoted to PEIA PPB plan C.

PEIA PPB Plan D - PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-network coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

PEIA PPO - The PEIA Preferred Provider Organization (PPO) is the network of providers from whom PEIA Preferred Provider Benefit (PPB) members can receive care to get the highest benefit level. This network consists of all properly licensed WV providers who provide health care services or supplies to any PEIA participant, as well as most out-of-state providers in UnitedHealthcare Choice Plus Preferred Provider Organization. For services provided outside of the State, contact UMR to find a network provider.

Pharmacy Benefits Manager (PBM) - A company with which PEIA has a contract to administer the prescription drug benefit component of PEIA PPB plans. The PBM processes and pays prescription drug claims and helps manage the prescription drug benefit.

PHI – Protected Health Information as defined in Section 1171 of Part C of Subtitle F of Public Law 104-191 (August 21, 1996): Health Insurance Portability and Accountability Act of 1996: Administrative Simplification. These statutory definitions are of health information and individually identifiable health information.

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

Plan Year - A 12-month period beginning July 1 and ending June 30 for active PEIA participants. January 1 to December 31 for participants in the Special Medicare Plan.

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

Preauthorization - A voluntary program that allows you to contact UMR in advance of a procedure to verify that the service is a covered benefit and medically necessary.

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

Pre-existing condition - A physical or mental condition that had been diagnosed, treated or for which the patient had incurred expenses before the patient became covered by the Plan. As of July 1, 2010, PEIA no longer has a pre-existing condition limitation. Pre-existing conditions are covered as of the effective date of coverage in the PEIA plan.

Preferred Provider Benefit Plan (PPB) - The PEIA PPB Plan is the preferred provider benefit (PPB) plan offered by PEIA and includes the PEIA PPB Plan A and PEIA PPB Plan B, PEIA PPB Plan C, & PEIA PPB Plan D as applicable. This plan replaced the PEIA Indemnity Plan on July 1, 1999. The PEIA PPB Plan provides medical care through a PPO Network of providers based on where an insured lives and where care is received.

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

Prescription Drug Network - A group of pharmacies that have an agreement with the PBM to provide services to PEIA insureds.

Primary Care Provider (PCP) - A general practice doctor, family practice doctor, internist, pediatrician, geriatrician, OB/GYN, nurse practitioner, or physician assistant working in collaboration with such a physician, who, generally, provides basic diagnosis and non-surgical treatment of common illnesses and medical conditions.

Prior Approval - The required process of obtaining approval from UMR for out-of-state or out-of-network care under the PEIA PPB Plans.

Prior Authorization - The required process of obtaining authorization from the Rational Drug Therapy Program for coverage for some non-specialty prescription medications and from Express Scripts for some specialty prescription medications under the PEIA PPB Plans.

Protected Person: An adult individual, eighteen years of age or older, who has been found by a court, because of mental impairment, to be unable to receive and evaluate information effectively or to respond to people, events, and environments to such an extent that the individual lacks the capacity: (A) To meet the essential requirements for his or her health, care, safety, habilitation, or therapeutic needs without the assistance or protection of a guardian; or (B) to manage property or financial affairs or to provide for his or her support or for the support of legal dependents without the assistance or protection of a conservator.

Prospective Payment System (PPS) - The methodology used for reimbursing inpatient hospital services.

Provider - A hospital, physician or other health care provider, licensed, where required, and performing within the scope of that license.

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

Public Employee Insurance Agency (PEIA) - The state Agency that arranges for health and life insurance benefits for west Virginia's public employees. PEIA administers the PEIA PPB Plan, and contracts with all the MCOs that are offered to public employees.

Qualifying Event - A qualifying event is a personal change in status which may allow you to change your benefit elections. Examples of qualifying events include, but are not limited to, the following:

1. Change in legal marital status – marriage or divorce of policyholder or dependent;
2. Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship;
3. Change in employment status of the employee's spouse or employee's dependent – switching from part-time to full-time employment status or from full-time to part-time, termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in employee/dependent becoming ineligible for coverage; and
4. Dependent satisfies or ceases to satisfy eligibility requirement. **Qualifying events which end eligibility (such as divorce, termination of Guardianship/parental rights, etc.) must be reported to PEIA immediately.** Step-children must be removed from coverage by the policyholder upon finalization of a divorce.
5. Dependent child is removed from the home and placed in the legal custody of the State.
6. Policyholder and/or dependent is placed in the custody of the State or Federal government, i.e. jail, prison, State group facility, etc.

If you experience a qualifying event, you have the month in which the event occurs and the two following calendar months to act upon that qualifying event and change your coverage. If you do not act within that time frame, you cannot make the change until the next Open Enrollment. **Qualifying events which end eligibility (such as divorce, termination of Guardianship/parental rights, the placement of a member and/or dependent in State or Federal custody, the placement of a dependent child into State custody, etc.) must be**

reported immediately. Stepchildren must be removed from coverage by the policyholder at the time of a divorce. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce. For purposes of this section, "Reporting" means the proper submission of a "Change in Status" form to the member's Employer Agency Benefit Coordinator and/or the proper submission of the Qualifying Event through the PEIA Manage My Benefits Portal with the appropriate supporting documentation, e.g. a copy of the divorce decree, Court Order(s), etc. "Calling" and/or e-mailing and informing your participating employer and/or PEIA of an event does not meet the reporting requirements of this section.

For purposes of Guardianships, if the Guardianship is granted by a court after the protected person reaches the age of 26 and the protected person was not continuously covered under the eligibility requirements of the Disabled Child section of this Plan Document, then the protected person shall not be eligible for coverages as a dependent under PEIA benefits.

Situations which are not Qualifying Events include, but are not limited to: granting of Visa or residency status, dependent over age 18 moving in with a policyholder, foreign exchange students coming to live with a policyholder, grandchildren living with grandparents without a Legal Guardianship.

Rational Drug Therapy Program (RDT) - The Rational Drug Therapy Program of the WVU School of Pharmacy provides clinical review of request for drugs that require prior authorization under the PEIA PPB Plans.

Reasonable and Customary - The usual, customary, and reasonable amount determined by the plan for a geographic area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill, or expertise to treat the patient successfully.

Resident PPB Plan Participants - PEIA PPB plan participants who live in West Virginia or a bordering county of a surrounding state.

Resource-Based Relative Value Scale (RBRVS) - A fee schedule that bases professional services reimbursement on the amount of resource costs required to diagnose and/or treat patients- instead of paying based on charge histories.

Retiree Health Benefits Trust fund (RHBT) - Entity created by WV Chapter 15, article 16D to administer the WV Other Post Employment Benefit plan (OPEB).

Retired Employee - An insured who qualifies for PEIA as a retired employee pursuant to W.Va. Code §5-16-2.

Secondary Payor - The plan or coverage whose benefits are determined after the primary plan has paid. The order of payment is determined by rule explained in Appendix G.

Special Medicare Plan - The plan created by PEIA to provide benefits to retirees unable to access providers in the Medicare Advantage plan and those retirees who became eligible for Medicare benefits during a plan year. Medical claims under this plan are paid by Medicare first, then by UMR and prescription claims are paid by Express Scripts. The medical benefits are

identical to those provided to members of the Humana MAPD plan, including a plan year that runs from January through December.

Specialty Injectable Drugs: These are prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring. The PEIA PPB Plans cover specialty injectable drugs through a program managed by UMR.

Specialty Medications - Specialty medications are high-cost injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of the patient's drug therapy. Some specialty medications are covered under the medical benefit and are managed by UMR, and some are covered under the prescription drug benefit and administered by Express Scripts. Those covered under the prescription drug benefit, have a two-tier copay; after meeting your deductible, preferred specialty drugs have a $100 copay, non-preferred specialty drugs have $150 copay. Specialty Injectable drugs managed by UMR require 20% coinsurance after deductible. All specialty medications covered under the prescription benefit (oral and self-injectable) require prior authorization through Express Scripts. PEIA will allow a one-time initial fill of certain specialty medications at a retail pharmacy.

Spousal Surcharge: PEIA is required by law to apply a monthly spousal surcharge to active employees of State agencies, colleges, universities, and county boards of education if your spouse is eligible for employer-sponsored coverage through his/her employer and has PEIA coverage. The spousal surcharge will be added to health insurance premiums each month. If your spouse is eligible for coverage as an employee of a PEIA-participating agency, has Medicare, Medicaid, TRICARE or is retired, the spousal coverage surcharge does not apply.

Subrogation - The right of the PEIA or a PEIA contracted insurer or MCO to succeed to an insured's right of recovery against a third-party who is, or may be, legally liable and to receive full reimbursement and recovery.

Summary Plan Description (SPD) - An annual publication by PEIA which is provided to Policyholders and which summarizes the benefits, benefit levels, limitations and other requirements which are in the PEIA Plan Document.

Tobacco Free - A person who has not used tobacco products (including cigarettes, cigars, pipes, and chewing and/or smokeless tobacco; including e-cigarettes and/or vaping oils derived from tobacco) in the last six months and will not use tobacco products for the next year.

Tobacco use: For purposes of the PEIA health and life insurance plans, tobacco use includes the use of cigarettes, cigars, pipes, and chewing and/or smokeless tobacco; including e-cigarettes and/or vaping oils derived from tobacco.

TPA (Third-Party Administrator) - A company with which PEIA has contracted to provide services such as customer service, subrogation, utilization management, and claims processing services to PEIA insureds.

TPA-C - Third-Party Administrator for Medical Claims.

TPA-P - Third-Party Administrator for the Prescription Drug Plan.

TPA-UM - Third-Party Administrator for Utilization Management for the Medical Benefits Program.

TruDataRX: A vendor that offers additional management on certain classes of medications for policyholders and their dependents. TruDataRx uses clinical data to maintain or improve clinical pharmaceutical care and reduce pharmacy benefit costs.

UMR: The third-party administrator that handles medical claim processing, Complex Condition CARE, utilization management, precertification, prior approval, and customer service for the PEIA PPB Plans.

UnitedHealthcare Choice Plus PPO: PEIA's out-of-state Preferred Provider Network. Not all providers in the UnitedHealthcare Choice Plus PPO network may participate with PEIA. Kings Daughters Medical Center in Kentucky remains out-of-network for PEIA, regardless of their network status with the PPO network. Also, PEIA does not use the PPO network in Washington County, Ohio (with the exception of Memorial Hospital System, which is now in-network for PEIA members), and Boyd County, Kentucky. PEIA reserves the right to remove providers from the network, so not all providers listed in the network may be available to you.

Unsecured Protected Health Information - Means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Pub. L. 111-5.

Utilization Management - A process by which PEIA controls health costs and saves money for plan members. Components of utilization management include pre-admission and concurrent review of all inpatient stays, known as precertification; prior review of certain outpatient surgeries and services; and Complex Condition CARE. Utilization management is handled by UMR.

Virgin Pulse: Program Provider for PEIA's new voluntary wellness program.

Waiver of Premium - If an insured becomes disabled before the insured is age 60 and while insured, basic life insurance coverage may continue as long as the insured is disabled without further payment of premium if approved for a waiver of premium by the life insurance carrier. To be considered disabled, the insured must be unable to work for pay or profit. An insured must complete an application to continue the basic life with a waiver of premium. An application for waiver of premium must be provided to PEIA's life insurance carrier within 12 months of the last day worked.

Wellness Program – Any program or initiative designed and intended to improve the quality of life and/or overall health and wellness of the insureds. Such programs may be all-encompassing or they may target or address specific metabolic, health and/or wellness conditions such as obesity, hyperlipidemia, diabetes, tobacco use, exercise, hypertension, stress management, substance use/abuse, mental health, care utilization, or other health matters.

Years of Service: Credited years of service as reported by the Consolidated Public Retirement Board (CPRB), or for those in the Teachers Defined Contribution Plan or a non-State retirement plan, the years of service reported by the employing agency or the non-State plan.

II: PARTICIPATION

II.1. Eligibility to Participate

Active Employees. All regular full-time employees (including elected officials) of the following entities are eligible for enrollment in the PEIA insurance plans:

- State of West Virginia;
- West Virginia Legislature;
- State colleges and universities;
- Members of the W.Va. Board of Education;
- County Boards of education, including elected members of the boards of education;
- Certain permanent full-time substitute education employees on a 30-day or more contract;
- Counties, cities, or towns (if the employer elects to participate in the program);
- Comprehensive community mental health centers and mental retardation centers authorized pursuant to W.Va. Code § 27-2A-1, et seq.; and
- Other individuals and government bodies specified in the West Virginia Code Chapter 5, article 16 (if the employer elects to participate in the program)

Any eligible employer which is not mandated by State law to participate must enter a Participation Agreement with PEIA and agree to at least three years' participation. PEIA may require such employers to pay all premiums one month in advance.

The term "full-time" means a permanent position that is considered full-time by the participating agency and that requires services to be performed at least 20 hours-a-week, unless otherwise exempt under the provisions of the West Virginia Code.

The PEIA is not an alternate plan for employees of local government agencies. Either PEIA is the only plan offered by the entity or the entity may not participate.

You and Your Spouse Are Both Public Employees. Two active public employees who are married to each other, and who are both eligible for benefits under PEIA may Elect to enroll as follows:

1) as Family with Employee Spouse in any plan; 2) as "Employee Only" and "Employee and Child(ren)" in two different plans; 3) as "Employee Only" and "Employee and Child(ren)" in the PPB Plan (remember you'll have two deductibles and two out-of-pocket maximums this way); or 4) as "Employee Only" and "Employee and Child(ren)" in the same managed care plan. All children must be enrolled under the same policyholder. If no children are to be covered, you may enroll as "family with Employee spouse" or as separate "Employee Only" plans. Both employees are eligible to enroll for the basic life policy, as well as optional and dependent life insurance.

Beginning January 1, 2007, to qualify for the Family with Employee Spouse premium, both employees MUST have a basic life insurance. During the life insurance, open enrollment in fall 2006, couples who were already subject to the Family with Employee Spouse premium, but who

do not both have life insurance will be required to apply for the coverage. If the life insurer will not issue the basic life insurance for medical reasons, then PEIA permits existing Family with Employee Spouse couples to continue to receive the premium discount, even if both do not have basic life insurance. For new plan members on and after July 1, 2006, the Family with Employees Spouse premium discount will not be granted unless both employees are basic life insurance policyholders in the plan.

Since both spouses, as policyholders, are eligible to make independent benefit elections, both spouses receive the Shopper's Guide, Tobacco Affidavit/transfer Form, Summary Plan description, and other relevant benefit information.

Spousal Surcharge: If both spouses are public employees, the surcharge does not apply, but you may need to act to avoid the surcharge. If the spouse who is not the health policyholder has Basic Life insurance, you do not need to complete a Spousal Surcharge Affidavit. If the spouse who is not the health policyholder DOES NOT have Basic Life insurance, you must complete a Spousal Surcharge Affidavit to avoid paying the surcharge.

Disability Retirement. A member who is granted disability retirement by a state retirement system or who receives Social Security disability benefits is eligible to continue coverage in the PEIA Plan as a retired employee, provided that the member meets the minimum years of service requirement of the applicable state retirement system. Members in this category continuously covered on or before July 1, 2010, pay the same premiums as those with 25 or more years of service. Those covered on or after July 1, 2010, may continue coverage, but will pay the full, unsubsidized premium for that coverage. If you receive Social Security Disability benefits, please send a copy of your Disability Award letter to PEIA. Generally, those awarded Social Security disability benefits will receive Medicare benefits after a two-year waiting period. When you receive your Medicare ID card, you must provide a copy of that card to PEIA immediately. Disability retirees may be eligible for a life insurance waiver of premium.

Retired Employees. Active employees who retire are eligible for PEIA health and life benefits, provided they meet the minimum eligibility requirements of the applicable state retirement system and if their last employer immediately prior to retirement: is a participating employer under Consolidated Public Retirement Board and, as of July 1, 2008, forward, is a participating employer with PEIA. Active Employees who as of July 1, 2008, have ten years or more of credited service in the CPRB and whose employer at the time of their retirement does participate with CPRB, but does not participate with PEIA will be eligible for PEIA retiree coverage; provided: they otherwise meet all criteria under this heading. PEIA may require as a prerequisite to providing coverage to the retiree that their employer agree, in writing, upon a form prescribed by PEIA that the employer will pay to PEIA the non-participating retiree premium on behalf of the retiree or retirees. Active employees who are members of the Teacher's Defined Contribution Retirement plan must be either: fifty-five years of age and have twelve or more years of credited services; or be at least sixty years of age with five years of service; and their last employer immediately prior to retirement must be a participating employer under that, or the CPRB system to qualify to continue PEIA insurance benefits upon retirement. Employees who participate in non-State retirement systems, but which are CPRB system affiliated, contracted, or approved (such as TIAA-CREF and similar plans), or are approved, in writing, by the PEIA Director must, in the case of education employees, meet the minimum eligibility requirements of the Public

Employees Retirement System to be eligible for PEIA as a retiree. Eligible retirees not participating with PEIA immediately before their retirement or retirees who enroll with PEIA after the expiration of the calendar month of their retirement and the following two (2) calendar months may only enroll during open enrollment or upon the occurrence of a qualifying event. If your life insurance lapses after retirement for any reason, for example, for non-payment of premiums, you will not be permitted to reinstate that coverage; you will need to seek life insurance from another source.

Certain non-state agencies that participate in the PEIA health and life insurance plans for active employees have "opted out" of offering their employees PEIA's retiree insurance coverage, called the WV OPEB plan. If an employer opts out of the WV OPEB plan or is ineligible to participate in the WV OPEB plan due to retirement system participation, they are opting out of retiree eligibility for PEIA health and life coverage. Other post-employment benefits (OPEB) refers to the benefits, other than pensions, that a state or local government employee receives as part of his or her package of retirement benefits. **Please be aware that, regardless of previous employment, previous or current coverage through PEIA and years of service, if an employee transfers to an opt-out agency immediately prior to retirement, the employee will not be eligible for retirement health or life insurance benefits through PEIA.**

Deferred Retirement. If you separate from employment before your retirement from a participating employer under the State retirement plan, you may not enroll in PEIA as a retiree if you have other earned income just prior to retirement. If you are self-employed or have earned income from any other source, you will not be permitted to enroll as a retiree. To be eligible to enroll in PEIA, your last employer immediately prior to retirement must have been a public entity that participates in the CPRB retirement system or a CPRB affiliated retirement plan (effective March 13, 1999) and in PEIA (effective July 1, 2008).

Emergency Medical Services retirement – Age 50-55. An individual between the ages of fifty and fifty-five years, inclusive, who is eligible to and retires under the Emergency Medical Services Retirement System shall be eligible for insurance coverage under PEIA. The premium cost for such coverage shall be borne entirely by the retired individual. The premium amounts for such coverage shall be set and adjusted as necessary, by the Public Employees Insurance Agency, shall reflect the total cost to provide such coverage and shall not be subsidized by any, or any portion of any other program, fund, group or other entity subject to or administered under the West Virginia Public Employees Insurance Act. Such individuals may not use accrued annual leave or sick leave to purchase health insurance hereunder until reaching age fifty-five.

State police Retirement System – Age 50-55. An individual between the ages of fifty and fifty-five years, inclusive, who is eligible to and retires under the State Police Retirement System shall be eligible for insurance coverage under PEIA. The premium cost for such coverage shall be borne entirely by the retired individual. The premium amounts for such coverage shall be set and adjusted as necessary, by the Public Employees Insurance Agency, shall reflect the total cost to provide such coverage and shall not be subsidized by any, or any portion of any other program, fund, group or other entity subject to or administered under the West Virginia Public Employees Insurance Act. Such individuals may not use accrued annual leave or sick leave to purchase health insurance.

Deputy Sheriff Retirement – Age 50-55. On or after January 1, 2000, an individual between the ages of fifty and fifty-five years, inclusive, who is eligible to and retires under the West Virginia Deputy Sheriff's retirement System shall be eligible for insurance coverage under PEIA. The premium cost for such coverage shall be borne entirely by the retired individual. The premium amounts for such coverage shall be set and adjusted as necessary, by the Public Employees Insurance Agency, shall reflect the total cost to provide such coverage and shall not be subsidized by any portion of any other program, fund, group or other entity subject to or administered under the west Virginia Public Employees Insurance Act. Such individuals may not use accrued annual leave or sick leave to purchase health insurance.

Dependents. The term "dependents" include:

- the policyholder's legal spouse – PEIA does not recognize "common law" marriage;
- the policyholder's biological children, legally adopted children, or stepchildren under age 26; and
- other children for whom you are the court-appointed guardian under age 18.

From time to time PEIA may conduct eligibility audits to verify that policyholders and dependents in the plan qualify for coverage. If policyholders are audited, they may have to produce documentation for the dependent(s) in question, including, but not limited to: marriage certificates, birth certificates, and/or their most recent Federal tax return showing that they have claimed the dependent on their taxes. If the policyholder cannot prove that the dependent qualifies for coverage, coverage will be terminated, and PEIA will pursue reimbursement of any medical or prescription drug claims paid during the time the dependent(s) was/were ineligible. In the event that an ineligible dependent is removed from the plans as the result of a review or audit, PEIA will not refund the Employee and/or Employer share of the difference(s) in premiums to the Participating Agency and/or Entity and/or the employee as the failure to report and/or otherwise disclose the ineligibility in a timely manner is/was an error of commission and/or omission solely on part of the employee member, and through no fault of the State of West Virginia and/or PEIA.

PEIA reserves the right to hire third parties to conduct eligibility audits. Failure to respond to an eligibility audit may result in an administrative proceeding and the denial of any future PEIA benefits.

PEIA is required by law to apply a monthly spousal surcharge to active employees of State agencies, colleges, universities, and county boards of education if your spouse is eligible for employer-sponsored coverage through his/her employer and has PEIA coverage. The spousal surcharge will be added to health insurance premiums each month. If your spouse is eligible for coverage as an employee of a PEIA-participating agency, has Medicare, Medicaid, TRICARE or is retired, the spousal coverage surcharge does not apply.

Legally adopted children may be enrolled effective on the date of birth if enrolled during the calendar month of birth or the following two calendar months if legal documentation is provided stating that the PEIA policyholder became financially responsible for claims incurred by the adopted child on the date of birth. Financial responsibility usually begins on the date of placement by a legal authority having jurisdiction for adoptions as assigned by the sovereign State. Informal

agreements to care for a child do not qualify as an adoption. All foreign adoptions require documentation from the United States Department of State and/or the United States Department of Homeland security that the adoption has been conducted in accordance with the provisions of The Hague Convention on the Protection of Children and Co-operation in respect of Intercountry Adoption (Convention) entered into force for United States on April 1, 2008.

Any and/or all eligibility documents submitted to PEIA from a foreign country must be translated into English by an independent third party. Such translations must represent a true and correct statement of the contents of the original document and must include the following:

a. The date of the translation
b. The printed name and signature of the person(s) doing the translation
c. A notarized statement validating the authenticity of the translation

With regard to adoptions. any claim(s) related to the birth mother are not payable under this Plan, unless she is PEIA-eligible in her own right.

Coverage for a divorced spouse and any step-children the policyholder has not legally adopted shall terminate on the last day of the month in which the final decree of divorce is entered. **The final divorce must be reported to PEIA immediately by the policyholder.** Step-children must be removed from coverage by the policyholder at the time of a divorce. Coverage for a child shall terminate at the end of the month in which the child turns age 26, unless the child qualifies for continued coverage as described above in this Plan Document.

Disabled Child. Your dependent child may continue to be covered after reaching age 26 if he or she is incapable of self-support because of mental or physical disability. To be eligible:

- the disabling condition must have begun before age 26
- the child must have been covered by PEIA upon age 26; and
- the child must be incapable of self-sustaining employment and chiefly dependent on you for support and maintenance

To continue this coverage, the WV PEIA Disabled Dependent Disability Application must be obtained from PEIA, completed by a licensed physician, and returned to PEIA with all supporting medical records, between 2-3 months prior to the dependent's 26th birthday, to prevent a potential lapse in coverage.

Surviving Dependents. The PEIA Medical Benefits Plan is available to the surviving spouse and dependents of a decreased active or retired employee who were enrolled and covered as dependents under the deceased employee's medical insurance coverage at the time of the employee's death. A surviving spouse who is pregnant at the time of the death of the employee may enroll the newborn child. Surviving dependents are not eligible for life insurance. If such a surviving dependent is eligible for PEIA coverage in their own status as an employee or retired employee/retired employee. They may not maintain more than one status.

The surviving dependent must enroll in the calendar month the employee's death occurs or the following two calendar months to avoid any lapse in coverage, otherwise, they may not enroll until open enrollment or a qualifying event. Also, surviving dependents must enroll in the same plan in which they were covered at the time of the policyholder's death. During the next

open enrollment, they may select any plan for which they are eligible. Coverage for surviving dependents terminates at the end of the month in which the surviving dependent no longer elects to participate, fails to pay the premium, or becomes ineligible due to age or re-marriage. If a divorce occurs after the re-marriage, re-enrollment as a surviving dependent is not allowed. The surviving spouse must immediately notify PEIA if they re-marry.

Nonpayment of claims based on custodial status. PEIA shall not be responsible for any and/or all medical and/or pharmaceutical claims incurred while a policyholder or covered dependent is in the legal custody of the state and/or federal government. Persons shall be deemed immediately not eligible for participation in the Plan(s) if they are in the legal custody and/or are in the care and/or control of a state and/or federal government based on a writ, Order, or decree. Such examples of ineligible custodial status include, but are not necessarily limited to: pretrial and/or pre-adjudication detention and/or incarceration(s); incarceration(s) in a juvenile or adult correctional facility; involuntary hospitalization(s) by Order of a Court of competent jurisdiction; and/or legal custodial status exerted by a child protective services agency or an adult protective services agency.

II.2. Enrollment

Procedures. Active employees and retirees may enroll in the PEIA Plan at their place of employment. At the time of enrollment, the enrollee may select the type of coverage (PPB Plan or managed care) and enroll any eligible dependents. Eligible dependents covered by the PEIA must participate in the same health plan as the policyholder unless they are non-Medicare-eligible dependents of a Medicare-eligible retiree or a Medicare-eligible dependent of a non-Medicare-eligible retiree.

Participation in the PEIA benefits plan is not automatic. Policyholders must complete the proper enrollment forms. Enrollment in a PEIA benefit plan authorizes a policyholder's employer or retirement system to deduct premiums for coverage from his/her salary or pension. Policyholders are responsible for notifying PEIA of any change in their address, marital status, Medicare eligibility, their eligibility status, or status of their dependent(s).

When both active employee spouses are eligible for PEIA coverage:

1) each may enroll as a policyholder in the PPB Plan;

2) each may enroll separately, with one being a policyholder in the PPB Plan and one being a policyholder in a managed care plan;

3) each may select a different managed care plan, although both spouses can't be policyholders in the same managed care plan; or,

4) they may enroll as a family unit for family coverage with one spouse as the policyholder in either the PPB Plan or a managed care plan, and the other spouse covered as a dependent carrying life insurance only.

When dependent children are involved, spouses must decide which one will be the policyholder who covers the children. This decision must be made at the time of enrollment, and all eligible dependents must be enrolled under one policyholder.

If alive, the spouse of a deceased employee will be considered the policyholder for all other dependents of the deceased employee. If a surviving minor child is the survivor policyholder, a guardian must be appointed to contract for premium payment responsibility.

Enrollment Periods

Active Employees. Active employees may enroll for PEIA health or life benefits at the time they are hired, although coverage will not begin until they are actively at work (see Commencement of Coverage in this section). Active employees who enroll in the calendar month they are hired, or the following two calendar months will not be required to submit a statement of health for optional life insurance not exceeding $100,000. Active employees who choose not to enroll for health coverage during this initial period may do so only during open enrollment or upon the occurrence of a qualifying event. Active employees who choose not to enroll for life insurance coverage (basic, optional, or dependent) during this initial period may do so later in accordance with current guidelines, but will be required to submit a statement of health and must be approved by PEIA's life insurance carrier before coverage will begin.

Retired Employees. Retired employees continue coverage by enrolling in the PEIA Plan. All employees must enroll when changing to retired status in order to maintain continuous coverage. Retirees electing coverage after the calendar month of or the two following calendar months following retirement may enroll later only during open enrollment or upon the occurrence of a qualifying event. Retired employees wishing to maintain life insurance or optional dependent life insurance upon retirement must enroll for this coverage during the month of retirement or the following two calendar months. Retired employees wishing to elect new or increased Optional Life Insurance or Optional Dependent Life Insurance must enroll and submit a statement of health during the calendar month of or the two calendar months following their retirement. Coverage will be effective subject to the approval of the PEIA's life insurance carrier. Retired employees may not elect or increase life insurance coverage after the two calendar months following their retirement.

Dependents. Dependents may be enrolled by a policyholder at the time the policyholder enrolls with the PEIA Plan. New dependents such as a new spouse, newborn or adopted child may be enrolled during the calendar month of or the two calendar months following the date of the qualifying event (e.g., marriage, birth, or placement of a child for adoption). Dependents are not covered unless enrolled, even if the dependent is a newborn child and the pregnancy was reported to the TPA-UM. Dependents of an active employee may be otherwise added to the PPB Plan only in the calendar month of or two calendar months following a qualifying event or during open enrollment. Dependents of an active employee may be added to life insurance during open enrollment. Dependent of an active employee may be added to life insurance during open enrollment, but if at any time other than when the policyholder initially enrolls the dependents must submit a statement of health. Dependents of a retired employee cannot be enrolled for dependent life insurance outside the calendar month of or the two calendar months following a qualifying event. Dependents may not be added to a managed care plan outside the open

enrollment period unless there has been a qualifying event. (See **Enrollment** in this section.) Dependents who lose their eligibility, such as through a divorce, may be removed from the Plan at any time throughout the plan year.

Surviving Dependents. In the event of the death of an active or retired employee, dependents that were covered as a dependent under the medical coverage of the employee at the time of death are eligible to enroll for health coverage as surviving dependents during the month of the death and two following calendar months. Surviving dependents are not eligible for life insurance. In the event of the death of the employee spouse who is the policyholder in the PEIA Plan, when the surviving dependent is also an active or retired public employee who is benefit-eligible in his or her own right, the surviving dependent must choose their eligibility status. He or she must choose whether to enroll in the PEIA Plan as a surviving dependent of the policyholder, or as an active or retired employee. The surviving spouse may not enroll in both statuses. Surviving dependent children may continue coverage to age 26.

Open Enrollment Choices. During the Spring of each year, the PEIA will have an open enrollment period to allow policyholders to select health care coverage from the PEIA PPB Plan or one of the PEIA's managed care offerings. Policyholders may make health insurance coverage changes during open enrollment without a qualifying event. Any coverage changes will become effective on July 1. The policyholder's dependents must participate in the same plan as the policyholder. Medicare-eligible retirees are limited to the MA and the PD Plans, except under very limited circumstances.

Medical Identification Cards. Policyholders will usually receive medical identification cards within 30 days of enrollment in the PEIA PPB Plan. The medical identification card shall include the insured's name and identification number. Policyholders will receive two cards for family coverage and one card for single coverage. Policyholders may obtain additional cards for children not residing in their household, or to replace lost cards.

II.3. Commencement of Coverage

Active Employees. Coverage for active employees is effective the first day of the month following the later of the date of employment or the date of enrollment. If the date of enrollment is the first day of the month, the effective date is the first day of the following month. Employees must enroll for coverage during their "initial enrollment period", which is the calendar month of their employment and the two following calendar months. Employees not enrolling during this period, must wait until the next open enrollment or a qualifying event. The employee must be "actively-at-work" for coverage to commence. In order for an employee to be considered "actively at work" he/she must:

- perform the normal tasks of the job on a full-time basis for a full workday on the day coverage (or an increase in the coverage amount) is to begin; and

- perform the normal tasks at one of the places of business or at a location to which the employee must travel to do his/her job

Employees who enroll for additional life insurance coverage outside of the initial enrollment period by providing a statement of health will have an effective date for that coverage of the first day of the month following approval by the insurance carrier.

PEIA requires non-citizen members and their dependents to provide documentation that they are in the United States legally before eligibility is granted. Non-citizen policyholder members must provide documentation to PEIA that they are eligible for employment in order to be eligible for coverage.

Medicare for Active Employees - For PEIA PPB plan active employees who are age 65 or older and eligible for Medicare, as long as the policyholder is an active employee, PEIA will be their primary insurer, except in a few rare cases. As long as the policyholder is an active employee, they do not need to sign up for Medicare Part B. When the policyholder prepares to retire, they must enroll for Medicare Part B. If they do not enroll in Medicare Part B, they will be ineligible for coverage by the MAPD Plan or PEIA, as applicable and their coverage may be terminated. The MAPD Plan is the ***only*** plan available to Medicare-eligible retirees and Medicare-eligible dependents of retired employees (except under very limited circumstances, the Special Medicare Plan).

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

Retired Employees. Retired employees and their dependents will have continuous, uninterrupted coverage only if they enroll in the calendar month retirement occurs or the following two calendar months. If the retired employee enrolls for medical coverage at a later date enrollment may only be done during open enrollment or upon the occurrence of a qualifying event. Retirees may not enroll for life insurance at a later date.

Retirees and their dependents who are Medicare eligible must enroll for Medicare Part A and B. The PEIA Plan will not cover Medicare-eligible retirees and their Medicare-eligible dependents that have not enrolled for both Part A and B coverage. Enrollment in a plan other than PEIA's MAPD Plan will make the Medicare beneficiary ineligible for PEIA's medical or prescription drug benefits.

When a retired employee or a dependent of a retired employee, becomes an eligible beneficiary of Medicare, they must enroll in Medicare Part A and Medicare Part B.

Generally, all Medicare-eligible retired employees and Medicare-eligible dependents of retired employees have coverage through Humana's Medicare Advantage (MA) and Prescription Drug (PD) Plans (MAPD). This plan provides both medical and prescription drug coverage for those Medicare-Primary members. To be eligible for the MA and PD plans, the member must enroll for Medicare parts A and B. If you do not enroll in Medicare Parts A and B and pay the monthly premium, you will not be eligible for the MA and PD plans, which is the only coverage offered to retire, Medicare-eligible members and Medicare-eligible dependents of retired employees.

If you become eligible for Medicare prior to age 65, you must send a copy of your Medicare card, or other evidence to support Medicare coverage, to PEIA. This notification may allow PEIA to reduce your premiums, and will make the claims payment process go much more smoothly.

Retired Employees hired on or after July 1, 2010: No Subsidy. The PEIA Finance Board has voted that employees hired on or after July 1, 2010 will receive no premium subsidy when they retire and participate in PEIA as retired employees. Such retired employees must pay the full cost of their participation in the Plan.

Retirees from non-state entities which employer joined PEIA on or after July 1, 2010 will also receive no premium subsidy and must pay full cost of their participation in the Plan. Such non-state retirees will be assigned a "hire date" in the PEIA system(s) which is the same as the date they enroll in PEIA as an active employee.

With respect to active employees who have a break in service or retired employees who become re-employed and go back to active employee status participating in the plan, the following rules apply to determine their date of hire for premium subsidy purposes:

1. Active employees hired before July 1, 2010 who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2010) hire date.
2. Retired employees who had an original hire date prior to July 1, 2010, may return to active employment and retain their pre-July 1, 2010, original hire date for purposes of determining their eligibility for premium subsidy.

Dependents. As long as the dependent has been enrolled by a newly enrolled active employee, the coverage of the dependent will begin on the same day as the employee's coverage. If the employee is not "actively at work" on the date coverage would be effective, coverage will become effective on the first day the employee is "actively at work".

If the employee acquires a dependent after the employee's initial effective date, the coverage for the new dependent will begin on the first day of the month following the new dependent's enrollment. Coverage is not automatic. The employee must enroll the dependent.

In the case of a newborn child of an employee covered by PEIA, the newborn must be enrolled by the employee in the calendar month the birth occurs or the following two calendar months in order to qualify for retroactive coverage to the date of birth. In that event the employee's PEIA premium will be adjusted retroactively to the month of the newborn's birth. If the newborn is not enrolled in the month of birth or the following two calendar months, the newborn may not be enrolled until the next open enrollment or upon the occurrence of a qualifying event. A statement of health will also be required for optional dependent life insurance.

Legally adopted children may also be enrolled effective from their date of adoption if enrolled during the calendar month of adoption or the following two calendar months if legal documentation is provided stating that the PEIA policyholder become financially responsible for claims incurred by the adopted child on the date of adoption. In that event the employee's PEIA premium will be adjusted retroactively to the month of adoption. Informal agreements to care for a child do not qualify as adoption. All foreign adoptions require documentation from the United

States Department of State and/or the United States Department of Homeland Security that the adoption has been conducted in accordance with the provisions of The Hague Convention on the Protection of Children and Co-operation in Respect of Intercountry Adoption (Convention) entered into force for the United States on April 1, 2008.

If a retired employee enrolls dependents already in the plan in the calendar month retirement occurs or the following two calendar months, the coverage will be continuous and uninterrupted. If the retired employee's dependents are not enrolled at that time, they may not be enrolled until the next open enrollment or until a qualifying event.

PEIA requires documentation to support the eligibility of all dependents. Such documentation may include, but not be limited to: marriage certificates, birth certificates, National Child Support Orders, copies of adoption paperwork (e.g. Court Orders, adoption decrees, etc.), social security numbers, and/or other legal documents validating the dependent's eligibility. Coverage may be pended for the dependent until all of the required documentation is submitted to PEIA. Coverage may be termed for failure to submit required documentation.

Surviving Dependents. Surviving dependents of an active or retired public employee, that were insured by PEIA under the employee's comprehensive health coverage (either in the PEIA PPB Plan, the Special Medicare plan, or in a managed care plan) at the time of the employee's death, may elect to continue the same coverage as a policyholder in your own right under that health plan. If you are also eligible for PEIA coverage due to your status as an active employee or a retired employee, you must elect between surviving dependent status and status as an active or retired employee. To do so, you will need to complete a Surviving Dependent enrollment form available from PEIA. If you are a surviving spouse and you choose not to enroll immediately for coverage, you may elect PEIA coverage in the future, Medicare-eligible dependents of deceased retirees will be covered by the MA and PD plans. Dependent children may elect surviving dependent coverage until the age of 26.

If a surviving dependent enrolls in the calendar month the employee's death occurs or the following two calendar months, the coverage will be continuous and uninterrupted. If the surviving dependent does not enroll during that period, they may not enroll until the next open enrollment or until a qualifying event.

If you are a surviving spouse and you choose not to enroll immediately for coverage, you may elect PEIA coverage in the future during open enrollment, if you have not remarried.

The surviving spouse's eligibility for PEIA coverage terminates upon remarriage. Coverage will end on the last date of the month of the remarriage. If a divorce occurs after the remarriage, re-enrollment as a surviving dependent is not allowed. The surviving spouse must immediately notify PEIA if they remarry. Any surviving spouse who becomes ineligible due to re-marriage, and fails to immediately report that re-marriage, shall be responsible for repaying PEIA for any and/or all claims incurred during their period of ineligibility.

Dependents, who were covered at the time of the policyholder's death, are also eligible to enroll. See the earlier section on dependents to determine what persons are eligible.

II.4. Termination of Coverage

Active Employees. The coverage for the employee terminates when the employee is no longer eligible or when the group (employer's) coverage terminates, whichever occurs first.

For employees on delayed payroll, coverage will terminate at the end of the month in which their employment terminates, although they may continue to receive paychecks due to their delayed payroll status.

In the case of voluntary termination, the basic medical coverage for the employee and dependents terminates at the end of the month in which the employee voluntarily ceases employment. The employer continues to be liable for premiums of such employee until proper termination notification is received by PEIA and such premiums will not be refunded outside of the PEIA Refund policy even though no coverage is in force.

In the case of involuntary termination, such as a reduction in work force, coverage may continue for three additional months after the end of the month in which the employee goes off the payroll. Eligible enrolled dependents are included in the three-month extension. The extension of the basic health and /or basic life coverage is provided at no additional cost to the employee; however, the employee is required to continue to pay his/her portion of the premium during the three-month period in order to continue coverage.

An employee discharged due to misconduct is not entitled to or eligible for the three-month extension of coverage which applies in other involuntary termination situations; however, to the extent the employee and/or dependents are contesting the charges of misconduct through the appropriate administrative processes, the three-month extension of coverage may be provided. If the charges of misconduct are upheld, the full premium expense for the three months of extended coverage must be reimbursed by the employee through the respective payroll location.

Insurance coverage for an insured will be terminated retroactively to the last day of preceding month if the monthly premium is not paid by the 5th day of the following month of coverage, with the exception of Medicare MA or PDP members, which requires PEIA to comply with CMS termination procedures.

In the event an active employee or covered dependent violates the terms and conditions of the plan(s), and PEIA conducts an administrative proceeding pursuant to West Virginia Code §5-16-12, PEIA shall terminate coverage(s) and set off any payment of any benefits or other payment due to that/those person(s) until any overpayment is recovered.

Retired Employees. Coverage for retired employees in the PEIA PPB plan or a managed care plan terminates at the end of the month in which the retired employee terminates coverage or the month of coverage suspension for failure to pay the premium.

Failure to Pay Premium

Your coverage as an active or retired policyholder, and coverage of your dependents, will be terminated if you fail to pay your premium contributions when due. Premiums are due by the fifth day of the month following the month for which the premium was invoiced. Example: May premium is due June 5. If payment is not received by PEIA within 30 days following the due date, all coverage may be suspended. If payment is not received within 45 days following the due date, health and life insurance coverage will be canceled, and all medical and prescription drug claims

incurred will be your personal responsibility. Canceled life insurance cannot be reinstated, even if past-due premiums are paid. The cancellation is permanent, and you will need to seek life insurance from another provider. PEIA will also submit premiums over-due by 45 days to a collection agency.

Direct Pay

For non-Medicare policyholders who pay premiums directly to PEIA, if is not received by PEIA within 30 days following the due date, a termination notice containing the termination date will be mailed to the policy-holder. All claims incurred following the termination date will be the policyholder's personal responsibility. The policyholder has the right to appeal the termination in writing within 60 days following the termination date.

1) If terminated policyholder appeals the termination in writing within 60 days from the date of termination, he or she must pay the past-due premiums, apply to pay premiums by direct draft from a bank account, and may be granted uninterrupted medical and prescription coverage at PEIA's discretion. Life Insurance cannot be reinstated.
2) If the terminated policyholder appeals the termination in writing more than 60 days following the date of termination, PEIA may only allow re-enrollment for health coverage if the policyholder enrolls as a new enrollee and agrees to pay premiums by direct draft from a bank account. In this case, there may be a break in the period of coverage. Two terminations for failure to pay within a 12-month period may result in permanent disqualification from coverage under the PEIA plan.

If extenuating circumstances prevent the policyholder from appealing within 60 days of the termination, the policyholder may send a written request and the PEIA director may grant a waiver of the 60-day requirement, at his or her discretion.

For Medicare policyholders who pay premium directly to PEIA, failure to pay premiums will result in termination from the plan consistent with applicable Medicare rules.

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

- the policyholder terminates or loses coverage;

- for divorce from the spouse (termination of the spouse and any step-children the policyholder has not legally adopted is effective at the end of the month in which the divorce is final, and policyholder must immediately report the divorce to PEIA) whether or not the decree requires the policyholder to provide health benefits to ex-spouse and/or step-children. Step-children must be removed from coverage by the policyholder at the time of a divorce;

- the dependent child reaches age 26;

- the dependent is voluntarily removed from the Plan by the policyholder;

- dependent child over the age of 26 ceases to be deemed handicapped;

- dependent child over whom the policyholder is court-appointed guardian reaches age 18.

The policyholder may voluntarily terminate coverage for dependents only during open enrollment or with a qualifying event by completing the appropriate forms.

Surviving Dependents. Coverage for surviving dependents terminates at the end of the month in which the surviving dependents no longer elects to participate, fails to pay the premium, or becomes ineligible due to age or marriage. Re-marriage must be reported immediately in writing to PEIA by surviving dependent. Any surviving spouse who becomes ineligible due to re-marriage, and fails to report that re-marriage, shall be responsible for repaying PEIA for any and/or all claims incurred during their period of ineligibility.

Confined Insured. An insured who is confined to a hospital or other (non-penal) medical facility rendering medical care on the date coverage would otherwise terminate will remain covered through the date of discharge (for facility charges only). PEIA shall not be responsible for any and/or all medical and/or pharmaceutical claims incurred while a policyholder or covered dependent is in the legal custody of the state and/or federal government based on a writ, Order, or decree. Examples of such custodial status include, but are not necessarily limited to: pretrial and/or pre-adjudication detention and/or incarceration(s); incarceration(s) in a juvenile or adult correctional facility; involuntary hospitalization(s) by Order of a Court of competent jurisdiction; and/or legal custodial status exerted by a child protective services agency or an adult protective services agency.

Local Government Agencies and other Non-Mandatory Participants. Coverage for insureds participating through employment with a local government agency or other non-mandatory participating employer will terminate on the last day of the month in which the employer participates, unless the insured is eligible retiree or a dependent of an eligible retiree and eligible to enroll by virtue of their eligible retiree status.

II.5. Changes in Participation Status

Elections at open enrollment. Employees must make their annual elections (i.e., plan choices) during open enrollment and may not change their annual elections absent a "qualifying event" which changes their participation status. It is policyholder's responsibility to keep PEIA enrollment records (marital status, dependent status, address, phone number, email address, etc.) up to date. The policyholder must notify their benefit coordinator or PEIA immediately of any changes in participation status or in family situation, and make the appropriate change to keep PEIA coverage up to date. Examples of such changes include retirement or disability retirement, a change of address, a change in marital status, or a dependent child no longer qualifying for coverage.

If the policyholder fails to notify their benefit coordinator or PEIA promptly of changes in participation family status, the employing agency may look to the policyholder for reimbursement of premiums the employer paid in error, and PEIA or the Plan may adjust claims paid for ineligible enrollees.

Dependents Status to Member Status. An employee (other than a spouse) who is covered as a dependent under a family medical plan of another eligible employee and becomes eligible to enroll as a policyholder may become a policyholder by completing the proper enrollment forms and paying the proportionate share of the premium. If the change of status causes a lapse in coverage there will be no coverage during that lapse.

Transfer from one Participating Employer to Another. Any policyholder who transfers from one participating employer to another and re-enrolls during the calendar month of transfer or the following two calendar months will have continuous coverage in the same plan, provided he/she has completed the necessary enrollment forms with his/her employer. An individual changing employment from a State agency to a participating non-State agency or vice versa will, for purposes of exchanging leave for PEIA coverage upon retirement, be treated as a new hire unless other arrangements are agreed to by PEIA and the new employer. For purposes of coverage change, deductible, out-of-pocket maximum, the individual will be considered a transfer.

If the policyholder transferring from one State agency to another wish to add a spouse or other dependent the policyholder must wait until open enrollment, unless there is a qualifying event. Also, the policyholder may not add dependents to coverage if covered by a managed care plan until open enrollment, unless there is a qualifying event.

Employer Responsibility to Make Changes. It is the responsibility of Employers participating in the PEIA plans to keep their PEIA enrollment and eligibility information and records up to date. PEIA is under no obligation to make adjustments and/or credits for changes in the employer's workforce that were not properly reported to PEIA. Further, employers may be held liable for failing to report situations or circumstances that directly affect the eligibility of one or more members including having to repay PEIA and/or the State for claims paid for ineligible members and their dependents.

II.6. Leaves of Absence

Medical Leave. (W.Va. Code § 5-16-24) Any employee on a medical leave of absence due to an injury or illness that is not incurred in the course of employment activity and is not considered a Workers' Compensation claim, will be entitled to continue coverage until he/she returns to work, provided the following conditions are met:

- the employee and employer continue to pay their proportionate shares of premium costs for the period of the medical leave, but not for a period greater than one year;

- if the medical leave extends beyond one year, the employee may be required to pay the full premium costs;

- the employer must intend that the employee return to work and must continuously hold a funded position open for the employee return to work;

- during the period of the medical leave, the employee is required to submit to the employer, at least once a month, a statement from a qualified physician certifying that the employee is unable to return to work. The employer must retain the statements in the employees file and make them available for PEIA's review, upon request; and

- failure of the employer to hold open a vacant job position or to provide the physician statements, above, will result in loss of eligibility of the employee and action taken against the employer.

In Leave of Absence situations where the employee is required to pay their share of the premium, it is the employer's responsibility to establish the method or means for that premium collection and to track it on a monthly basis. As Leaves of Absence are granted by the employer, the employer assumes the responsibility for the full payment of premiums for the member. PEIA will not "retro-term" employee members for their failure to pay the employee share of the premiums nor credit the employer for past months that the employee failed to pay.

It is the employer's responsibility to make the determination regarding an employee's eligibility for a leave of absence. It is important to note that a leave of absence is intended for an employee who is expected to return to work and for whom the employer maintains an open position. It is not intended to extend medical benefits for individuals who are not eligible to retire nor for those who have applied for disability and are not able to return to work, or for whom a position is not being held open. Such a person is not an employee, and it is improper to continue his or her health coverage as if he or she were still an employee. Employers are reminded that under State law it is a felony to misrepresent any material fact to obtain or provide PEIA benefits to which a person is not entitled. (See, W. Va. Code §5-16-12). PEIA is required by law to report all violations of state or federal law to the authorities having jurisdiction.

Medical Leave – Workers' Compensation. Any employee who is on a "workers' compensation" leave of absence due to injury or illness arising from employment and is receiving temporary total disability payments is entitled to continue coverage until he/she can return to work. The employer is required to continue to pay its proportionate share of the medical insurance premium as long as the employer-employee relationship exists, and the employee is receiving or actively seeking Workers' Compensation benefits. Once the temporary total disability claim has been settled, the employee is no longer eligible to continue under this provision.

Personal Leave. An employee may continue insurance coverage while on a personal leave of absence if the leave is approved by the employer. Payment of the monthly premium will be according to any policy or agreement established between the employee and the employer. Failure to remit the monthly premium to PEIA will result in termination of insurance coverage.

Family Leave. Any employee may continue insurance coverage while on an approved family leave in accordance with W.Va. Code § 21-5D-1 et. seq. Payment of the monthly premium will be according to any policy or agreement established between the employer and employee. Failure to remit the monthly premium will result in termination of coverage.

Military Leave. An employee who is on an approved military leave of absence without pay is entitled to continue health benefit coverage for as long as the employee continues to make the required premium payments. The employee is responsible for paying 100 percent of the health and life premium unless other arrangements are made with the employer or the Governor by Executive order dictates otherwise.

An employee who terminates employment immediately prior to entering active duty who makes application for reinstatement within 90 days after leaving the military is eligible to re-enroll for PEIA health coverage upon reinstatement without being considered a new member, and without other penalty) e.g. original hire date, pre-existing condition limitations). In addition, an employee and any dependents may be enrolled with coverage effective on the date the employee returns actively at work or, at the discretion of the employee, may elect to have coverage effective the first day of the month following the date of election to re-enroll as long as the employee is actively-at-work.

Leaves of Absence for Teachers and School Service Personnel. Any teacher or school service personnel employee returning from an approved leave of absence that extended for a period of one year or less may be restored to the same PEIA benefits to which that employee had at the time of the approved leave of absence.

II.7. Extending Employer–Paid Coverage for Certain Retirees

West Virginia Code § 5-16-13, under certain conditions, allow participating employees compelled or require by law to retire before age 65 or who voluntarily retire as provided by law to use accumulated sick and annual leave days to extend their employer-paid PEIA coverage. In order to participate in this benefit, the employee must retire from a participating (in PEIA and CPRB) employer and be drawing a pension from his/her respective retirement system. The leave must be used immediately at the time of retirement. Policyholders who elect to defer retirement or who are not eligible for payment of retirement benefits at the time they leave active employment are not eligible for the extension of coverage. Eligible retired employees may not use this extension for part of a month. When both spouses are eligible for this benefit and are retired, they may request that PEIA coordinate their leave with their respective employers to effectively combine their sick and annual leave to extend their family coverage. If an employee dies before using all their respective extension of service credit, the benefit ceases and does not pass on to the spouse or dependents.

If the retired employee changes his/her plan from single to family or vice versa, PEIA will then recalculate the amount of remining earned extended insurance coverage.

If an employee changes from single to family, such change may be made only at open enrollment or upon a qualifying event.

The death of an employee with or without the family plan terminates any and all of their remaining earned extended insurance coverage. From the date of the employee's death, the dependents shall be entitled to continue their participation coverage and completion of surviving dependent enrollment forms.

Employees hired on or after July 1, 2001, are not eligible for this benefit.

Please Note: If you retire, and then return to active full-time employment with a participating agency, you will lose your right to use your sick and/or annual leave for extended employer-paid PEIA coverage. When you return to active employment and have PEIA benefits as an active employee you will be treated as a new hire and your new effective date of coverage with PEIA will be after July 1, 2001. Two exceptions will be made to this rule:

1. Active employees hired before July 1, 2001, who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2001) hire date.
2. Retired employees who had an original hire date prior to July 1, 2001, may return to active employment and retain their pre-July 1, 2001, original hire date for purposes of determining their eligibility for this benefit, but may only use leave earned after they return to active employee status.

Participating Employee (Other than Certain Higher Education Faculty). Retiring employees eligible for extended employer-paid PEIA coverage, other than certain higher education faculty as described in this Section, may extend the employer-paid PEIA coverage by surrendering their accrued sick and annual leave days in accordance with the following formula:

- For eligible employees hired by their employer and who have been continuously covered by the PEIA since before July 1, 1988, 2 days of sick or annual leave may be converted into the full premium for one month's single coverage and three days' sick or annual leave may be converted into one month's family coverage; and,

- For all other eligible employees hired by their employer and who entered PEIA after July 1, 1988 and before July 1, 2001, or if there was a lapse in coverage during the period, 2 days of accrued annual or sick leave may be converted into 50% of the premium for one month of single coverage and 3 days of sick or annual leave may be converted into 50% of the premium for one month of family coverage; and

- Employees hired on or after July 1, 2001, or if there was a lapse in coverage after this date, are not eligible.

Higher Education Faculty. Participating employees who are full-time higher education faculty members employed on an annual contract basis other than for twelve months may convert 3 1/3 years of teaching service to 1 year of PEIA single coverage or 5 years of teaching service for 1 year of PEIA family coverage only if the employee was hired before July 1, 2009.

II.8. Continuation of Coverage After Termination

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) entitles employees, retired employees, and covered dependent(s) to continue medical coverage in certain cases when coverage would otherwise terminate, provided the employee, retired employee, and/or dependent(s) pays the full premium. These circumstances and provisions are described in this section.

Active Employees. Covered active employees who lose eligibility for coverage because of I) voluntary or involuntary termination (except for gross misconduct), II) reduction in hours to part-time status, or III) assignment to active duty military service may elect to continue medical coverage for themselves and their dependents at their own expense for up to 18 months from date coverage would have terminated. It is the responsibility of the employer to report to PEIA

any employees who are COBRA-eligible within 30 days of the date their coverage would ordinarily have terminated under the Plan. The PEIA will then notify the employee within 14 days of the right to continue coverage.

Retired Employees. An employee who retires and who meets the minimum eligibility requirements is eligible for COBRA coverage up to 18 months, as long as that person pays the full premium. The retiree may also be eligible to participate as a retired employee, without a time limitation, and pay PEIA's substantially reduced retiree premium.

Disabled Employees. The 18-month maximum period under COBRA may be extended to 29 months for any COBRA beneficiary who is determined to be disabled under the Social Security Act at any time during the first sixty (60) days of this COBRA coverage. It will be the responsibility of the COBRA beneficiary to notify the PEIA of his/her disabled status before the end of the 18-month coverage period, and within 60 days of any Social security disability termination. If Social Security determines the employee is no longer disabled, the beneficiary must notify the PEIA within 30 days of final determination. PEIA may terminate the COBRA coverage at the beginning of the month starting 30 days after the final determination.

Dependent Children. An active employee or retired employee may continue coverage on dependent child if the child no longer meets the definition of covered dependent as defined in the Plan. Loss of eligibility may result from attainment of age 26. Coverage may be continued for up to 36 months following the date coverage would have terminated. It will be the responsibility of the active employee or retired employee to notify the PEIA within 60 days of loss of a dependent's eligibility. The TPA – C will then notify the employee or retiree of the right to elect continued coverage on that dependent within 14 days.

Divorced Spouse. In the event of a divorce from an active or retired employee, the divorced spouse may elect to continue medical coverage for up to 36 months from the date coverage would have otherwise terminated. It is the responsibility of the policyholder to notify the PEIA of the divorce immediately of the date coverage would terminate, and the TPA – C will notify the spouse of the option to continue coverage within 14 days.

Surviving Spouse/Dependent(s). Upon the death of an active employee or retired employee, the surviving spouse and dependent(s) may elect to continue coverage up to 36 months. For surviving dependent children, coverage may continue up to 36 months beyond the termination date for children as set forth in the Plan. Either the employer of the surviving dependent must notify the PEIA within 60 days of the death of the employee or retired employee. The TPA – C will then notify the dependent within 14 days of the right to continue coverage. The surviving spouse/dependent may also qualify for continued coverage as a policyholder (see, Eligibility to Participate in this Section).

Conditions of Coverage. The following provisions apply to all insureds for whom PEIA coverage is extended pursuant to COBRA:

- Continuation of coverage is optional on the part of the employee, retired employee, spouse, or dependent; and those for whom coverage is extended will be required to pay the full monthly group premium, which will include a 2 percent administrative fee, for the applicable coverage type.

- For disabled COBRA beneficiaries, PEIA may charge 150 percent of the applicable premium during the 19th through 29 the months of coverage. There will be no contribution made from State or employer funds.

- All premiums must be remitted to TPA-C.

- PEIA is required by federal law to offer continuation of coverage for certain specified periods of time; however, failure to make prompt premium payments will constitute reason for termination of coverage prior to the expiration of the required extended coverage.

- PEIA may be required to offer continuation of coverage to a qualified beneficiary even if they are covered under another group health plan, if necessary for the beneficiary to avoid pre-existing condition limitations.

- An election to continue coverage under COBRA must be made within 60 days starting from the latest of:
  (1) the date on which the qualifying event occurs;
  (2) the date on which you lose (or would lose) coverage under the plan due to the qualifying event; or
  (3) the date on which you are informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and procedures for doing so.
  The insured will then have up to 45 days to pay the applicable premium to the TPA–C, retroactive to the date coverage would otherwise have terminated.

  To enroll for COBRA benefits, complete the forms and return to UMP or contact UMR at 1-800-207-1824.

- During the period of continued coverage, medical benefits will be the same as those normally provided by PEIA. Should PEIA implement any changes in benefits or premium rates during the period of extension, the continuation coverage and cost will be affected accordingly.

- If continued coverage is elected, new dependents may be added during the period of continuation and cannot exceed the policyholder's duration of the original 18 months (employee) or 36 months (dependent) extension of coverage,

- The continuation option applies only to medical benefits. There are no extension provisions for employee, retired employee, or dependent life insurance other than the conversion options ad addressed in this Plan.

- An insured enrolled in a MCO will be offered continuation through the MCO Plan. Additionally, if the insured has elected to continue coverage, the insured will retain the

right to change plan enrollment during the regular annual open enrollment period to be effective at the beginning of the next Fiscal Year.

- An insured enrolled in an MCO will be given the opportunity to elect either the PEIA's or the MCO's plan during open enrollment unless the insured moves outside of the MCO enrollment area.

COBRA coverage does not require evidence of insurability due to the continuous coverage provision.

Procedures for Notification of COBRA Eligibility. When a PEIA insured loses eligibility to participate in either the PEIA PPB Plan or a managed care plan, the TPA-C will, upon notice of the event, send a letter to the insured regarding the date the eligibility to participate ends and the terms under which coverage under COBRA may be extended. The letter will be sent to the last known address of the insured. COBRA letters will not be sent to the insured when PEIA coverage would terminate because of one of the following circumstances:

- COBRA coverage was refused on the termination form; or

- no qualifying event has occurred (i.e., a dependent being voluntarily removed by the policyholder).

Termination of COBRA Coverage. Coverage for those persons who elect to extend their PEIA medical benefits through COBRA will terminate at the end of the month in which any of the following events occur:

- At the end of the Period of Coverage specified by COBRA (e.g., 18-, 29- or 36- month period);

- Upon the insured becoming covered as an employee under another group health plan that does not limit coverage for any pre-existing conditions;

- For a divorced spouse or dependent, who becomes covered under another group health plan that does not limit coverage for any pre-existing conditions;

- Failure of the insured to pay their premium within 30 days of the due date;

- The insured becoming entitled to Medicare after the election of COBRA; or,

- Upon a disabled employee no longer considered disabled by Social Security.

A qualified insured who has elected COBRA benefits and continues coverage for the full 18, 29, or 36 months will be removed from the account by the PEIA automatically at the end of the coverage period.

A "Policyholder Termination of Coverage" form is required to remove a qualified beneficiary who has elected COBRA benefits and has not continued coverage for the full 18, 29

or 36 months. The COBRA policyholder must complete a "Change in Status" form to remove a qualified dependent from COBRA family coverage.

II.9. Conversion

Life Insurance Conversion Coverage. The PEIA's contract with the carrier for the Basic and Optional Life and Accidental Death provides that the carrier must offer a conversion policy for insureds who are no longer eligible to participate through the PEIA. Prior to termination, the employee's benefit coordinator will notify the insured that the policy is being canceled because of loss of eligibility to participate under the PEIA Plan and will provide information on how the insured may convert the insurance to an individual policy.

III: PLAN ADMINISTRATION

III.1. Premium Accounts

Premium Accounts Section. The PEIA will maintain a separate account for each participating employer and for each policyholder who pays premiums either directly to the PEIA or through a retirement plan. Separate accounts will also be maintained for those policyholders participating in the Retiree Premium Assistance Program. The Premium Accounts section of the Agency has the responsibility for billing and collecting premiums and reports to the Chief Financial Officer.

Coverage Types. Coverage types are established by the Finance Board as part of the PEIA's annual financial plan. Coverage types are as follows:

- Policyholder
- Policyholder with child(ren)
- Family
- Family with Employee Spouse
- Retiree Only
- Non-Medicare/Medicare
- Retiree with Family Coverage

-Retiree with Family Coverage

- Policyholder with non-Medicare Dependents
- Policyholder with Medicare Dependents

-Life Insurance only

Premium Rates. Premium rates are established by the Finance Board as part of the PEIA's annual financial plan. After determining the cost of administering the Plan and receiving from the Governor an estimate of the total revenues that the State will make available to fund the PEIA, the Finance Board apportions that cost between employers, providers, and policyholders.

PEIA is required by law to apply a monthly spousal surcharge to active employees of State agencies, colleges, universities, and county boards of education if your spouse is eligible for employer-sponsored coverage through his/her employer and has PEIA coverage. The spousal surcharge will be added to health insurance premiums each month. If your spouse is eligible for coverage as an employee of a PEIA-participating agency, has Medicare, Medicaid, TRICARE or is retired, the spousal coverage surcharge does not apply.

In setting premium rates, the Finance Board may consider different levels of costs. For active employees, the levels may be based on the policyholder's ability to pay. For retired employees, the levels may be based on the retired employee's covered years of service on record with a State retirement system, ability to pay, or other relevant factors, including but not limited to Medicare eligibility.

The Finance Board may allocate a portion of the premium costs to participating employers and employees to subsidize the cost of coverage to participating retired employees.

The PEIA Finance Board sets rates payable by employers who have retirees, dependents of retirees or surviving dependents participating in the Plan. The PEIA may bill a non-participating (not participating in PEIA as an active group) employer a premium as established by the Finance Board to subsidize the cost of retired employees, dependents of retired employees or surviving dependents that participate in the State Retirement Plan.

For local government agencies and other employers who are not mandatory participants in the Plan, the Finance Board will establish a rate per active employee participating in the Plan based on the coverage type. The employer will determine what portion of the premium will be paid by the active employee.

Members participating in the Plan through COBRA will pay 102% of the active premium amount. Disabled COBRA Participants will pay 150% of the active premium amount.

Tobacco-Free Discount. PEIA's premium are based on the tobacco-use status of insureds. Tobacco- free insureds will receive the preferred monthly premium rate, which is $25.00 lower for single coverage and $50.00 lower for family coverage. Plan insureds must be tobacco-free for six (6) months to qualify for the discount. Newly hired PPB Plan insureds must have been tobacco-free for six (6) months prior to their effective date of coverage to qualify for the discount.

Tobacco-free insureds must sign an affidavit and return it before the end of open enrollment to receive the reduced premium rate for the following full plan year. For family coverage, all enrolled family members must be tobacco-free to qualify the family for the reduced rate. Once filed, a tobacco-free affidavit will remain effective until amended unless PEIA in any subsequent Plan Year requires that a new affidavit be submitted. PEIA reserves the right to review medical records to check for tobacco use. PEIA offers a tobacco cessation benefit. Tobacco-Free means a person who has not used tobacco products (Includes cigarettes, cigars,

pipes, and chewing and/or smokeless tobacco; including e-cigarettes and/or vaping oils derived from tobacco) in the last six months and will not use tobacco or similar products for the next year.

It shall be considered a violation of West Virginia Code §5-16-12 for a person to knowingly and/or willingly submit false information on a PEIA Tobacco affidavit.

If an individual fails to file a tobacco-free affidavit before the end of open enrollment, the insured may do so at a later date if they have been tobacco-free for six months. However, the insured will not receive the tobacco-free discount for the entire plan year. Upon receipt of a "late" tobacco-free affidavit, PEIA will process the affidavit within sixty days and the insured will receive the tobacco-free discount for the remainder of the plan year. PEIA will not apply the tobacco-free discount retroactively for late affidavits, regardless of the reason.

PEIA reserves the right to perform audits to verify policyholder and/or dependent tobacco status. If a member or dependent is found to be a tobacco user, but has been reported as "tobacco free", PEIA will immediately change the member and/or dependent's status to that of a tobacco user.

If your doctor certifies on a form provided by the PEIA, that it is unreasonably difficult due to a medical condition for you to become tobacco-free or it is medically inadvisable for you to become tobacco free, PEIA will work with you for an alternative way to qualify for the tobacco-free discount. Send all such doctors' certifications and requests for alternative ways to receive the discount to: PEIA Discount Alternatives, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345.

Premium Payments. All premium payments shall be made payable to the Public Employees Insurance Agency and shall be sent to the PEIA's Premium Accounts Section. The full premium payment for policyholders is due by the 5th day of the following month for which coverage is in effect (i.e., for coverage for February, payment must be made by March 5th).

For active employees of State Agencies, and State Colleges and Universities, the State of West Virginia State Auditor's Office shall collect the employer and employee premium for health and life insurance through the EPIC system and will remit those funds to PEIA. For active employees of County Boards of Education, the employer shall collect the employee share through payroll deduction and shall pay to the PEIA the full premium amount monthly (employer and employee share).

For active employees of local government agencies and other employers that are not mandatory participants in the Plan, the employer shall forward the full premium amount by check or electronic fund transfer via the automated clearinghouse process (ACH) to the PEIA.

For active employees on personal leave, the premium will be billed each month to the employer. Responsibility for payment of premium will be according to any policy or agreement established by the employer with the employee. Failure to remit the premium due each month to the PEIA will result in termination of the employee's insurance coverage retroactive to first of that month.

For retirees participating in one of the Consolidated Public Retirement Board systems, their share of the premium will be deducted from their monthly retirement check and forwarded

by the appropriate retirement system to the Agency. If the retiree's pension is not sufficient to cover the cost of the monthly premium, a direct-pay account will be established, and the retiree will be required to remit the balance of the premium due on a monthly basis.

Premiums for retirees using sick leave and/or years of service credit to extend their employer-paid health coverage must be paid by their last employer from which they retired and must be submitted by State Agencies and State Colleges and Universities by intergovernmental transfer (IGT). This premium is not collected through the EPIC system. If a retiree chooses to terminate health and basic life insurance coverage while using service credits to pay for their insurance premiums, there will not be a refund issued for any portion of unused months of credit.

Furthermore, and annual administrative fees must also be remitted through IGT for State agencies (i.e., fees are not collected and remitted through the EPIC system). Administrative fees for all other employer types shall be paid by check or electronic fund transfer via ACH.

Retired Employees Who Retired Before July 1, 1997. Retired employees who retired prior to July 1, 1997, pay premiums based on the plan they choose and eligibility for Medicare. Some retired employees may use sick or annual leave to extend employer-paid health coverage.

Retired Employees Who Retired on or After July 1, 1997. Employees who retire on and after July 1, 1997 (if hired before July 1, 2010), will pay premiums for the PEIA PPB Plan based on their eligibility for Medicare and credited years of service. Employees with 25 or more years of service will be charged the same premium as those who retired before July 1, 1997. Those with fewer than 25 years of service will pay higher premiums in tiers as set by the Finance Board. Retired employees (continuously covered since before July 1, 2010) using accrued sick and/or annual leave or years of service to extend employer-paid insurance will have all, or a portion of this premium covered by the accrued leave.

Disability retiree premiums are assessed on twenty-five (25) years of service if the member has maintained continuous coverage since before July 1, 2010. Employees hired on and after July 1, 2010, will not receive any plan subsidy of their health insurance premiums at retirement, even if they retire as a result of a disability.

Extending Employer-Paid Insurance Upon Retirement. Employees may be eligible to extend employer-paid insurance with any leave balances available upon retirement. To take advantage of this benefit, the eligible employee must move directly from active public employment into his/her respective retirement system. If the employee chooses to separate from employment but, not to immediately retire, sick and annual leave or years of service credit cannot be deferred for use later. Elected public officials are not eligible for this benefit. This benefit terminates when the policyholder dies; it cannot be used by surviving dependents. They may, however, continue coverage by paying the monthly premium.

Using Accrued Sick and Annual Leave to Extend Coverage. Employees of State Agencies, County Boards of Education, or local agencies enrolled in the PEIA PPB Plan or any of the managed care plans, may be able to use any accrued, sick and/or annual leave to extend employer-paid insurance coverage upon retirement. This extended coverage must be for full months. The amount of this benefit depends on the policyholder's effective date of coverage. Employees hired on or after July 1, 2001, are not eligible for this benefit.

Before July 1, 1988: If a policyholder elected to participate in the plan before July 1, 1988 and has been continuously covered by PEIA since that time, then the additional coverage is calculated as follows:

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

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

Between July 1, 1988 and June 30, 2001: If an employee elected to participate in the PEIA Plan on or after July 1, 1988, and before July 1, 2001, or if a lapse in coverage occurred during the period, then the additional coverage is calculated as follows:

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

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

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

The policyholder may also have the option to use accrued leave to increase retirement benefits from the retirement system. The policyholder must choose between additional retirement benefits and extended employer-paid insurance coverage at the time of retirement. Accrued leave may not be divided to increase the retirement benefit and to extend employer-paid insurance coverage. Once the policyholder has made their choice they may not change their election.

On or after July 1, 2001: Employees who elected to participate in the plan on or after July 1, 2001, are not eligible to use leave to extend coverage. Also, **Please Note:** If you retire then return to active employment with a participating agency, you will lose your right to use your sick and/or annual leave for extended employer-paid PEIA coverage. When you return to active employment and have PEIA benefits as an active employee, you will be treated as a new hire with an effective date of coverage in the PEIA plan after July 1, 2001. Therefore, you will be ineligible for the sick/annual leave benefit. Two exceptions will be made to this rule:

1. Active employees hired before July 1, 2001, who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2001) hire date for purposes of this benefit.
2. Retired employees who had an original hire date prior to July 1, 2001, may return to active employment and retain their pre-July 1, 2001, original hire date for purposes of determining their eligibility for this benefit, but may only use leave earned after they return to active employee status.

Extending Coverage for Higher Education Faculty. Full-time faculty members employed on an annual contract basis for a period other than 12 months may extend employer-paid insurance coverage based on years of teaching service. The benefit is calculated as follows:

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

5 years of teaching service = 1 year of family coverage

Employees hired on or after July 1, 2009, are not eligible for this benefit. Two exceptions will be made to this rule:

1. Active employees hired before July 1, 2009, who separate from public service but return within two years of their separation may be restored to their original (pre-July 1, 2009) hire date for purposes of this benefit.
2. Retired employees who had an original hire date prior to July 1, 2009, may return to active employment and retain their pre-July 1, 2009, original hire date for purposes of determining their eligibility for this benefit, but may only use leave earned after they return to active employee status.

Policyholder/Spouse Both Public Employees. If a policyholder and spouse are both public employees eligible for extended employer-paid insurance coverage, their accrued leave may be combined to extend employer-paid family coverage depending upon agreement of their former employers. If the policyholder and spouse retire concurrently, they may be able to combine their accrued leave to purchase months of extended employer-paid coverage. If one spouse should die prior to the expiration of all months of extended employer-paid coverage, PEIA will consider any months of extended employer-paid coverage already used to have been those contributed by the deceased employee. Of the remaining months of extended employer-paid coverage, any that are attributable to the surviving employee may be used by the surviving employee. In no instance, however, shall any employee be permitted to use months of extended employer-paid coverage earned by a deceased employee.

Premium Assistance Programs. Retired employees with 5 or more years of service whose total annual income is less than 250% of the current federal poverty level may receive assistance in paying a portion of their PEIA monthly health premium. Medicare-eligible retirees with 15 or more years of service may receive assistance with drug co-payments through a grant provided by the PEIA. For co-payments, see Appendix H. Applicants must be enrolled in the PEIA PPB Plan. Managed care members are not eligible for this program. Retired employees using accrued sick and/or annual leave to pay their premiums are not eligible for the premium assistance portion of this program until their accrued leave or years of service credit is exhausted. However, they are eligible for co-payments assistance. Applications are mailed to all retired employees each spring.

Retired members covered under The Health Plan are not eligible for this program.

Life Insurance Premiums. Life insurance premiums for all employees are set by PEIA's life insurance carrier subject to PEIA's approval. Optional life insurance premiums are paid by the employee and are based on age and amount of coverage. For retirees, basic life insurance premiums are paid by the retiree with the exception of retirees using extended or paid insurance.

Managed Care Plans. Enrollees in the managed care plans offered by the PEIA pay premiums determined by the managed care plans. Premiums are published in the *Shopper's Guide* prior to each open enrollment. The published premiums are set for a Plan Year unless the West Virginia Insurance Commissioner requires a mid-year change to ensure a plan's solvency. For State Agencies, County Boards of Education and Colleges and Universities, the employer will contribute the same amount toward an employee's coverage as if the employee were enrolled in the PEIA PPB Plan. The employee will pay the employee share of the premium established by

PEIA. Local government agencies will be billed the full premium by PEIA and will determine their own levels of employer/employee premium sharing.

The managed care plan being offered are part of the PEIA benefits package and policyholders may enroll for any plan for which they meet the eligibility guidelines. An employee's plan choice is binding for one Plan Year unless the employee moves outside the enrollment area of the chosen plan.

Failure to Pay Premiums. Failure of an employer or policyholder to pay the monthly premium by the 5th of the month following the month for which the premium is invoiced (due date) will result in cancellation of the policyholder's participation in the Plan retroactive to the last day of the month of coverage suspension. For Medicare-eligible retirees and Medicare-eligible dependents of retirees, Medicare rules will apply.

If payment is not received by PEIA within 30 days following the due date, all medical claims may be pended. Additionally, the PEIA drug card may be suspended. If payment is not received within 45 days following the due date, coverage will be canceled, and all claims incurred will be your personal responsibility.

Checks returned to PEIA by the bank for insufficient funds, closed account, etc., will be returned to the employer or policyholder, as appropriate, for replacement by either a postal money order or cashier's check. If a money order or cashier's check is not remitted to PEIA within 30 days of notification by PEIA of the default, or within the standard collection period established by PEIA, insurance coverage provided by the PEIA will be terminated for failure to pay premium retroactive to the last day of the month of coverage suspension. If an insured's coverage is terminated for failure to pay premiums, the coverage will not be reinstated unless the insured pay all amounts owed to PEIA and establishes an automatic bank withdrawal to pay the insured's premiums thereafter. Such reinstatement is in the discretion of PEIA.

Direct Pay. For policyholders who pay premiums directly to PEIA, if payment is not received by PEIA within 30 days following the due date, a termination notice containing the termination date will be mailed to the policyholder. All claims incurred following the termination date will be the policyholder's personal responsibility. The policyholder has the right to appeal the termination in writing within 60 days following the termination date.

If the termination policyholder appeals the termination in writing 60 days from the date of termination, he or she may pay the past-due premiums, apply to pay premiums by direct draft from a bank account, and may be granted uninterrupted coverage at PEIA's discretion.

If the terminated policyholder appeals the termination in writing more than 60 days following the date of termination, PEIA, in its discretion, may only allow re-enrollment if the policyholder enrolls as anew enrollee and agrees to pay premiums by direct draft from a bank account. In this case, there may be a break in coverage. Two terminations for failure to pay within a 12-month period may result in permanent disqualification from coverage under the PEIA plan.

If extenuating circumstances prevent the policyholder from appealing within 60 days of the termination, the policyholder may appeal for and the PEIA director may grant, at his or her discretion, a waiver of the 60-day requirement.

Monthly Reports. By the 15th day of each month, the PEIA shall provide to each employer a report showing all of their employees enrolled in the Plan, each employee's coverage type and the cost of coverage. This report shall reflect the eligibility records of the PEIA as of the date of this report.

The employer is responsible for verifying the accuracy of the monthly report and reporting any discrepancies to the PEIA.

If an employee should appear on the report for that month but does not, the employer must immediately contact their PEIA eligibility representative to determine the status of the submitted enrollment transaction, forward the enrollment form, or approve the electronic enrollment transaction.

The employer must terminate an employee who should not appear on the invoice due to termination or ineligibility. For a policyholder who is changing coverage type or has had a change not reflected on the billing, the employer need only change the remittance amount until the coverage code (s) or eligibility status has been updated by PEIA eligibility. Forms or electronic transactions reflecting these changes, if not already forwarded, are to be sent immediately to the PEIA or approved electronically by the employer.

Any remittance changes made by the employer must be supported with an approved eligibility transaction to be effective. Until such time, invoiced amount is due.

When all changes have been made, the current remittance will be recalculated and forwarded by the 5th of the month following the month for which coverage was invoiced.

Administrative Expense and Enrollment Fee. The PEIA will determined annually the amount necessary to pay the administrative costs of the Plan, and each participating employer will pay to the PEIA the amount determined per year, per employee. Employers will be billed annually, on July 1, for all employees, and will be billed on an individual basis for new employees enrolled after July 1. Administrative fees are not prorated for employees. Additionally, an enrollment fee set by PEIA is charged to non-state agencies each time they join the Plan. PEIA encourages online transactions and may charge a separate paper-processing fee.

Refunds. The method of payment of refunds by the PEIA is dependent upon: 1) whether the refund is due to a policyholder or an employer; and 2) if due to a policyholder, whether the policyholder is an active employee or retired, non-Medicare eligible retiree, or Medicare-eligible retiree or Medicare-eligible dependent(s) of a deceased retiree.

Active Employee. If an overpayment occurs on a monthly billing due to an incorrect amount being deducted or paid, a refund is due to the employee. To correct this overpayment, the employer shall make a refund directly to the employee, and take a credit on the PEIA billing to reflect the previous overpayment.

Non-Medicare Eligible Retiree/Surviving Dependent/COBRA. If an overpayment occurs due to an incorrect premium being deducted or paid, or due to an erroneous coverage code, a request for refund should be made to PEIA.

Medicare-Eligible Retiree/Medicare-Eligible Dependent(s) of Retiree. Medicare rules apply.

Employer. When there is an overpayment on the employer contribution, a credit must be taken by the employer on the billing.

Administrative Expense Fee. Same procedure as for "Employer".

Refund Timeframes. If the error was on the part of the employer or policyholder, a request for refund with an incurred date within the current fiscal year shall be refunded during that current fiscal year from current fiscal year funds. A request for refund due with an incurred date in an immediate previous fiscal year or earlier may be ineligible for a refund.

Where a refund is requested due to the termination of an employee's coverage and the failure of the employer to timely submit the termination information to PEIA, the PEIA is not obligated to refund more than two (2) month's premium. If such employee has incurred health care claims between the date intended for termination by the employer and the actual termination date, no refund is due. Any premiums beyond two (2) months premium shall be treated as forfeited to PEIA and no coverage will be provided for such forfeited premium amounts.

When the error occurred on the part of PEIA, refunds shall be made without regard to time lapsed. When the error resulting in an apparent refund is not the fault of PEIA, such that the error is the fault of the employer or employee, no refund will be issued.

III.2. Contracts

The operation of the PEIA requires the assistance of numerous vendors. Such vendors include, but may not be limited to, the third-party administrators for medical claims, prescription drug claims and utilization review, manages care organizations offering coverage to PEIA members, the agency's actuaries, the cafeteria plan administrator, the life insurance administrator, auditors and consultants.

Awarding Contracts. W.Va. Code § 5-16-3 and 5-16-8 authorize the Director to enter into contracts necessary to carry out the day-to-day operations of the Agency. Pursuant to W.Va. Code § 5-16-9, such contracts are not subject to the purchasing rules of the West Virginia Department of Administration.

Insurance Contracts. Before entering into any contract for insurance coverage, including plan or plans for group hospital and surgical insurance coverage, group major medical insurance coverage, group prescription drug insurance coverage, and group life and accidental death insurance coverage, the Director shall invite competitive bids from all qualified and licensed insurance companies or carriers who may wish to offer plans for the insurance coverage desired. The Director shall award the bid on a competitive basis taking into account, among other things, the vendors' experience and facilities. The PEIA shall not pay a finder's fee or commission for

such contracts, and any such fee paid by a prospective vendor must be related to actual services rendered or performed by the agent or agents.

TPAs. Awards of contracts for the PEIA's medical claims processing, prescription drug processing and utilization management services and other professional services shall be made by the Director on a competitive basis upon such criteria as the Director believes appropriate for the benefit of the PEIA plans.

Professional and Consulting Services. Awards of professional and professional consulting services contracts shall be made by the Director on a competitive basis or sole source basis. The determination not to competitively bid these contracts may be made when the contract is for less than $10,000, the selected vendor has specific knowledge or experience that is not available from other prospective bidders, or, in the sole discretion of the Director, he/she determines that putting the contract out for competitive bid would not be in the best interest of the Agency. The Director shall state within the contract the reason or reasons why the contract was awarded as a sole source contract.

Inter-Agency Agreements. From time to time, it is necessary for the PEIA to enter into agreements with other State agencies to further the goals of the PEIA and/or the State of West Virginia. Such agreements do not require a competitive bid and are entered into at the sole discretion of the Director.

Renewing, Extending and Amending Contracts. Contracts and agreements entered into by the PEIA generally contain provisions outlining conditions for renewing, extending, amending and terminating the contract or agreement. All such renewals, extensions and amendments may be entered into by the PEIA at the sole discretion of the Director, and must be reduced to writing.

III.3. Payments

Payment of Claim Expenses. The adjudication of medical claims is made by the PEIA's Third-Party Administrator for Medical Claims (TPA-C) and the adjudication of prescription drug claims is done by the PEIA's Third-Party Administrator for Prescription Drugs (TPA -P).

The TPA–C will cause claim checks or EFTs to be made payable directly to in-state providers and the TPA-P will cause claim checks or EFTs to be made payable directly to the participating Network Pharmacy. For policyholders who paid for the services or prescriptions, and who are seeking reimbursement, see Filing Claims Section IV (medical) and Section V (prescription drugs). The payment of life and AD&D claims is addressed in Section VI.

III.4. Payment of Administrative Expenses

Professional, Contractual and Operating Expenses. All professional, contractual and operating expenses of the PEIA shall be submitted to the PEIA on a detailed invoice. Invoices will be verified by the PEIA Fiscal Officer and approved by the PEIA Chief Financial Officer or another person authorized by the PEIA Director. Approved invoices will be forwarded to the State Auditor for payment.

Third-Party Administrative Expenses. Payment of the monthly administrative fee to PEIA's Third-Party Administrators will be in accordance with the terms of their respective contracts.

When payments are based, either in whole or in part, on enrollment figures, the PEIA's Eligibility Section will confirm the enrollment figures. Payments to TPAs shall be reviewed and approved by the PEIA Chief Financial Officer, or another person authorized by the PEIA Director.

Payments to Managed Care Organizations. Payments to managed care organizations providing medical coverage to PEIA members will be made in accordance with their respective contracts. The PEIA Fiscal Officer, or other designee, will verify the enrollment data for purpose of determining the correct monthly payment.

III.5. Audits

Hospital. Audits of hospital claims will be performed by the TPA-C. Audits will be performed for all out-patient service claims that, in the aggregate, exceed $5,000 and, for selected DRGs for in-patient claims, and for other in-patient claims that are $25,000 or more. The TPA – C will review an insured's medical file and compare the file documents with the submitted claims. When discrepancies are discovered, the TPA-C will take the necessary corrective action, to include requested a refund from the facility or deducting the over-payment from the provider's check. The TPA-C will prepare and deliver a report to the Director each month on the activities of the hospital audit program.

Providers. PEIA will periodically conduct audits of provider claims. By submitting claims to PEIA, the provider is deemed to have agreed to cooperate with such audits, including but not limited to directly providing copies of requested records to PEIA or its contracted auditors.

Insured. Audits of claims paid to the insured will be performed by the TPA-C for charges paid of $2,500 or more. When discrepancies are discovered, the TPA-C will take the necessary corrective action, to include requesting a refund from the insured, or deducting the overpayment from any checks to the insured. PEIA may also perform audits to determine member or dependent eligibility.

Pharmacy. Each year, the TPA-P will conduct an audit of at least 5% of pharmacies participating with the PEIA. Pharmacies will be chosen at random for the audit. The audit will include a comparison of claims with the records of the pharmacy to verify, among other things, that the claims are consistent with the prescriptions and authorized refills and that the PEIA is not being charged in excess of the pharmacy's ordinary and customary price for prescription drugs.

Employer. The PEIA's Premium Accounts Section audits the monthly reports and premium payments from participating agencies. Discrepancies in the monthly reports or payments are reported to the participating agency, and any amounts owed to the PEIA must be remitted per the PEIA collection policy. PEIA may also perform audits to determine member or dependent eligibility.

Eligibility. PEIA will from time to time conduct audits to verify eligibility of employees and their dependents, including but not limited to tobacco status. PEIA may request, and employers and employees must provide, reasonable documentation such as tax forms, marriage licenses, divorce decrees, visas, or birth certificates, etc.

TPAs. The PEIA employs, or requires a TPA to employ through contractual agreement, an independent accounting firm to audit the records of its third-party administrator for medical and

prescription drug claims. The includes a SAS-70 Type II and an operational audit of claims processing. These audits will be conducted on a yearly basis and will include not less than six (6) months' claims data.

Agency. The PEIA will employ an independent accounting firm to perform an audit of the PEIA's financial statements. The audit will be performed on a yearly basis and in accordance with the requirements developed by the Financial, Accounting and Reporting Section (FARS) of the West Virginia Department of Administration.

Legislative. Pursuant to W.Va. Code § 4-2-1. Et seq., the legislative Auditor is required periodically to conduct a post audit of the records of the PEIA. The PEIA's Chief Financial Officer shall be responsible for coordinating and facilitating such audits with the Legislative Auditor.

Patient Audit Program. The patient audit program provides for payment to an insured of up to fifty percent (50%) of any overpayments from the PEIA PPB Plan or Prescription Drug Program which are actually recovered by PEIA through the program. The program is intended to help detect and correct overcharges or overpayments resulting from clerical error, miscalculation, fraud and charges for services not received.

Upon request, the PEIA will supply a patient audit report form outlining the steps to follow when filing for this program. The insured must initiate the patient audit report for any overpayments prior to the request or receipt of any recovered amounts by TPA-C or TPA-P. If the TPA-C or TPA-P detects or corrects an error before the insured has filed the patient audit report, the insured may not collect.

A billing error qualifies for the audit program if, after a thorough investigation, the TPA-C or TPA-P receives a refund from the provider. The PEIA must have paid the incorrect amount and then received a refund before payment is allowed under this program. The insured will be paid 50% of the amount recovered as an overpayment.

Reported errors must be at least $50 to qualify for this program and must be submitted within 60 days of the date on the Explanation of Benefits statement. Awards under this program have a maximum of $1,000 annually per policyholder.

MCO members are not eligible for the patient audit program.

III.6. Quarterly Reports

Pursuant to W.Va. Code § 5-16-26, by the 13th day of January, April, July and October of each year, the Director shall prepare a financial report for the approval of the Finance Board. Once approved, the report will be presented to the Joint Committee on Government and Finance. The report will include:

- A summary of the cost of the Plan of health care for claims incurred in the previous calendar quarter;

- A summary of funds accrued to the Plan by legislative appropriation, employer and employee premiums and otherwise in the preceding calendar quarter for payment of health care claims;

- An explanation of cost containment measures, increased premium rates, any other Plan changes adopted by the Director in the preceding calendar quarter; estimated cost savings and enhanced revenues resulting there from, and a certification that the Director made a good faith effort to develop and implement all reasonable health care cost containment alternatives;

- Expected claims costs for next calendar year;

- Such other information as the Director deems appropriate; and

- Any other financial or other information as may be requested by the Committee.

III.7. Employer's Responsibility

Notification to Employees. All participating employers must give written notice to each covered employee within their agency of any changes in benefits to insureds. W.Va. Code § 5-16-8.

Certification of Enrollment. All such forms must be submitted by the agency in a timely manner and in the event of employee termination, immediately. An appropriate official of the employer agency shall on an employee's enrollment form, certify the eligibility of the employee and on any other change in status forms or transactions on behalf of the employee, certify that the information on the form or transaction is accurate, to the best of the official's knowledge. The enrollment form shall be signed by the following persons:

- The chief executive of the agency or their designee, and
- The employee.

Deduction of Premium. The agency shall upon the enrollment of an eligible employee make the appropriate provision for the deduction of premium from the employees pay and shall remit the appropriate premium to PEIA.

Earned Extended Insurance Coverage. All agencies are responsible to remit to PEIA the monthly premiums for retired employees qualifying for earned extended insurance coverage for the time period of the employee's qualifying for earned extended insurance coverage for the time period of the employees earned extended insurance coverage. Employees of non-State agencies who retire may receive the earned extended insurance coverage only if the employee qualifies as a retired employee and only if the employee's agency pays the amount of earned extended insurance coverage. If the agency fails to pay the PEIA, then the employee's earned extended insurance coverage may be terminated. For each employee retiring from an agency when the retiree is to use accrued annual leave or sick leave in exchange for continued PEIA premium payment into retirement the agency shall provide on the retiree's enrollment forms:

- The date of hire of the employee and whether the employee has been continuously employed by the agency since that date;
- The date of the employee's separation from employment and the date of retirement, if known;

- The number of accumulated unpaid sick and annual leave days to be credited to earned extended insurance coverage;
- Whether the employee wants his/her unpaid accumulated sick and/or annual leave credited to a single or family plan; and
- The number of months of earned extended insurance coverage as calculated by the employee's agency.

Non-state Agencies. The following applies to non-state agencies participating or seeking to participate in PEIA:

Participation Agreement. A participation agreement must be executed between the participating non-state agency and the PEIA governing the participation of said non-state agency in the PEIA plan. The participation agreement must be a minimum term of three (3) years.

West Virginia Retiree Health Benefit Trust Participation (Retiree Trust). The Retiree trust is intended to address the Other Post Employment Benefit (OPEB) liability of employers with current or future retirees participating in the PEIA health plans. State law mandates that all employers with employees who are eligible or who will become eligible to participate in PEIA as retirees, are MANDATORY participants in the Retiree Trust. (W.Va. Code §§5-16d-1 et seq.)

Non-State employers may opt out of the Retiree Trust ONLY upon a written Certification, under oath, to PEIA that the employer has no employees who are eligible or who will become to participate in the PEIA health plan as retirees. The employer must also agree to defend and hold PEIA harmless from any and all claims by employees of the employer requesting PEIA coverage. PEIA will provide forms for non-State employers wishing to opt out of the Retiree Trust. PEIA will use the following policies in determining whether to accept an employer opt out request:

WV OPEB Plan Participation Scenario and Policy Document

Table 1 is a list of various scenarios concerning participation the WV Other Post Employment Benefit (OPEB) Plan. All scenarios assume participation with PEIA.

Any employer that opts out of the WV OPEB Plan, but remains on PEIA, must still contribute to the Trust at the minimum annual required payment (MARP) level. When opting out of the WV OPEB plan the employer is opting out of retiree eligibility and the billing of the remaining Annual Required Contribution (ARC).

If the employer opts out of PEIA, they may still be required to pay the non-participating premiums for their retirees still participating in PEIA, but they will no longer be considered a participating employer in the WV OPEB plan if they sign the Opt Out Hold Harmless Agreement. It will be the responsibility of the employer to determine their OPEB expense and liability, if any.

Table 1

List of Scenarios Regarding Employer WV OPEB Plan Participation

	CPRB Participating Employer	Retirees in PEIA Currently	Retirees in PEIA in Past
Employer Wishes to Opt Out of WV OPEB Plan			
Scenario 1	Yes	Yes	Yes
Scenario 2	No	Yes	Yes
Scenario 3	No	No	Yes
Scenario 4	No	No	No
Scenario 5	Yes	No	No
Employer Wishes to Participate in WV OPEB Plan			
Scenario 6	No	No	No
Scenario 7	No	No	Yes
Scenario 8	No	Yes	Yes
Scenario 9	No	Yes	No
No Action from Employer			
Scenario 10	No	No	No
Scenario 11	No	No	Yes
Scenario 12	No	Yes	Yes
Scenario 13	No	Yes	No

Table 2	
Policies for Scenarios Regarding Employer WV OPEB Plan Participation	
Employer Wishes to Opt Out of WV OPEB Plan	
Scenario 1	Reject opt out request. Employer participates in both PEIA and CPRB.
Scenario 2	Reject opt out request based on current PEIA retirees. Employer may be able to re-apply for opt out upon 5 years of no retiree participation in PEIA.
Scenario 3	Approve opt out request if employer signs hold harmless agreement and the past retiree participation is now beyond 5 years from last retiree's termination from PEIA; or Reject opt out request based on past retirees. Employer may be able to re-apply for opt out upon 5 years of no retiree participation in PEIA.
Scenario 4	Approve opt out request if employer signs hold harmless agreement.
Scenario 5	Reject opt out request. Employer participates in both PEIA and CPRB.
Employer Wishes to Participate in WV OPEB Plan	
Scenario 6	Approve, if Director approves retirement plan.
Scenario 7, 8 and 9	Approve, if Director approves retirement plan; or Effective January 1, 2013, new retirees must have 10 years of service as of January 1, 2013 to be eligible and Agency will be removed from the WV OPEB plan upon 5 years from last retiree's termination date.
No Action from Employer	
Scenario 10	Advise of new law and request decision to apply for approval of retirement plan. Failure to submit and receive approval of retirement plan will result in removal from WV OPEB plan eligibility.
Scenario 11, 12 and 13	Advise of new law and request decision to apply for approval of retirement plan. Advise they had been grandfathered due to past or present participation and, without approval of retirement plan, effective January 1, 2013, new retirees must have 10 years of service as of January 1, 2013, to be eligible or employer may request to opt out if there have been no retirees in the last 5 years and signs a hold harmless agreement.

(All terms are as defined in W.Va. Code §5-16d-1 et seq.)

Withdrawal from the Plan. When any participating non-state agency chooses to withdraw from or terminate the West Virginia Public Employees Insurance Plan:

a. Written thirty (30) days' notice shall be required prior to formal withdrawal from the Plan;
b. All non-state agency retirees participating in the CPRB and covered by the PEIA prior to the effective date of these rules may remain covered under the conditions of their present coverage and subject to the agency's payment of premiums as addressed above;
c. All non-state agency retirees not participating in the CPRB or a retirement system approved, in writing, by the PEIA Director must look to the withdrawing non-state agency for coverage and are not eligible to continue participation in PEIA; and
d. As of April 9, 2021, any withdrawing non-state agency may not re-enter the plan unless the non-state entity's eligibility to participate is specifically continued under W.Va. Code §5-16-29.

IV: SECTION 125 PLAN

ARTICLE I – INTRODUCTION

1.1 Purpose of Plan. The purpose of this Plan is to permit Participants to choose between cash and certain non-taxable health and welfare benefits provided by the Employer. In accordance with this purpose, the Plan provides Premium Conversion Benefits, which are non-taxable benefits provided automatically to Participants through payroll deductions upon the satisfaction of eligibility requirements (unless such benefits are declined for cash), and provides Mountaineer Flexible Benefits, which are non-taxable benefits provided to Participants only upon their election and agreement to payroll deductions.

1.2 Authorization. West Virginia Code Section 5-16-14 authorizes Director of the State of West Virginia Public Employees Insurance Agency to develop and implement deductible and employee premium programs which qualify for favorable income tax treatment under section 125 of the Internal Revenue Code of 1986, as amended.

1.3 Cafeteria Plan Status. The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Code, and is to be interpreted in a manner consistent with the requirements of Section 125.

1.4 Effective Date. The Plan is amended and restated effective January 1, 1996.

ARTICLE II – DEFINITIONS

For all purposes, herein, the following definitions and terms shall apply:

2.1 "Administrator" means PEIA and such other TPA as may be appointed from time to time by PEIA to supervise the administration of the Plan.

2.2 "Basic and Optional Life Insurance Program" means the group term life insurance plan offered by PEIA through a contractual arrangement with an insurance carrier of term life insurance under which benefits are excluded from the Employee's gross income pursuant to section 79 of the Code.

2.3 "Benefit Election Form" means the form promulgated by the Administrator by which an eligible Employee makes his benefit election(s) as described in Section 4.1 of the plan and in accordance with Article IV.

2.4 "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or Subsection of the Code includes reference to any comparable or succeeding provision of any legislation, which amends, supplements or replaces such Section or Subsection.

2.5 "Compensation" means the total compensation for services paid or made available by the Employer to an Employee including elective contributions or deferrals which would be included in the Employee's compensation except for the operation of Code sections 125, 403(b), or 457.

2.6 "Contributions" means Employee contributions as described in Article IV used to purchase Premium Conversion Benefits and Mountaineer Flexible Benefits.

2.7 "Dental Benefit Plan" means the dental care plan, or plans, offered by PEIA under which benefits are excluded from the Employee's gross income pursuant to Section 105 of the Code.

2.8 "Dependent" means any person, which falls within the definition of dependent provided in Section 125 of the Code.

2.9 "Dependent Care Expenses" has the meaning specified in Article II of the Dependent Care Reimbursement Plan.

2.10 "Dependent Care Reimbursement Plan" means the State of West Virginia Public Employees Insurance Agency Dependent Care Reimbursement Plan.

2.11 "Director" means the Director of PEIA.

2.12 "Effective Date" means with respect to this amendment and restatement, January 1, 1996.

2.13 "Eligible Employee" means any Employee who is eligible to participate in the Medical Benefit Plan.

2.14 "Employee" means any common-law employee of the Employer.

2.15 "Employer" means the State of West Virginia, its boards, agencies, commissions, departments, institutions or spending units, or county board of education, or eligible municipality or other eligible local entity which elects to participate in the Plan.

2.16 "Health Care Expenses" has the meaning specified in Article II of the Medical Reimbursement Plan.

2.17 "Highly Compensated Individual" means a Participant which is (a) and officer, (b) a shareholder owning more than 5 percent of the voting power or value of all classes of stock of the Employer, (c) highly compensated, or (d) a spouse or dependent (within the meaning of Section 152 of the Code) of an individual described in (a), (b), (c) above.

2.18 "Key Employee" means any person who is a key employee as defined in Section 416 (i) (1) of the Code.

2.19 "Long-Term Disability Plan" means the long-term disability plan offered by PEIA under which benefits are excluded from the Employee's gross income pursuant to Section 106 of the Code.

2.20 "Medical Benefit Plan" means the Employer's respective medical insurance plan(s) and any contract or contracts with health maintenance organizations or group plans in effect from time to time which provide for health care benefits.

2.21 "Medical Reimbursement Plan" means the State of West Virginia public Employees Insurance Agency Medical Reimbursement Plan.

2.22 "Mountaineer Flexible Benefits" means, collectively, the Vision Benefit Plan, Dental Benefit Plan, Long-Term and Short-Term Disability Plan, the Dependent Care Reimbursement and Medical Reimbursement Plan, Health Savings Account, Hearing Aid Plan, and related plans.

2.23 "Open enrollment" means the period of time prior to or during a Plan Year which PEIA has designed and communicated to Eligible Employees as the period within which they may make elections to allocate Contributions under the Section 125 Plan. The open enrollment period may be changed from year to year by PEIA.

2.24 "Participant" means each Eligible Employee who elects to participate in the Plan in accordance with Article III.

2.25 "PEIA" means the State of West Virginia Public Employees Insurance Agency and any successor thereto.

2.26 "Period of Coverage" for the Premium Conversion Benefits means the period of time during the Plan Year in which a Participant is eligible to participate in the Plan under the terms of the Plan and pursuant to the laws of the State of west Virginia. In no event, shall the Period of Coverage commence prior to, nor terminate after, the commencement and ending dates of the Plan Year.

For the Mountaineer, Flexible Benefits, the Period of Coverage shall be the PEIA Plan year. The Period of Coverage, shall generally be twelve (12) months, except for Plan Years during which an Employee is a Participant for less than the entire Plan Year. A Period of Coverage shall not be for a duration which would enable a Participant to defer the receipt of Compensation or to obtain coverage under the Plan only for periods during which a Participant expects to incur Health Care Expenses or Dependent Care Expenses or require medical insurance coverage.

2.27 "Plan" means the State of West Virginia Public Employees Insurance Agency Section 125 Plan as set forth herein, together with any and all amendments and supplements hereto.

2.28 "Plan Year" means the twelve-month benefit period.

2.29 "Premium Conversion Benefits" means the Medical Benefit Plan and Basic and Optional Life Insurance Program.

2.30 "Spouse" means an Employee's legally married husband or wife.

2.31 "TPA" means the third-party administrator retained by PEIA to administer the Plan.

2.32 "Vision Benefit Plan" means the vision plan offered by PEIA under which benefits are excluded from the Employee's gross income pursuant to section 105 of the Code.

The masculine gender, whenever used herein, shall include the feminine, and the singular shall include the plural and vice versa, unless the context clearly indicates otherwise.

ARTICLE III – PARTICIPATION

3.1 Commencement of Participation. All Eligible Employees may participate in and enter the Plan.

(a) With respect to Premium Conversion Benefits, each Eligible Employee shall automatically become a Participant in this Plan for a Period of Coverage on the first day of the month following enrollment in the Medical Benefits Plan, unless the employee properly files with the Administrator a Benefit Election Form to decline participating in the Plan in accordance with section 4.5.

(b) With respect to the Mountaineer Flexible Benefits, participation begins when the Eligible Employee elects, pursuant to Section 4.5, to allocate the Contributions available under this Plan to pay for such benefits during an open enrollment period. An eligible Employee who is hired after open enrollment is not eligible to participate in the Plan until the next open enrollment.

(c) The effect of participation, in this Pan is that the Participant's Compensation will be reduced, pursuant to this Plan, by an amount equal to the amounts required as employee contributions for the benefits elected by the Participant.

(d) Except provided in Section 3.2 and 4.8, an election to participate in the Plan with respect to a particular Plan Year shall remain in effect for the remainder of that Plan Year.

3.2 Cessation of Participation. Except as provided in Article VIII, a Participant shall cease to be Participant as of the earlier of (a) the date on which the Plan terminates, (b) the date on which the employee ceases to be an Eligible Employee, or (c) the date on which he/she has elected to cancel the applicable benefit coverage(s) under Article IV.

3.3 Reinstatement of Former Participant. A Former Participant who is rehired shall become a Participant again in accordance with Section 3.1. However, in the case of a Participant who separates from service with the Employer during a Period of Coverage and elects to revoke existing benefit elections and terminates the receipt of benefits for the remaining portion of the Period of Coverage, upon return to service, such a Former participant shall be prohibited from making new benefit elections for the remaining portion of the Period of Coverage.

3.4 Relation to Other Eligibility Requirements. Each of the optional benefits incorporated in this Plan, such as the Mountaineer Flexible Benefits and Premium Conversion Benefits, may have its own eligibility requirements for participation, which may differ from those set forth in this Plan. The eligibility requirements set forth in this Plan relate only to participation in this Plan and shall have no effect on such other eligibility requirements.

ARTICLE IV – BENEFIT OPTIONS

6.1 Benefit Elections. A Participant may elect under this Plan to receive full Compensation for any Period of Coverage in cash or have a portion of his/her Compensation contributed to the plan by the Employer toward the cost of one or more of the following optional benefits:

(1) Benefits available to the Participant as Premium Conversion Benefits, including, but not limited to, benefits available under the Medical Benefit Plan and Basic and Optional Life Insurance Program;

(2) Benefits available to the Participant as Mountaineer Flexible Benefits, including, but not limited to, the Vision Benefit Plan, Dental Benefit plan and Long-Term Disability Plan, but excluding the Dependent Care Reimbursement and the Medical Reimbursement Plans; and

(3) Benefits available to the Participant under the Dependent Care Reimbursement and the Medical Reimbursement Plans.

6.2 Salary Reduction. By participating in the Plan, each Participant agrees to have his/her annual Compensation reduced by the cost of the benefit(s) selected by him or her under the Plan.

6.3 Description of Benefits Other Than Cash. While the election to receive one or more of the optional benefits described in Section 4.1 may be made under this Plan, the benefit will be provided not by this Plan but by the Employer's Dependent Care Reimbursement Plan, the Medical Reimbursement Plan, any Premium Conversion Benefit plans, and Mountaineer Flexible Benefit plans. The type and amounts of benefits available under each option, and the other terms and conditions of coverage and benefits under such options shall be established and set forth in each of the above plans described in Section 4.1 as provided in their respective Plan Documents, and in the group insurance contracts and prepaid health plan contracts that constitute (or are incorporated by reference) those plans. The benefit descriptions in such plans and contracts, as in effect from time to time, are hereby incorporated by reference into this Plan.

6.4 Election of Optional Benefits In lieu of Cash. A participant may elect under this Plan to receive one or more of the optional benefits described in Section 4.1 in accordance with the procedure described in section 4.5. If a Participant elects any such benefit described in Section 4.1(1) or 4.1(2), the Participant's Compensation will be reduced by the amount of the Participant's share of the cost of the selected benefit as determined by the Employer, and an amount equal to the reduction will be contributed by the Employer under the respective plans described in Sections 4.1(1) and 4.1(2) to cover the Participant's share of the cost of such optional benefit. Such amount shall be adjusted automatically in the event of a change in such cost. The balance of the cost of such benefit, if any, shall be paid by the Employer with non-elective Employer contributions. If a Participant's net pay is not sufficient to fully fund the salary reduction for benefits offered under Sections 4.1(1) and 4.1(2), the contribution can be made up in the future when the Participant has earned salary sufficient to fund such benefit election.

If a Participant elects an optional benefit described in Section 4.1(3), the Participant's case Compensation will be reduced, and an amount equal to the reduction will be credited by the Employer to reimbursement account in accordance with the Dependent Care Reimbursement Plan and/or the Medical Reimbursement Plan. If a Participant's net pay is not sufficient to fund the salary

reduction for benefits offered under Section 4.1(3) for any payroll period, the Participant's ability to contribute for such payroll shall be determined in accordance with the Dependent Care Reimbursement Plan and/or Medical Reimbursement Plan.

6.5 Election Procedure. With respect to the cash benefit described in Section 4.1, the Participant must file a Benefit Election Form with the Administrator to receive this taxable cash benefit, and thereby refuse to receive the qualified tax-free benefits known as the Premium Conversion Benefits.

Each Participant who desires optional benefit coverage(s) under Sections 4.1(2) or (3), shall so specify on the appropriate Benefit Election Form, as provided by the Employer, and shall agree to a corresponding reduction in Compensation. The amount of the reduction in the Participant's Compensation for the Period of Coverage for each optional benefit described in Sections 4.1(2) and (3), shall be the amount elected by the Participant, subject to the limitations set forth in the separate plan Document governing such benefits.

Each Benefit Election Form described in this Section 4.5 must be completed and returned to the administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the Period of Coverage.

6.6 New Participants. An Employee who is hired after the Effective Date and who becomes a Participant in accordance with Section 3.1 or 3.3 hereof shall be provided a Benefit Election Form, as soon as practicable after his date of hire.

An Employee may elect or decline participation in the optional benefit coverage(s) in accordance with Section 4.5 hereof. If a Benefit Election Form must be completed and returned to the Administrator, such form must be returned on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's compensation reduction agreements will apply.

6.7 Failure to Elect. Except as otherwise provided under Section 4.5, a Participant who has elected to be a Participant in the Premium Conversion Benefit described in Section 4.1(1) shall automatically and simultaneously become a Participant in this Plan for such Period of Coverage, without having to complete and return a Benefit Election Form. The Participant shall also be deemed to have agreed to a reduction in Compensation for such Period of Coverage equal to the Participant's share of the cost from time to time during such Period of Coverage of each such optional benefit the Participant is deemed to have elected for such Period of Coverage. If a Participant fails to return a completed Benefit Election Form to the Administrator on or before the specified due date for any subsequent Period of Coverage, the Participant shall be deemed to have elected to continue the same Premium Conversion Benefit elections as in the prior Period of Coverage.

With regard to the Mountaineer Flexible Benefits, the Dependent Care Reimbursement benefits and the Medical Reimbursement benefits described in Sections 4.1(2) or (3) respectively, a Participant failing to return a completed Benefit Election Form to the Administrator on or before the specified due date for any Period of Coverage shall be deemed to have elected cash compensation in lieu of such optional benefits, regardless of the election in effect during any preceding Period of Coverage.

6.8 Changes by Administrator. If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year the non-discrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, Highly Compensated Individuals, principal shareholders, or owners with or without the consent of such individuals, it may be necessary for the Administrator to change the Plan.

6.9 Irrevocability of Election by the Participant During the Period of Coverage. Elections made under the Plan (or deemed to be made) with respect to the Optional Benefits described in Section 4.1 shall irrevocable by the Participant during the Period of Coverage, subject to a change in family status. A Participant may revoke a benefit election for the balance of Period of Coverage and file a new election only if both the revocation and the new election are on account of and consistent with a change in family status as defined below.

A change in family status for this purpose includes marriage or divorce of the Employee, death of the Employee's Spouse or dependent, birth or adoption of a child of the Employee, a dependent child becoming eligible for CHIP, termination or commencement of employment of a Spouse, the switching from part-time to full-time employment status or from full-time to part-time statue by the Employee or the Employee's Spouse and the taking of an unpaid leave of absence by the Employee or the Employee's Spouse and such other events that the Administrator determines will permit a change or revocation of an election during a Period of Coverage under regulations and rulings of the Internal Revenue Service. A Participant may also revoke a benefit election and in lieu thereof receive, on a prospective basis, coverage under another benefit plan with similar coverage if coverage is significantly curtailed or ceases during a Period of Coverage or if the premium amount of a benefit plan significantly increases. Election changes are also permitted where there has been a significant change in health coverage of the Employee or Spouse attributable to the Spouse's employment. Any new election under this Section 4.9 must be filed by the participant with the Administrator within 62 days of the qualifying event, and shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after an election from is completed and returned to the Administrator.

6.10 Automatic Termination of Election. Elections made under this Plan (or deemed to be made) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under the respective plans described in Section 4.1 may continue if and to the extent provided by such plans.

4.11 Maximum Employer Contributions. The maximum amount of Employer contributions under the Plan for any Participant shall be the sum of (a) the maximum amounts which the Participant may receive in the form of dependent care reimbursement under the Dependent Care Reimbursement Plan and as health care reimbursement under the Medical Reimbursement Plan, as set forth in such plan, and (b) the costs from time to time of the most expensive Premium Conversion Benefits and Mountaineer Flexible Benefits available to the Participant (including the portion of such costs payable with non-elective Employer Contributions).

4.12 Effective Periods for Elections. Only compensation earned after an Employee elect's participation in the Plan may be used to purchase optional benefits described in Section 4.1 for a Participant. Participants may not carry over any overused contributions or benefits from one Period of Coverage to a subsequent Period of Coverage.

4.13 Nondiscrimination. Notwithstanding any provisions of insurance coverage provided for under this Plan and any other provisions of this Plan, this Plan shall not discriminate as to eligibility to participate, contributions or benefits in favor of Highly Compensated Individuals or Key Employees.

ARTICLE V – ADMINISTRATION OF PLAN

5.1 Plan Administrator. The Administrator shall have the sole responsibility for the administration of this Plan which responsibility is specifically described in this Plan. The Administrator shall have the authority to appoint such other person or committee from time to time to supervise the administration of the Plan. The designated representatives of the Administrator shall have only those specific powers, duties, responsibilities and obligations as are specifically given them under this Plan.

The Employer shall have the sole responsibility for making the contributions provided for under Article IV hereof. PEIA shall have the sole authority to amend or terminate, in whole or in part, this Plan at any time with the approval of PEIA's Director.

The Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. Furthermore, the Administrator may rely upon any such direction, information or action of another Employee of the Employer as being proper under this Plan, and is not required

under this Plan to inquire into the propriety of any such direction, information or action. It is intended under this Plan that the Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act failure to act of another Employee of the Employer. Neither the Administrator nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

All usual and reasonable expenses of the Administrator that are not properly chargeable to or payable by the Plan (including payment out of forfeitures pursuant to Section 5.4) shall be paid by the Employer, and any expenses not paid by the Employer shall not be the responsibility of the Administrator personally. The Administrator or any other designated representative of the Employer who is an Employee of the Employer shall not receive any compensation with respect to services hereunder except as such person may be entitled to benefits under this Plan.

5.2 Records and Reports. The Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participant and the balances, if any, which are maintained under this Plan. The Administrator shall be responsible for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 125 plans.

5.3 Other Powers and Duties of the Administrator. The Administrator shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not limited to, the following:

(a) To prescribe such procedures as the Administrator deems necessary or proper to be followed by Participants in the filing of applications for benefits;

(b) To construe and interpret the Plan, its construction and interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To prepare and distribute, in such manner as the Administrator determines to be appropriate, information explaining the Plan;

(e) To receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(f) To furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate;

(g) To receive, review and keep on file (as it deems convenient and proper) reports of benefit payments by the Employer and reports of disbursements for expenses directed by the Administrator;

(h) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(i) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocations, delegation, or designation to be in writing.

The TPA shall have no power to add to, subtract from, or modify any of the terms of the Plan, or to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan.

Notwithstanding anything herein to the contrary, any claim which arises under the plans described in Section 4.1 shall not be subject to review under this Plan, and the Administrator's authority under this Section shall not extend to any matter the determination of which an Administrator under the respective plan is empowered to make.

5.4 Examination of Records. The Administrator shall make available to each Participant for examination (at reasonable times during normal business hours) such of the records under the Plan as pertain to such Participant. The Administrator shall be responsible for complying with all notice, reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 125 Plans.

5.5 Reliance on Tables, etc. In administering the Plan, the Administrator shall be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of the administrators of the plans described in Section 4.1 or by accountants, counsel (legal or otherwise), or other experts employed or engaged by the Administrator.

5.6 Rules and Decisions. The Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Administrator, whether discretionary or otherwise, shall be exercised in a uniform and consistent manner so that all persons similarly situated will receive substantially the same treatment. When making a determination or calculation, the Administrator shall be entitled to rely upon information by a Participant, the Employer, or legal counsel of the Employer.

5.7 Procedures. The Administrator may act at a meeting or in writing without a meeting. The Administrator may adopt such bylaws and regulations as it deems necessary for the conduct of its affairs.

5.8 Authorization of Benefit Payments. The Administrator shall issue directions to the Employer concerning all benefits which are to be paid from the Employer's general

assets pursuant to the provisions of the Plan, and warrants that all such directions are in accordance with the Plan.

5.9 Application and Forms for Benefits. The Administrator may require a Participant to complete and file with the Administrator an application for a benefit and all other forms approved by the Administrator, and to furnish all pertinent information requested by the Administrator. The Administrator may rely upon all such information so furnished it, including the Participant's current mailing address.

5.10 Facility of Payment. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a benefit or installment thereof hereunder is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such person or to the person's legal representative or to a relative of such person for such person's benefit, or the Administrator may direct the Employer to apply the payment for the benefit of such person in such manner as the Administrator considers advisable. Any payment of a benefit or installment thereof in accordance with the provisions of this Section 5.11 shall be a complete discharge of any liability for making of such payment under the provisions of the Plan.

5.11 Indemnification of Administrator. The Employer agrees to indemnify and to defend to the fullest extent permitted by law, any individual serving as the Administrator or as a member of a committee designed as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against any and all liabilities, damages, costs and expenses (including reasonable attorney's fee and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or failure to act in connection with the Plan, if such act or failure to act is made in good faith pursuant to the provisions of the Plan.

5.12 Claims Procedure.

(a) A claim for benefits under the Plan shall first be filed with the TPA. Notice of the decision shall be furnished to the claimant by the TPA within a reasonable period of time after receipt of the claim by the TPA. If a Participant does not receive notice of denial of a claim for benefits under the Plan within 90 days of the filing of such claim, then the claim shall be deemed denied.

(b) A claimant may review all pertinent documents and may request a review by the TPA of any claim. Any such request must be filed in writing with the TPA within 90 days after the earlier of (i) receipt by the claimant of written notice of the decision on the claim or (ii) 90 days after the initial filing of such claim. Such written request for review shall contain all additional information which the claimant wishes the TPA to consider. Notice of the decision on review shall be furnished in writing to the claimant within 90 days (unless special circumstances require an extension of up to 90 additional days) following the receipt of the request for review. The TPA's

written decision shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan or of the Plan Documents on which the decision is based.

(c) If such claim is denied by the TPA, a claimant may appeal in writing to PEIA. Such appeal must be filed with PEIA within 30 days of receipt of the TPA's decision denying such claim. All information relating to the denial, including a copy of the denial letter from the TPA, must be supplied to PEIA by the claimant. PEIA shall, after reviewing the facts, make a final determination and notify the claimant of its decision. Such decision shall be final and binding.

5.13 Claims and Review Procedure for Insured Benefits. To the extent that benefits hereunder are provided by an insurance company, the provisions of Section 5.12 shall not apply to claims for such benefits, and claims shall be filed with and subject to review by such insurance company.

ARTICLE VI – AMENDMENT AND TERMINATION OF PLAN

6.1 Amendment and Termination. PEIA hopes and expects to continue this Plan indefinitely and every effort has been made to arrange its provisions so that it will meet future conditions insofar as they can be foreseen. However, in order to protect against unforeseen circumstances, PEIA reserves the right to make any amendment it deems necessary or desirable, or to terminate this Plan at any time by an instrument in writing executed by the Director of PEIA.

However, no such amendment or termination of the Plan shall adversely affect the rights of any Participant hereunder (a) with respect to any balance remaining in his Dependent Care Reimbursement Plan or Medical Reimbursement Plan at the time of such amendment or termination; or (b) with respect to any claims incurred prior to such amendment or termination for the optional benefits described in Section 4.1 hereof.

ARTICLE VII – MISCELLANEOUS PROVISIONS

7.1 Information to be Furnished. Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

7.2 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or Administrator, except as provided herein. No Employer or Employee upon termination of employment or otherwise shall have additional rights or benefits under the Plan, except as provided from time to time under this Plan, and then inly the extent of benefits payable under the Plan to such Employee or beneficiary. All payments of benefits as provided for in this Plan shall be made solely out of the

assets of the Employer and the Administrator shall not be liable therefore in any manner.

7.3 Governing Law. This Plan shall be construed, administered and enforced according to the laws of the State of West Virginia.

7.4 Selection of Beneficiaries. In the case of any insurance policy which permits or requires the naming of a beneficiary, it shall be the responsibility of the Employee to see to it that this is done. The Employer shall not be liable for any loss or cost which may result from such failure. The Employer's responsibility shall be limited to joining in the execution of any documents as requested by an Employee or insurance carrier in order to carry out the purpose of this Plan.

7.5 Non-alienation of Benefits. Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable hereunder, shall be void. The Employer shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits hereunder.

7.6 Divestment of Benefits. Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.

7.7 Discontinuance of Contributions. In the event of a permanent discontinuance of contributions to the Plan, all Participants shall receive any and all benefits to which they were entitled as of the date the discontinuance of contributions occurred.

7.8 Non-guarantee of Employment. Neither the establishment or continuance of the Plan, nor any modification thereof, nor the establishment or continuance of any Medical Benefit Plan or any trust, nor the payment of any benefits, shall give any participating Employee, or other person whomsoever the right to be retained in the service of any Employer or PEIA, and all Participants and other Employees shall remain subject to discharge to the same extent as if the Plan had never been adopted.

7.9 Binding Effect. Subject to the other provisions of the Article VII, this Plan shall be binding upon PEIA and each Employer, their successors and assigns, and upon anyone participating in, or claiming benefits under, the Plan, including each Participant and each of the beneficiaries, heirs, executors, administrators, Authorized Individuals, successors and assigns.

7.10 Severability. If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective, unless such action would then render the Plan inoperable relative to its original intent.

7.11 Construction of the Plan. The Director may construe any ambiguous provisions of the Plan, correct any defect, supply any omission, or reconcile any inconsistency, in such manner and to such extent as the Director in his discretion may determine; any such action of the Director shall be binding and conclusive upon all Participants.

7.12 Benefits Solely from Assets. The benefits provided hereunder will be paid solely from the assets of the Employer. The benefits provided by the Plan are given in exchange for the Participant's salary reduction agreement. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset for the Employer from which any payment under the Plan may be made.

ARTICLE VIII – CONTINUATION COVERAGE

8.1 Right to Elect Continuation Coverage. To the extent required by COBRA, a Participant, the Participant's Spouse, ex-spouse, and the Participant's dependent child can elect continuation coverage of such optional benefits available under the Employer's Medical Benefit Plan and Medical Reimbursement Plan, Dental Benefit Plan, and Vision Plan.

V: MEDICAL BENEFITS PLAN

V.1. Introduction

The Medical Benefits Plan described in this section refers to medical benefits offered as part of the PEIA Preferred Provider Benefit (PPB) Plan. The PEIA PPB Plan replaced the PEIA Indemnity Plan effective July 1, 1999. For a discussion of medical benefits provided through one of PEIA's managed care offerings, refer to Section VII of this Plan. For a discussion of prescription drug benefits offered as part of the PEIA PPB Plans A, B, and D please refer to Section VI of this Plan.

The Medical Benefits Plan pays for a wide range of health care services for PEIA insureds. These benefits include hospital services, medical services, surgery, durable medical equipment and supplies. To be covered, the service must be medically necessary or be a specified preventive care or wellness service.

PEIA PPB Plan C

Plan C is a High Deductible Health Plan that is different than the more traditional PEIA Plans A, B and D. While the core benefits of Plan C are similar to Plans A, B, and D the

deductibles, co-payments coinsurance, and out-of-pocket expenses are very different. Certain benefits are also treated differently or are not available under Plan C. The Plan C PEIA Summary Plan Description (SPD) sets out the details of Plan C and should be referred to for Plan C information. See the SPD specific to Plan C for any information about Plan C. The sections below apply to the PEIA PPB Plans A and B and D when there is a reference to the PEIA PPB Plan or the Medical Benefits Plan. While the sections may generally apply to PPB Plan C, specific information relating to benefits, copays, coinsurance, deductibles, and out-of-pocket maximums are set out in the SPC and may be different for Plan C.

PEIA PPB Plan D

PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-network coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

V.2. Deductibles, Coinsurance, Copayments and Plan Maximums

The PEIA PPB Plans are designed to provide as much care as possible within the State of West Virginia. The PEIA Preferred Provider Organization (PPO) is made up of West Virginia providers who accept PEIA's reimbursements and providers in the UMR/PEIA PPO Network to provide services to PEIA for out-of-state care. For a detailed description of the network, see PEIA PPO in this Section. The deductibles and coinsurance amounts paid by insureds vary based on where care is received and the provider's participation in the PEIA PPO.

Under the cost-sharing benefit design of the PEIA PPB Plan, some services are paid at 100% with no copayment or deductible; some are subject to a copayment only; some are subject to the coinsurance and deductible, and some are subject to the copayment, coinsurance, and deductible. The following section describes the applicable cost-share involved with each type of service.

Deductibles. A deductible is the amount that an insured must pay toward approved medical expenses before the Medical Benefits Plan begins to pay. Services applied to the deductible must have been received in the same Plan Year in order for it to count toward the deductible for the Plan Year (i.e., expenses incurred in one Plan Year cannot be used to meet a deductible for a subsequent plan Year).

Deductibles for the Medical Benefits Plan are based on the employee's annual salary, tier of coverage (Employee Only, Employee and Child(ren), Family, or Family with Employee Spouse), employment status, and whether the employee gets services within the PEIA PPO Network or outside the network. Medical expenses for an individual may apply to both the

individual's deductible and the family deductible; however, an individual may not otherwise use the medical expenses of another individual to meet the individual deductible. Once the family deductible has been met, then the deductible requirement will be satisfied for the Plan Year for each and every member of the family.

There is also a separate deductible for services received outside of the PEIA PPO. The OOSINNA deductible is twice the amount of the in-network deductible. Any medical charges applied toward the OOSINNA deductible for services received outside of the PEIA PPO can also be applied to the in-network deductible. However, the in-network deductible cannot be applied to the OOSINNA deductible; it must be satisfied separately.

Deductible for Family with Employee Spouse coverage are based on the average of the two employees' salaries. Add the annual salaries together and divide by two to get the basis of the premium. This provision does not apply to local government agency employees or retired employees. The deductible for local government agencies in PPB Plan A is the same as that of the active employee salary tier for employees with a salary range of $36,001 to $42,000.

A current listing of deductibles for the PEIA PPB Medical Benefits Plans A, B, and D is contained in Appendix C. Deductibles for the Prescription Drug Plan are addressed in Section VI and are separate from the Medical Plan.

Coinsurance. Once the annual deductible has been met (and copayment, when applicable), the Medical Benefits Plan will pay a percentage of the allowed amount for the covered service. The allowed amount is the maximum level of payment that the PEIA has authorized for a covered service. The coinsurance amount (20% or 40%) is determined according to where the insured lives, where the services are received and whether the provider participates in the PEIA PPO Network and whether prior approval is granted. For services provided within the State of West Virginia or in a bordering county of a surrounding state using PPO providers, the Plan pays the higher level of benefit toward the allowed expense and the insured pays the remaining portion. These amounts increase to 40% when an insured who lives in West Virginia or a bordering county accesses care from non-PPO providers outside of the State and beyond the bordering counties or from non-PPO providers in bordering counties or from out-of-state PPO providers without prior approval. Coinsurance levels due from insureds may be reduced by obtaining prior approval whenever they receive services either outside of the State or from non-PPO providers.

A current schedule of coinsurance for services covered under the Medical Benefits Plan is contained in Appendix C. For information concerning the PEIA PPO Network, **see PEIA PPO** in this Section.

Copayments. A copayment is a flat dollar amount for which the insured is responsible upon receipt of medical services. Certain services are subject to a copayment under the Medical Benefits Plan, including all physician's office visits, except well child care visits and certain preventive care visits. Specialty care office visits will be subject to a $40 copayment. Insureds do not have meet the annual deductible in order for the office visit copayments to apply. However, these copayments amounts do not count toward the out-of-pocket maximum.

Certain other services covered under the Medical Benefits Plan are subject to a copayment in addition to the standard coinsurance level after the annual deductible has been

met. The coinsurance amounts paid for these services do count toward the out-of-pocket maximum.

A current schedule of copayments for services covered under the Medical Benefits Plan is contained in Appendix C.

Non-Covered Services. Non-Covered services are the members' responsibility.

Out-of-Pocket Maximums. An out-of-pocket maximum is the most money, in coinsurance, (excluding copayments), that an insured has to pay covered services in one Plan Year. After the out-of-pocket maximum, has been met by an insured, the Medical Benefits Plan will pay the coinsurance amount of the PEIA allowance in addition to the Plan benefit amount already paid by the Plan for the remainder of the Plan Year. Amounts paid toward annual deductibles, for copayments, for precertification penalties, for prescription drugs and for services not covered under the Plan do not apply to the out-of-pocket maximum. The out-of-pocket maximum includes only medical coinsurance.

The out-of-pocket maximum is based on employment status, annual salary, where services are received and whether the provider participates in the PEIA PPO.

There are separate out-of-pocket maximums for in-network and OOSINNA expenses. For insureds living within the State of West Virginia or bordering county, any medical charges, which result from care received from a West Virginia provider or from a UMR/PEIA PPO Network Provider with prior approval will be applied to the in-network out-of-pocket maximum. Insureds living beyond the bordering counties of the state may apply any medical charges incurred from care received through a participating network provider to the in-network out-of-pocket maximum. All other charges for covered services are applied to the OOSINNA out-of-pocket maximum, unless previously approved by the TPA-C.

Medical charges applied to the in-network out-of-pocket maximum cannot be used to satisfy the OOSINNA out-of-pocket maximum. However, expenses for OOSINNA services can be applied to the in-network out-of-pocket maximum. A current list of out-of-pocket maximums is contained in Appendix D.

V.3. Benefit Maximum

Annual Maximums. For certain types of covered services, the Medical Benefits Plan will pay up to a set amount per Plan Year. Those services and the specific amounts are contained in Appendix D.

The PEIA may authorize payments, if indicated in Appendix D, in excess of the annual maximum when the service is medically necessary as recommended by its Third-Party Administrator for Utilization Management (TPA-UM). In order for the service to be covered, approval for exceeding the annual maximums must be received from the TPA-UM prior to obtaining the service. Approval can be obtained in the same manner as a precertification request as described in this Section.

V.4. Providers

Eligibility. In order to be eligible for payment as a covered service under the Medical Benefits Plan, the service must be rendered by a health care professional who is licensed and qualified under the laws of the jurisdiction in which the care is received and who is providing treatment within the scope of his/her professional license. Additionally, the provider must meet any PEIA policies surrounding particular PEIA benefit programs. If the service is provided by a medical facility such as a hospital or treatment center, the facility must be Medicare or Joint Commission on Accreditation and Healthcare Organizations (JCAHO) approved.

The Office of Inspector General (OIG) of the Federal Department of Health and Human Services, under Congressional mandate, has a program which may exclude individuals and entities from Medicare and other federally funded programs like Medicaid and CHIP. Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance Loans. The OIG maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities.

PEIA has adopted a policy to honor these exclusions. Providers on the OIG list will be removed from PEIA provider networks. Claims for services rendered by these non-network providers will be denied. Providers excluded by PEIA will be notified of the exclusion, in writing, and may appeal such exclusion to the Director within thirty (30) days of receipt of the notice.

Reimbursement Rates. Reimbursement rates for all providers are established by the PEIA and are not subject to review by the West Virginia Health Care Authority. These rates represent the maximum amount the PEIA will pay for a covered service. PEIA will notify providers of changes to the reimbursement rates within thirty days, when possible.

West Virginia Physicians and Other Health Care Professionals. West Virginia physicians and other health care professionals are paid according the Resource-Based Relative Value Scale (RBRVS) and policy provisions. Services included under RBRVS are processed to allow charges up to the RBRVS fee allowance. Services billed that are not covered by RBRVS will be subject to set discount, maximum allowance or discount from charges.

West Virginia Facilities. Most West Virginia hospitals are paid for inpatient admissions in accordance with the Prospective Payment System (PPS) methodology. Generally, most outpatient services performed at a facility are paid according to the Outpatient Prospective Payment System (OPPS). Services not paid through OPPS, are paid according to the RBRVS, or other, PEIA payment schedule. Facility admissions and services that are not covered under the PPS or OPPS methodology will be paid on a discount-from-charges basis.

Out-of-State Physicians and Other Health Care Professionals. Physicians and other health care professionals participating in the UnitedHealthcare Choice Plus PPO are paid according to their contractual agreements. Services of out-of-state non-participating physicians and providers are not covered unless it is emergency are or services not available in West Virginia and are approved in advance by TPA-C. Such approved services may be paid a negotiated rate, paid in full or most often paid the West Virginia fee allowance. In some circumstances, the insured may be paid directly when the provider is a nonparticipating provider. When a member has seen two physicians NOT working in the same practice, for two separate opinions, and those opinions both suggest getting care out of state, PEIA would usually consider that attempting/failing to find available care in state.

Out-of-State Providers. Out-of-state providers participating in the UnitedHealthcare Choice Plus PPO are paid according to their contractual agreements. For non-participating facilities services are not covered unless it is an emergency, or the services are approved in advance by the TPA-C. With respect to such emergency or approved services, inpatient and outpatient services may be paid on a negotiated rate, paid in full or paid the West Virginia fee allowance. In some circumstances, the insured may be paid directly when the provider is a nonparticipating provider.

Established Relationship. If a member has seen a physician outside of West Virginia for a specific condition and needs to have a follow up visit the same condition or the same diagnosis, PEIA may consider that an established relationship. Seeing the same physician outside of West Virginia for a new problem or condition does not mean that the member has an established relationship with this physician. The establishment is based on a clinical situation, not a person-to-doctor visit. The relationship is establishment only when the previous clinical scenario is being re-addressed. For example, if a member sees an orthopedic doctor in another state for a shoulder diagnoses and then later for a knee diagnoses the member is not considered to have an existing established relationship with that doctor. However, if the same shoulder injury were to recur, the relationship would be considered established.

Durable Medical Equipment (DME) and Supplies from West Virginia Providers. DME and supplies are paid in accordance with the DME fee schedule as determined by PEIA.

Home Health Care from West Virginia Providers. Home Health Care is paid in accordance with the Home Health Care Fee Schedule as determined by PEIA.

Other Services. All other covered services not subject to RBRVS, PPS or an established fee schedule are paid on a discount-from-charge or discount-from-payment basis.

PEIA PPO. The PEIA Preferred Provider Organization (PPO) is made up of all West Virginia providers who accept PEIA's insureds as patients. This includes providers located within the State of West Virginia, as well as in the bordering counties of the surrounding state, who participate. Care for covered services received from a provider in the PEIA PPO by a PEIA insured are generally covered at the highest level of benefit and the services received do not require prior approval.

PEIA PPB Plan D has NO coverage for out-of-state services. Plan D members cannot receive services outside WV, except in a medical emergency or when UMR determines that a needed service is not available within WV. In these cases, out-of-state care is covered as in-network care.

Resident of West Virginia and Bordering Counties. In order to ensure that the highest level of benefit is paid for out-of-state care (beyond the bordering counties to West Virginia), a PEIA insured who lives within the State of West Virginia or in one of the bordering counties must obtain prior approval for all services received, except in the case of an emergency. West Virginia residents and insureds living in bordering counties will be subject to a higher coinsurance when the receive out-of-state care (beyond the bordering county) that has not been previously approved, even if the provider is a member of the UnitedHealthcare Choice Plus PPO.

PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-state coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

Out-of-State Residents. PEIA insureds who live beyond the bordering counties of West Virginia may seek care from a UnitedHealthcare Choice Plus PPO participating provider at any time without prior approval for covered services. Covered services from a UnitedHealthcare Choice Plus PPO participating provider that have not received prior approval will be covered at the highest level of benefit for out-of-state residents only.

PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-state coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside west Virginia. All other services must be provided within West Virginia.

Emergency Out-of-State Care. If any PEIA insured who is a resident of West Virginia or a bordering county must seek true emergency medical care in another state, it is not necessary to obtain prior approval, and the service will be covered at the higher benefit level.

Medicare Primary Insureds. PEIA insureds who have Medicare as their primary plan are not subject to PPB Plan network requirements. It is not a requirement that they seek services from network providers and prior approval is not required.

Non-PPO Providers. Any PEIA insured may seek prior approval for a service to be provided outside of the State of West Virginia from a non-PPO provider. If the request is approved, the service will be covered at the higher benefit level (80%). Services received outside of the State from non-PPO providers without prior approval are not covered.

Sanctioned Providers. Providers, both in and out of state, who are under sanction by Medicare, Medicaid or both are excluded from PEIA's network for the duration of their sanction. Additionally, providers may be excluded from PEIA's network based upon adverse audit findings. If you have questions about a specific network provider, please contact UMR at 1-888-440-7342.

V.5. Covered Services

Medically Necessary Services. To be covered by this Medical Benefits Plan, the service must be medically necessary or be one of the listed preventive health or wellness services. Services rendered by a medical provider who is not authorized by this Medical Benefits to provide the service or supplies will not be covered. A service is considered to be medically necessary if it is:

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

The fact that an authorized health care provider has determined that a service is medically necessary does not necessarily make it a covered service. The PEIA reserves the right to make final determination on the medical necessity of the service based on the diagnosis and supporting medical data.

Specific Covered Services. The following is a list of services that are specifically covered under the Medical Benefits Plan. The appropriate level of coinsurance, copayment, and deductible apply to all services as described in this Section.

In this section, services marked with **"X"** require precertification in some or all circumstances.

Allergy Services. Including testing and related treatment; in-network care is covered with applicable coinsurance after deductible is met. Allergy testing (for more than 70 tests) requires precertification.

X Ambulance Services

- Local Ground Transportation: Services are covered when medically necessary for emergency patient transportation by a licensed ambulance service. The transportation must be to the nearest appropriate hospital for inpatient care, or medical emergency care, or transportation from a hospital to the nearest facility. Non-medically necessary, non-emergency ground transportation is not covered.

- Non-Local Ground Transportation: Transportation of a patient between a hospital which does not offer the required service to the nearest hospital which is able to provide those services is covered when medically necessary.

- Air Ambulance Transportation: Expenses for air ambulance services are covered up to the PEIA allowance if the services are medically necessary and the services provide transportation to the nearest hospital able to provide the treatment. The PEIA allowance for air-ambulance is the current Medicare Rural rate. The benefit limit for air ambulance services is $25,000 per occurrence with no annual limit. Non-emergency air ambulance transportation requires precertification and is generally not covered.

- Transportation from hospital to home is not covered, unless approved by the TPA-UM.

- Except in circumstances above, non-emergency transportation is not covered.

X Ambulatory Surgery. This benefit is subject to a $100 copayment and applicable coinsurance after the deductible has been met. See "Outpatient Surgery".

Annual Routine Physical and Screening Examination. The PEIA PPB Plans cover a routine physical exam once every year for insureds age 16 and over. Exams may be provided more often if the patient's medical history indicates a need, but these additional visits are subject to copayments. The Routine Physical and Screening Examination office visit, generally, includes, but is not limited to all health risk screenings and prevention counseling based on the age and gender of the patient required under the Patient Protection and Affordable Care Act (PPACA), Diagnostic testing, lab and x-rays, provided in conjunction with a routine physical are covered, if mandated under the PPACA or if medically necessary and billed with a medical diagnosis. PPACA screenings are covered at 100%. The applicable deductible and coinsurance will apply to other testing billed with a medical diagnosis. Only the screenings specifically required under PPACA or listed in this section, will be covered as routine screenings.

X Autism Spectrum Disorder. Applied behavior analysis (ABA) services when provided in-network are covered with applicable coinsurance after the deductible has been met.

X Aquatic Therapy. Physical therapy performed in water to assist in rehabilitation. This is a form of physical therapy and would fall under the **Pain Management and Rehabilitative Outpatient Services benefit.**

X Bariatric Surgery. This benefit is subject to a $500 copayment and applicable coinsurance after the deductible has been met. Must meet plan guidelines.

Birth Control. The following drugs and procedures are covered expenses for policyholders and their eligible dependents:

- Tubal Ligation;

- Vasectomy;

- Birth control pills: Birth control pills must be purchased at a drug store or through the mail order program and are covered under the Prescription Drug Plan;

- IUD and insertion;

- Birth control implants: covered expenses include the cost of the system and the charges for insertion and removal of the capsules one time every five years;

- Depo-Provera injections: covered once every three (3) months. Office visits are not covered when the injection is the primary purpose of the visit.

The Plan does not cover:

- Reversal of a vasectomy or sterilization; and

- Birth control implant covered expenses do not include charges for reinsertion of capsules for the one-year period after the removal if the capsules must be removed due to medical conditions.

Cancer Treatments. Treatments for cancer are covered expenses unless the treatment is experimental in nature. Bone marrow transplant treatment for cancer requires precertification by the Third-Party Administrator for Utilization Management (TPA-UM) (see Organ Transplants in this Section).

Cardiac or Pulmonary Rehabilitation. Benefits are limited to 3 sessions per week for 12 weeks or 36 sessions per year for the following conditions: heart attack in the 12 months preceding treatment, heart failure, coronary by-pass surgery or stabilized angina pectoris. Covered with applicable coinsurance after the deductible has been met.

- Cardiac rehabilitation for any other condition is not a covered expense.

Covered treatments may be provided at a clinic, a cardiac rehabilitation clinic, or the outpatient department of a hospital and are limited to three (3) sessions per week for 12 weeks or 36 sessions in a twelve-month period. Treatment must commence within twelve months of the cardiac event. Treatment is covered at applicable coinsurance after the deductible is met.

Chelation Therapy. Covered services include removal of unwanted metal ions from the body for the treatment of the following conditions:

- Hemochromatosis,

- Thalassemia (major),

- Cystinuria,

- Heavy metal poisoning from such substances as arsenic, copper, gold, iron, lead, or mercury,

- Wilson's Disease, and

- Control of ventricular arrhythmias, etc., associated with digitalis toxicity.

Chelation therapy treatment for the conditions listed above is not considered investigational. Chelation therapy is considered investigational, and is not covered for all other

conditions including reversal or prevention of coronary artery disease. If covered, in-network therapy is covered with applicable coinsurance after the deductible is met.

Chemotherapy. This treatment is covered when ordered by a physician and may be received on either an inpatient or outpatient basis. Most cancer treatments are case managed by the TPA-UM.

Childhood Immunizations. Plan approved immunizations for children through age 16 are covered at 100% of allowed charges, including the office visit. This benefit is not subject to deductible, coinsurance, or copayment.

Chiropractic Services. Services of a chiropractor for acute treatment of neuromuscular-skeletal conditions are included in the Pain Management and Rehabilitative Outpatient Services Benefit (see below) and are covered. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. Coverage may be extended beyond the 20-visit limit for members in case management due to a catastrophic illness or injury, if approved in advance by UMR. Initial 20 visits require a $20 copayment per visit. The copayment for the first two visits is waived for a diagnosis of back pain. Visits 21+, if approved by UMR, require a $25 copayment per visit and applicable coinsurance after the deductible is met. Office visits billed by the chiropractor are subject to a copayment and x-rays are covered with applicable coinsurance after the deductible is met. Preauthorization is recommended for services for children under age 16. See Pain Management and Rehabilitative Outpatient Services for more information.

Christian Science Treatment. Treatment for a demonstrable illness or injury if provided in a facility accredited by the Commission for Accreditation of Christian Science Nursing Facilities/Organizations, Inc. or by a practitioner accredited by the Mother Church is covered with applicable coinsurance after the deductible is met. No benefits will be paid for the purpose of rest or study, for communication costs, or if the person requiring attention is receiving parallel medical care. Coverage is limited to a maximum cost to the plan of $1,000 per plan year. If required, this benefit may be extended for inpatient care for up to 60 days per plan year.

X Cochlear Implants. Surgically implanted hearing devices when medically necessary.

Colorectal Cancer Screening. Routine screening to detect colorectal cancer as shown in the chart below are covered at 100% in-network with no deductible or coinsurance required. The related office visit expenses may be subject to the applicable office visit copayment.

Table: Preventive Care PPB Plan Benefits for PEIA

Benefit	Coverage
Colorectal Cancer Screening*	100% coverage in-network; 60% out-of-state, in-network, without approval. This benefit is covered as follows: Fecal-occult blood tests – 1 in 12 months/age 45 and over Flexible Sigmoidoscopy – 1 in 5 years/age 45 and over Colonoscopy – 1 every 24 months/high risk** patients or 1 every 10 years/age 45 and over X-ray, barium enema – 1 in 5 years/age 45 and over X-ray, barium enema – 1 in 24 months/high risk patients** Cologuard every 3 years/age 45 and older CT colonography age 45 and older

*Office visits associated with these services are subject to the applicable copayments, coinsurance, and deductibles.

**High risk is defined as a patient who faces high risk for colorectal cancer because of:

- Family history;
- Prior experience of cancer or precursor neoplastic polyps;
- History of chronic digestive disease condition (inflammatory bowel disease, Crohn's disease, ulcerative colitis; and
- Presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors.

(High risk status is not required if age 45 or older.)

X Cosmetic/Reconstructive Surgery. Services provided when required as the result of accidental injury or disease, or when performed to correct birth defects are covered with applicable coinsurance after the deductible is met.

Dental Services (accident-related only). Services provided to restore tooth structures damaged due to an accident are covered with applicable coinsurance after the $500 copayment and deductible are met. Biting and chewing accidents are not covered. The Least Expensive Professionally Acceptable Alternative Treatment (LEPAAT) for accident-related dental services will be covered. For example, the dentist may recommend a crown, but the Plan will only provide reimbursement for a large filling. Contact UMR for more information.

Dental Services (impacted teeth). Medically necessary extraction of impacted teeth is covered with applicable coinsurance after the $500 copayment and deductible are met. Extractions for the purpose of orthodontia are not covered.

DEXA Scans. Dexa Scans are covered for women under age 65 who are at an increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.

Dexa Scans are covered for women aged 65 years or older as a screening for osteoporosis as recommended by the USPSTF.

Diabetes Education. Services of a diabetes education program that meets the standards of the American Diabetes Association are covered with applicable coinsurance after the deductible has been met.

Dietitian Services. Services of a licensed, registered dietitian are covered with the appropriate office visit copayment. Coverage is provided when prescribed by a physician for members with chronic medical conditions. Diabetic patients see Diabetes Education above.

X Durable Medical Equipment (DME) and Prosthetics. Standard durable medical equipment is a covered expense. Precertification is required for all DME purchases of $1,500, or more, or rentals of $500 or for more than three months. If precertification is not obtained, a 30% penalty will be applied even if it is later determined that the DME was medically necessary. The insured's provider must submit a letter of medical necessity or call the TPA-UM stating the length of time the equipment will be needed, its cost, and the reason the equipment is needed. The PEIA covers the item, in accordance with the fee schedule for DME and supplies, if purchased, and rental up to the purchase price, if it is rented.

Durable medical equipment coverage does not include:

- Equipment primarily for comfort and convenience (such as remote controls and intercoms)
- Exercise equipment (such as stationary bicycles or weights)
- Educational equipment (including computers and vocabulary assistance devices);
- Environmental control equipment (including air conditioners or vacuum cleaners); or
- Portable whirlpool pumps (tub spas).

A further listing of some of the non-covered equipment is provided in Appendix E. If you have a question whether the DME is covered under the Plan, contact the TPA-C.

Ear Care. Hearing tests are covered as wellness benefits (office visit) for children under age 13. For individuals over the age of 12, hearing tests are covered if they are for a medical condition, including hearing loss unless it is hearing loss as a result of the normal aging process. Hearing tests as part of routine physical examinations are not covered for individuals over age 12.

Other covered ear care expenses include patching of perforated eardrum and otoplasty to correct birth defects.

Hearing aids, ear plugs, and ear molds are not covered expenses.

Emergency Services (including supplies). Services received in an emergency room when the condition has been certified as an emergency are subject to a $100 copayment and applicable coinsurance after the deductible has been met. Members who visit the emergency room (including independent freestanding emergency rooms) for non-emergency services an excessive number of times may be placed on case Complex Condition CARE or otherwise have payment for their ER services restricted or terminated by the PEIA Plans.

Emergency Room Treatment. Emergency Room treatment should be used only when there is an actual "Emergency Medical Condition" as defined by applicable State law: "Emergency Medical Condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected (by a prudent layperson) 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 a bodily part or organ." If you have such a condition, PEIA urges you to go immediately to a hospital emergency room or independent freestanding emergency room.

Emergency Room treatment should only be used when there is an actual "Emergency Medical Condition". An emergency medical condition is defined by applicable State law as:

"Emergency medical condition" that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected (by a prudent layperson) 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 a bodily part or organ.

If you have such a condition, PEIA urges you to go immediately to a hospital emergency room.

However, use of the emergency room for non-emergency care is inappropriate and very expensive for the member and the PEIA Plans.

Eye Care. Diagnosis and treatment of a disease, medical condition, or injury to the eye are covered expenses. Covered expenses include, but are not necessarily limited to, treatment for the following diagnoses:

- Neoplasm of the eye;
- Diabetic retinopathy and cataract;
- Disorders of the globe;
- Retinal detachments, defects, and other disorders;
- Chorioretinal inflammations, scars, and other disorders of the choroids;
- Disorders of the iris and ciliary body;
- Glaucoma;

- Cataracts;
- Keratitis;
- Disorders of the conjunctiva;
- Inflammation of the eyelids and other eyelid disorders;
- Disorders of the lacrimal system;
- Disorders of the orbit;
- Disorders of the optic nerve and visual pathing; and
- Disorders of binocular eye movements.

Claims for diagnoses which require additional review (preauthorization is recommended) by the TPA-C include:

- Visual disturbances;
- Blindness and reduced vision;
- Dyslexia; and
- Vision Therapy.

The first pair of contact lenses or eyeglasses after cataract or retinal detachment surgery is covered unless the surgery include a lens implant. Vision therapy services indicated by a medical diagnosis are also covered. Preauthorization is recommended, and this benefit is subject to the 20-visit outpatient therapy benefit limit.

Services not covered include routine or preventive eye care, refractions, eye exams, disorders of refractions and accommodation, radial keratomy, and other surgeries intended solely to restore or correct vision.

Foot Care. Expenses covered include medically necessary foot care performed by a health care provider practicing within the scope of his/her license. This would include such services as:

- Diagnostics services (such as X-rays and lab work);
- Orthotics (precertification is required);
- Treatment of bunions, neuromas, hammertoe, hallux valgus, calcaneal spurs or exostosis;
- Removal of nail matrix or root;

- Treatment of mycotic infections; and

- Diabetic foot care.

Expenses not covered include:

- Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), hypertrophy (growth of tissue under the skin);

- Cutting, trimming, or partial removal of toenails;

- Treatment of flat feet, fallen arches, or weak feet; and

- Strapping or taping of the feet.

Gynecological and Breast Exams. Annual screening pap smear and mammogram is covered. Office visits and general physicals associated with these exams are also covered with no deductible or coinsurance. Annual screening pap smears and mammograms are covered at 100% and are not subject to deductible, coinsurance or copayments.

Ongoing Condition CARE Program. The Ongoing Condition CARE Program identifies those individuals who have certain chronic diseases and would benefit from this program. Specially trained nurses work telephonically with members to help them improve their chronic diseases and maintain quality of life. UMR supports individuals with one or more of the nine targeted chronic categories:

1. Behavioral Health Disorders
2. Blood Disorders
3. Cardiovascular Disorders
4. Endocrine Disorders
5. Gastrointestinal Disorders
6. Genitourinary Disorders
7. Neuromuscular/Autoimmune Disorders
8. Oncology
9. Respiratory Disorders

Identified members are invited to participate in the appropriate Ongoing Condition CARE program, and then work with specially trained nurses through phone calls and printed materials to learn more about their condition and how to manage it.

In addition to the telephonic services, UMR Ongoing Condition CARE also provides Care Cues. Members will receive electronic notification if you have a registered email address on the UMR.com portal. Care Cues identify gaps in care and include information on ways to prevent long-term issues and avoid health care costs. Care Cues provide useful, personalized information based on an individual member's health care utilization, including information on provider visits,

prescriptions, and health screenings. Care Cues is a gap in care electronic tool within the Ongoing Condition CARE Program for managing a member's chronic condition(s).

Hemophilia Disease Management Program. To provide quality care at a reasonable cost, PEIA has partnered with the Charleston Area Medical Center (CAMC) and West Virginia University Hospitals (WVUH) to provide a Hemophilia Care Program to PEIA PPB Plan members. Members who participate in the program will be eligible for the following benefits:

- An annual evaluation by specialists in the Hemophilia Disease Management Program which will be paid at 100% with no deductible, copay or coinsurance. (This evaluation is not intended to replace, or interrupt care provided by your existing provider or specialists. This evaluation does not include routine or sick care visits with your doctor or ER).
- Hemophilia factor expenses incurred at CAMC or WVUH will be paid at 100% with no deductible, copay or coinsurance.
- Reimbursement for travel and lodging for an annual evaluation
    a) Child and 1 or 2 parents
    b) Adult and an accompanying adult
    c) Lodging will be at an approved hotel for a maximum of two (2) nights for one room only.
    d) Gas will be reimbursed at the IRS rate for one vehicle only.
    e) Receipts for food will be paid at 100% for the child and parents or for the 2 adults.

Lodging and Travel Expenses:

Lodging expenses include:

a) a) Expenses incurred by the patient traveling between his or her home and the participating facility to receive services in connection with the Hemophilia Disease Management Program.
b) b) Expenses incurred by the patient's companion to enable the patient to receive services from the Hemophilia Disease Management Program.

1. For children under the age of 18, lodging will be covered for one (1) or two (2) parents.
2. For patients over the age of 18, lodging will be covered for one (1) companion.

Lodging will be covered at 100% of the charge up to $107.00 per night.

Travel expenses (gas & meals) include:

1. Expenses incurred while traveling with the patient between the patient's home and the medical facility to receive services in connection with the Hemophilia Disease Management program.
2. Gas and toll receipts are required for reimbursement.
3. Reimbursement of meal expenses up to $55 per day per person. Receipts are required for the reimbursement of meals.

All claims must be submitted within the six-month timely filing period, including the submission of all travel expenses, and must be sent to the following address:

UMR
4700 MacCorkle Ave, SE
Suite 104
Charleston, WV 25304

For more information about this program please contact: UMR at 1-888-440-7342.

High Risk Birth Score Program. Infants identified at birth as being at risk for health problems are provided with six office visits in addition to the standard well-baby care. There will be no deductible or copayment required for these visits. The extra visits are to be scheduled when the baby is 2, 4, 8, 12, 16, and 24 weeks of age.

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

Hospice Care. When ordered by a physician, hospice care is covered with applicable coinsurance after the deductible is met.

X Hospital Inpatient Expenses. Hospital admissions due to illness, injury, mental health or substance abuse, detoxification, medical rehabilitation, or extended care in a skilled nursing facility are covered. Hospital charges related to pregnancy of a policyholder or spouse are also covered.

The TPA-UM must be notified 5 business days in advance by the admitting physician, or admitting facility, for review and/or case management prior to any planned hospital admission, unless the admission is for the treatment of medical emergency or related to an accident in which case the hospitalization must be reported to the TPA-UM within 48 hours of the admission. If the TPA-UM is not notified, a 30% penalty will apply even if the admission is later determined to be medically necessary.

Covered expenses include:

- Room and board (semi-private);
- Cardiac and ICU care; and
- Additional Services and supplies used for diagnosis or treatment while the insured is in the hospital.

The following services are not covered:

- Admissions which are not recommended or scheduled by a provider authorized to schedule admissions;

- Room and board which is not approved as medically necessary by the TPA-UM;
- Hospital stays which are not medically necessary or which are primarily for education or training;
- Charges for a diagnosis or procedure which is not covered by the PEIA;
- The difference between semi-private and private room charges;
- Charges for conveniences, such as TVs, telephones, hairdresser or barber services, and shaving supplies;
- Charges by a federal hospital for injuries, illness, or disability resulting from war;
- Charges due to a work-related injury or illness denied by Workers' Compensation; and
- Days for which the patient has a therapeutic leave of absence pass.

X Hyperbaric Oxygen Therapy. Covered with applicable coinsurance after the deductible is met.

Hypertension (High Blood Pressure) Screening. Hypertension screening services including a detailed office visit, blood pressure check, and chemistry profile are covered based on this schedule:

- One time between the ages of 20 and 30,
- Once every 3 years between the ages of 31 and 39, and
- Once every 2 years after age 40.

More frequent screenings are not covered expenses.

Immunizations. Following is a list of immunizations and the ages at which PEIA covers them at 100% of the fee allowance, catch up immunizations per CDC guidelines will also be covered at 100%. This list is subject to change as PEIA will follow any recommendations to the pediatric or adult immunization schedules published by the CDC.

https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

Polio (IPV): At 2 months, 4 months, 6-18 months, and 4-6 years.

Diphtheria-Tetanus-Pertussis (DTaP): At 2 months, 4 months, 6 months, 15-18 months, 4-6 years, a booster at age 11-12, and a single dose at age 16-18.

Tetanus-Diphtheria (Td): At 11-18 years with booster every 10 years.

Measles-Mumps-Rubella (MMR): At 12-15 months and 4-18 years.

Haemophilus Influenzae Type b (Hib): At 2 months, 4 months, 6 months, and 12-15 months OR 2 months, 4 months, and 12-15 months, depending on vaccine type.

Hepatitis B: At birth-2months, 1-4 months, and 6-18 months. If missed, get 3 doses starting at age 11 years.

Hepatitis A: Begin at 6 months, with second dose at least 6 months apart.

Pneumococcal disease (Prevnar™): At 2 months, 4 months, 6 months, and 12-15 months. If missed, talk to your health care provider.

Influenza: At 6 months and then annually.

Varicella: At 12-15 months and 4-6 years. Adults, if not previously immunized, 2 doses per lifetime

Meningococcal: At 2-10 years for certain children as recommended by the CDC, a booster at age 11-12, and a single dose at age 16-19.

Human Papillomavirus (HPV): Age 9-45

Rotavirus: At 2 months, 4 months, and 6 months depending on vaccine used.

Zoster(Shingles): age 50 and over

COVID: 6 months and older

For children through age 16, the plan covers immunizations and the associated office visit with no deductible, coinsurance, or copayment required. Also see "Well Child Care" in the SPD.

For adults and children over age 16, the plan covers immunizations provided and administered in a physician's office or pharmacy as recommended by the CDC at 100% in-network. The associated office visit is subject to the applicable copayment unless it is administered at the time of an "Annual Routine Physical and Screening Examination." Other immunizations covered with applicable coinsurance after the deductible is met. If purchased at a pharmacy, the member will be reimbursed according to PEIA's fee schedule.

Infertility and Sterility. Treatment of a medical condition resulting in infertility is covered. Services intended to enhance fertility or to treat or sterility, including prescription drugs, are not covered. The following procedures and related expenses, including the infertility work-up are not covered:

- In vitro fertilization;
- GIFT (gamete intrafallopian transfer);
- Embryo transport;
- Surrogate parenting;
- Donor semen; and
- All other methods of artificial insemination.

X Inpatient Hospital and Related Services. Confinement in a hospital including semi-private room, special care units, confinement for detoxification, and related services and supplies during the confinement are covered with applicable coinsurance after the copayment and the deductible are met. Unapproved out-of-network inpatient admissions are not covered.

X Inpatient Medical Rehabilitation Services. When ordered by a physician, coverage is subject to applicable coinsurance after the deductible is met and is limited to 150 days per plan year. In addition to penalties for failure to obtain precertification, all unapproved out-of-network inpatient admissions are not covered.

X Intensive Modulated Radiation Therapy (IMRT). Covered with applicable coinsurance after the deductible is met.

Mammogram. A routine mammogram every 1-2 year for women over 40 to detect breast abnormalities is covered at 100% in-network with no coinsurance or deductible required. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and is covered with applicable coinsurance after the deductible is met.

X Massage Therapy. Therapeutic services by a provider licensed to perform massage therapy for treatment of neuromuscular-skeletal conditions are covered under the Outpatient Therapy Benefit when ordered by a physician. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. Initial 20 visits require a $10 copayment and applicable coinsurance per visit. Coverage may be extended beyond the 20-visit limit for members in Complex Condition CARE due to a catastrophic illness or injury, if approved in advance by UMR. Visits 21 +, if approved by UMR, require a $25 copayment and applicable coinsurance per visit. Maintenance services are not covered. Combined coverage for all therapies is limited to a maximum of 20 visits per person, per plan year. See Outpatient Therapy Services for more information.

Mastectomy and follow-up. Any insured who is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with such benefits is entitled to receive the following procedures:

- Reconstruction of the breast on which the mastectomy was performed;
- Reconstruction surgery of the other breast to present a symmetrical appearance; and
- Prostheses and coverage for physical complications at all stages of the mastectomy procedure including lymphedemas.

Maternity Benefits. The PEIA PPB Plans A, B & D provide coverage for maternity-related professional and facility services, including prenatal care, midwife services and birthing centers. Maternity related services are covered for the employee and covered dependents.

Covered benefits include services normally provided in maternity cases including care during pregnancy, delivery, and postpartum or follow-up care. Birthing centers and certified nurse midwife services are covered.

- Professional Services. An uncomplicated pregnancy and delivery is paid at 100% under a global fee arrangement (a set amount the PEIA has established to cover obstetrical care, including delivery) after the annual deductible has been met and usually includes patient histories, physical examinations, recording of weight,

blood pressure and fetal heart tones, routine chemical urinalysis, and regular visits until delivery. Facility services for maternity care are covered with applicable coinsurance after the deductible is met.

One obstetrical profile is covered at 100% of the allowed amount after the deductible has been met, and usually includes:

- Hemoglobin/Hematocrit;
- Blood types, RH factor, RH immunization;
- Urine culture;
- Rubella titer; and
- Chemistry profile

One routine obstetrical sonogram or ultrasound is also covered at 100% of the allowed amount after the deductible has been met. Additional sonograms and ultrasounds are not covered unless they are medically necessary. When additional sonograms are determined to be medically necessary, they are covered with applicable coinsurance after the deductible has been met.

Other medically necessary maternity services are considered outside the global fee allowance.

- Pre-Payment Benefit. If the insured is eligible for maternity benefits under the Medical Benefits Plan, she can arrange to have a $500 maternity care pre-payment made to the attending provider by submitting the required pre-payment form and either an assignment of benefits form or a statement from the provider that the required deposit has already been paid. No portion of the $500 pre-payment will be applied to the deductible. Pre-payment benefits are not available to hospitals.

At delivery, the benefit normally paid to the physician will be reduced to account for the $500 pre-payment. The entire cost of the benefit (including the $500 pre-payment) cannot exceed the global fee allowance for delivery.

If the insured changes doctors during the pregnancy, the $500 pre-payment and benefits paid separately to each physician cannot exceed the global fee allowance. If the person is no longer covered under the Plan at the time of delivery, the amount of the pre-payment, minus any incurred charges must be repaid.

PEIA will cover certain medically necessary genetic testing the services are approved in advance by UMR.

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

You will need to contact UMR anytime you are admitted to the hospital during your pregnancy and within 2 business days of your admission for delivery, even if you are discharged in less than 2 days.

Maternity CARE provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of long-term hospital stays for both mothers and babies. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the member's risk level and educational needs.

UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they are pregnant. Members self-enroll in the pre-pregnancy coaching program by calling UMR's toll-free number. They are then contacted by nurse case managers who have extensive clinical backgrounds in obstetrics/gynecology. The nurses complete pre-pregnancy assessments to determine risk levels, if any, and provide members with education and materials based on their needs.

Medical Care. The PEIA pays for care by a health care provider while the insured is in the hospital and for office visits when the insured is not hospitalized.

Inpatient: Medical visits are covered once per day while the insured is in the hospital, up to the number of days of hospitalization. If the insured is treated by more than one provider for unrelated conditions, each provider's visits may be paid.

Outpatient: Visits to the provider for the diagnosis and treatment of medical conditions are covered.

Concurrent or Parallel Care: If the patient requires the service of two or more physicians for the treatment of unrelated conditions, benefits will be payable up to the PEIA Fee Schedule rate to more than one physician.

Consultations are covered when requested by the attending physician.

- CPT Codes for consultation services (99241 through 99255) are not covered when billed as such. However, consultations may be billed, when ordered by the attending physician, with the appropriate E & M code.

Medical Supplies. Supplies for ostomy and colostomy are covered if a letter from attending physician confirming medical necessity is provided.

Routine medical supplies such as tape, gauze, swabs, elastic bandages, diapers, thermometers, and aspirin are not covered expenses under any circumstances.

X Mental Health Services.

Inpatient programs, residential programs, and outpatient partial hospitalization day programs for mental health, chemical dependency and substance abuse are covered when

medically necessary. Precertification /Notification is required. Cases requiring more than 30 days inpatient or 60 days partial day treatment will be assigned to a nurse case manager. If approved, these services are covered with applicable coinsurance after the $100 copayment and the deductible are met. Residential treatment for substance abuse and other behavior issues must be approved in advance by UMR. Unapproved out-of-network treatment is not covered.

Outpatient mental health therapy, chemical dependency and substance abuse services are covered when medically necessary for short-term individual and/or group outpatient mental health therapy and chemical dependency services. This benefit includes evaluation and referral, diagnostic, therapeutic, and crisis intervention services performed on an outpatient basis. Cases requiring more than 20 visits will be assigned to a nurse case manager and must be approved by UMR. This benefit is covered with applicable coinsurance after the deductible is met.

MRA. Magnetic Resonance Angiography services when performed on an outpatient basis are covered with applicable coinsurance after the deductible is met.

X MRI. Magnetic Resonance Imaging services when performed on an outpatient basis are covered with applicable coinsurance after the deductible and applicable copayment.

X Neuromuscular stimulators and bone growth stimulators when criteria are met are covered with applicable coinsurance after the deductible is met.

Nutritional Supplements. When these supplements are required to sustain life, they will be covered. Nutritional supplements are not an allowed expense when they are used for weight management, to balance the normal diet, or in any other way by an individual who does not require them to stay alive. In most cases, conditions requiring nutritional supplements require case management. Preauthorization is recommended.

Oral Conditions (See also "Dental Services"). These services for mouth, teeth, and gum care are covered expenses:

- Accident-related dental services limited to the least expensive professionally acceptable alternative treatment, including extraction, oral examinations, repair to damaged teeth, replacement with prosthetic (false) teeth or replacement of existing prostheses;

- Medically necessary oral surgery, limited to orthognathic and ridge reconstruction;

- Diagnosis of myofascial pain; and

- Medically necessary surgical extraction of bony or tissue impacted teeth (except those removed for orthodontic purposes).

The TPA-UM must be notified 5 business days in advance for review of inpatient oral surgery.

These services are not covered: Cleanings; fluoride treatments; splints; gingival surgery; orthodontics; periodontics; treatment for temporomandibular joint dysfunction (TMJ); biting or

chewing injuries; complete or partial sets of prosthetic teeth or dental implants unless the loss is accident related; and all other dental services not specifically included in this plan.

X Organ Transplants. The PEIA, through its TPA-C, has access to a national organ transplant network (Network). A listing of participating facilities of this Plan is available through the TPA-UM or TPA-C.

An insured who requires an organ transplant must contact the TPA-UM prior to receiving any transplant related services. Organ transplants and related services are subject to pre-certification in accordance with PEIA's utilization management program.

Once an insured's annual deductible and out-of-pocket maximum have been met, the PEIA will pay one hundred percent of the cost of in-Network services for pre-transplant services, the transplant and one year of follow-up services; however, if the services span two plan Years, two deductibles and out-of-pocket maximums will apply. Copayments are also applicable and are not waived once the out-of-pocket maximum is met.

The TPA-UM will assist the insured and his/her physician with obtaining information about Network facilities, offer support and assistance in evaluating treatment options, and assist in the coordination for the transplant. In addition, the TPA-UM may authorize up to $5,000 per transplant reimbursement for patient travel, lodging and meals. A portion of this allowance may also be applied to reimburse one member of the patient's family or a friend providing support for their travel, lodging and meals. In order to qualify for this reimbursement, the transplant must take place at a Network facility and receipts are required. Further conditions, as appropriate, may be established by the TPA-UM according to the specifics of each case.

Transplant services at non-network facilities are not covered, unless approved in advance by the TPA-UM as medically necessary.

The PEIA will pay 100% of the allowed charges for prescription drugs after the insured has met the annual prescription drug deductible when the patient requires immunosuppressant drugs. This benefit is covered under the Prescription Drug Plan.

Where the donor does not have Health Insurance coverage and PEIA insures the recipient, PEIA will recognize the donor's medical expenses as part of the recipient's claim. PEIA will also recognize the donor's medical expenses as part of the recipient's claim if the donor has coverage, but his carrier refuses to recognize his expenses for a claim.

In determining donor benefits, PEIA will cover the donor's charges on the recipient's medical claim history. Donor's room and board is limited to the day of donation. The donor's surgical charge will be paid separately as a second operative procedure charged to the recipient. Testing for persons other than the chosen donor is not covered.

Where PEIA insures the donor, PEIA will recognize the donor's medical expenses under his own medical claim history to the extent that the recipient's insurance, if any, does not cover the donor's medical expenses; but PEIA will not include the recipient's expenses.

Where both the donor and recipient have health coverage and PEIA insures the recipient, PEIA will recognize under the recipient's claim the donor's medical expenses to the extent that the donor's medical insurance is not sufficient to cover his medical expenses.

In some instances, PEIA may insure both the donor and recipient either through the same or a different policyholder. In no instance, will PEIA pay an amount greater than that reimbursement which would be owing to the donor or the recipient individually.

Outpatient Diagnostics and Therapeutics. Diagnostics include tests and examinations needed to identify the medical problem that is causing symptoms. Therapeutics are treatments indicated to correct or lessen the medical problem. These expenses are covered if they are:

- An evaluation to establish the cause and nature of an illness and provide a logical basis for treatment;
- Actual treatment;
- Outpatient pre-admission testing; or
- X-ray examination or laboratory examination needed due to injury or sickness.

The following procedures/services must be pre-certified:

1. All admissions to out-of-state hospitals/facilities
2. All admissions to rehabilitation or skilled nursing facilities
3. Ambulance Service for Non-Emergency transport, including air ambulance
4. Any potentially experimental/investigational procedure, medical device, or treatment
5. Autism Spectrum Disorder services
6. Chemotherapy Drugs
7. Continuous glucose monitors
8. Durable medical equipment purchases and/or rentals of $500 per month rental or $1500 per purchase or more
9. Elective (non-emergent) facility to facility air ambulance transportation
10. Electroconvulsive shock therapy (ECT) and Trans magnetic stimulation (TMS)
11. Genetic testing with the exception of Cologuard
12. Home health care and/or IV therapy in the home after the twelfth visit.
13. Hyperbaric Oxygen Therapy (HBOT)
14. Insulin Pump (except Omnipod insulin delivery systems which are covered under the Prescription Drug Program and do not require prior authorization with standard quantity limits)
15. Outpatient IMRT (intensity modulated radiation therapy)
16. Outpatient MRI scan of the breast
17. Residential Medical and Behavioral Treatment
18. In-lab Sleep studies, services and equipment. See section on "sleep management services" in the SPD
19. Specialty drugs provided in a physician's office by a pharmacy or mail order.
20. Stereotactic Radiation Surgery and Stereotactic Radiation Therapy
21. Surgeries
    a) bariatric surgery
    b) cochlear implants or implantable interosseous devices (including bone-anchored)

c) potentially cosmetic surgeries including but not limited to abdominoplasty, blepharoplasty, breast reduction, breast reconstruction, panniculectomy, penile implants/vascular procedures, otoplasty, rhinoplasty, scar revision, testicular prosthesis, and surgery for varicose veins
d) endoscopic treatment of GERD
e) implantable devices which include: implantable pumps, electrical stimulators, implanted spinal drug delivery systems, neuromuscular stimulators, bone growth stimulators and mechanical heart valves
f) spinal fusion surgery
g) total joint replacement
h) uvulopalatopharyngoplasty
i) vertebroplasty, kyphoplasty, and sacroplasty

22. Transplants and transplant evaluations (including but not limited to: kidney, liver, heart, lung and pancreas, small bowel, and bone marrow replacement or stem cell transfer after high dose chemotherapy).

    PEIA will honor a precertfication approved by your previous insurer for the first 3 months of your enrollment in PEIA if the services are provided within the state to allow time for your provider's office to work through any precertifications and appeals. The services are still subject to all precertification requirements. It is important your provider's office let UMR know you are new to PEIA.

X Outpatient Therapy Benefit. Coverage for the following outpatient therapies is combined into one benefit and is available with applicable coinsurance after the deductible is met. The benefit is limited to a maximum of 20 visits per person per plan year for all the therapies combined. Coverage may be extended beyond the 20-visit limit when medically necessary, if approved in advance by UMR. Maintenance services are not covered. Initial 20 visits require a $10 copayment per visit. Visits 21+, if approved in advance by UMR, require a $25 copayment per visit.

- **Massage Therapy.** When ordered by a physician, therapeutic massage therapy services of a licensed massage therapist are covered with applicable coinsurance after the deductible and $10 or $25 copayment (details above) are met.
- **Outpatient Speech Therapy.** When ordered by a physician, this benefit is covered with applicable coinsurance after the deductible and $10 or $25 copayment (details above) are met.
- **Vision Therapy.** This benefit is covered with applicable coinsurance after the deductible and $10 or $25 copayment (details above) are met.

X Pain Management and Rehabilitative Outpatient Services. Coverage for the following outpatient therapies is combined into one. The benefit is limited to a maximum of 20 visits per person per plan year for all the therapies combined. Coverage may be extended beyond the 20-visit limit when medically necessary, if approved in advance by UMR. Initial 20 visits require a $20 copayment per visit. Visits 21+, if approved in advance by UMR, require a $25 copayment per visit and applicable coinsurance after the deductible is met.

- **Chiropractic Treatment.** Services of a chiropractor for treatment of neuromuscular-skeletal conditions are covered with the cost-sharing described above. Office visits are subject to a copayment and x-rays are covered with applicable coinsurance after the deductible is met.

- **Occupational Therapy.** This benefit is covered with the cost-sharing described above.

- **Osteopathic Manipulations.** Services of an osteopathic physician to eliminate or alleviate somatic dysfunction and related disorders are covered with the cost-sharing described above..

- **Outpatient Physical Therapy.** This benefit is covered with the cost-sharing described above.

Pap Smear. A Pap smear and the associated office visit to screen for cervical abnormalities are covered per the CDC guidelines every three years.. The screening is covered in full if conducted as a part of the Routine Physical and Screening Exam, or with a $10 preventive care office visit copayment, if not. When billed with a medical diagnosis (instead of as screening test), it is considered a diagnostic test, and the deductible and applicable coinsurance will apply.

Pediatric Care. PEIA covers all medically necessary and preventive services by a licensed physician, as recommended by the American Academy of Pediatrics, including:

- A routine schedule for active immunization of normal infants and children from birth through age 16 covered at 100% with no deductible, copayment, or coinsurance; and,
- Routine office visits for preventive care, and well-child visits as recommended by the American Academy of Pediatric from birth through age 16 covered at 100% and no deductible, copayment or coinsurance is required.

Physical Therapy. This benefit is included in the Pain Management and Rehabilitative Outpatient Services Benefit (see above) and coverage for the combined therapies is limited to 20 visits per person per Plan Year. This service is covered only when the patient is referred by a licensed physician, surgeon, dentist, osteopathic physician or surgeon. In order to be covered, physical therapy services must be performed by a provider practicing in accordance with the rules of the state board responsible for licensure of physical therapists and with state law.

Physician's Office Visits (treatment for illness, injury, or medical condition). These visits are subject to a copayment.

Prescription Drugs. Most prescription drugs are covered under the Prescription Drug Plan.

Preventive Care. The following services are covered in full in-network for all PEIA PPB Plans. The services are covered with no copayment only to the extent mandated by the Federal Patient Protection and Affordable Care Act (the Act). If the Act no longer mandates 100% coverage, the services will be subject to normal copayments applicable to similar services:

Type of Service	Your In-Network Cost
Covered Preventive Services for Adults	
Abdominal Aortic Aneurysm one-time screening for men aged 65-75 who have ever smoked	$0; Covered in Full
Alcohol Misuse screening and counseling	$0; Covered in Full
Aspirin use for men and woman of certain ages (requires a prescription; covered under prescription drug plan	$0; Covered in Full
Blood Pressure screening for all adults	$0; Covered in Full
Cholesterol screening for men age 35 and older and women age 45 and older or others at high risk	$0; Covered in Full
Colorectal Cancer screening for adults over 45	$0; Covered in Full
Depression screening for adults	$0; Covered in Full
Type 2 Diabetes screening for adults with high blood pressure	$0; Covered in Full
Diet counseling for adults at higher risk for chronic disease	$0; Covered in Full
HIV screening for all adults at higher risk	$0; Covered in Full
Immunization vaccines for adults-doses, recommended ages, and recommended populations vary: Hepatitis A — Hepatitis B Herpes Zoster — Human Papillomavirus Influenza (Flu Shot) — Measles, Mumps, Rubella Meningococcal — Pneumococcal Tetanus, Diphtheria, Pertussis — Varicella	$0; Covered in Full
Obesity screening and counseling for all adults	$0; Covered in Full
Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk	$0; Covered in Full
Tobacco Use screening for all adults and cessation interventions for tobacco users aged 18 and over (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	$0; Covered in Full
Syphilis screening for all adults at higher risk	$0; Covered in Full
Vitamin D for men and women of certain ages (requires a prescription; covered under prescription drug plan)	$0; Covered in Full
Covered Preventive Services for Women, Including Pregnant Women	
Anemia screening on a routine basis for pregnant women	$0; Covered in Full
Bacteriuria urinary tract or other infection screening for pregnant women	$0; Covered in Full
BRCA counseling about genetic testing for women at higher risk	$0; Covered in Full
Breast Cancer Mammography screenings every year	$0; Covered in Full
Breast Cancer Chemoprevention counseling for women at higher risk	$0; Covered in Full
Breastfeeding comprehensive support and counseling from trained providers, as well as Access to breastfeeding supplies, for pregnant and nursing women*	$0; Covered in Full
Cervical Cancer screening for sexually active women	$0; Covered in Full
Chlamydia Infection screening for younger women and other women at higher risk	$0; Covered in Fu
Contraception: Food and Drug Administration-approved contraception methods, sterilization procedures, and Patient education and counseling (contraceptives require a prescription; covered under the prescription drug plan)	$0; Covered in Full
Domestic and interpersonal violence screening and counseling for all women*	$0; Covered in Full
Folic Acid supplements for women who may become pregnant (requires a prescription; covered under prescription drug plan)	$0; Covered in Full
Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk	$0; Covered in Full
Gonorrhea screening for all women at higher risk	$0; Covered in Full
Hepatitis B screening for pregnant women at their prenatal visit	$0; Covered in Full
Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women	$0; Covered in Full
Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years For women with normal cytology results who are 30 or older*	$0; Covered in Full
Osteoporosis screening for women over age 60 depending on risk factors	$0; Covered in Full

Types of Service	Your In-Network Cost
Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk	$0; Covered in Full
Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	$0; Covered in Full
Sexually Transmitted Infections (STI) counseling for sexually active women	$0; Covered in Full
Syphilis screening for all pregnant women or other women at increased risk	$0; Covered in Full
Well-woman visits to obtain recommended preventive services	$0; Covered in Full
Covered Preventive Services for Children	
Alcohol and Drug Use assessments for adolescents	$0; Covered in Full
Autism screening for children at 18 and 24 months	$0; Covered in Full
Behavioral assessment for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.	$0; Covered in Full
Blood Pressure screening for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.	$0; Covered in Full
Cervical Dysplasia screening for sexually active females	$0; Covered in Full
Congenital Hypothyroidism screening for newborns	$0; Covered in Full
Depression screening for adolescents	$0; Covered in Full
Developmental screening for children under age 3, and surveillance throughout childhood	$0; Covered in Full
Dyslipidemia screening for children at higher risk of lipid disorders. Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.	$0; Covered in Full
Fluoride Chemoprevention supplements for children without fluoride in their water source (requires a prescription; covered under the prescription drug plan)	$0; Covered in Full
Gonorrhea preventive medication for the eyes of all newborns	$0; Covered in Full
Hearing screening for all newborns	$0; Covered in Full
Height, Weight and Body Mass Index measurements for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	$0; Covered in Full
Hematocrit or Hemoglobin screening for children	$0; Covered in Full
Hemoglobinopathies or sickle cell screening for newborns	$0; Covered in Full
HIV screening for adolescents at higher risk	$0; Covered in Full
Immunizations vaccines for children from birth to age 18-doses, recommended ages, and recommended population vary: Diphtheria, Tetanus, Pertussis — Haemophilus influenza type b Hepatitis A — Hepatitis B Human Papillomavirus — Inactivated Poliovirus Influenza (Flu Shot) — Measles, Mumps, Rubella Meningococcal — Pneumococcal Rotavirus — Varicella	$0; Covered in Full
Iron supplements for children ages 6 to 12 months at risk for anemia (requires a prescription; covered under the prescription drug plan)	$0; Covered in Full
Lead screening for children at risk of exposure	$0; Covered in Full
Medical History for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.	$0; Covered in Full
Obesity screening and counseling	$0; Covered in Full
Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.	$0; Covered in Full
Phenylketonuria (PKU) screening for this genetic disorder in newborns	$0; Covered in Full
Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk	$0; Covered in Full
Tuberculin testing for children at higher risk of tuberculosis Ages: 0 to 11 months, 1 to 4 years, 11 to 14 years, 15 to 17 years.	$0; Covered in Full
Vision screening for all children	$0; Covered in Full

Professional Services. Of a physician or other licensed provider for treatment of an illness, injury or medical condition. Includes outpatient and inpatient services (such as surgery,

anesthesia, radiology, and office visits). Office visits for annual preventive care are paid at 100%, while other physician services are covered with the applicable coinsurance after the deductible is met.

Prostate Cancer Screening. Coverage is provided for an annual office visit and exam to detect prostate cancer in men age 55 and over. The screening is covered in full if conducted as a part of the Routine Physical and Screening Exam, or with preventive care office visit copayment, if not. The PSA blood test associated with this screening, when ordered by a physician, is covered at 100% with no deductible or coinsurance in-network.

Prostheses and Implants. Covered expenses include:

- Artificial eyes, limbs, larynx, and other standard prosthetic devices;
- Lens implants after cataract surgery;
- Breast prosthesis
- Pacemakers, and other implants medically necessary due to illness or injury; and;
- Post-mastectomy bras and stump stockings (usually 3 per year are covered).

The removal of silicone breast implants is considered a medical necessity and will be covered in all cases. If the silicone implant was originally placed due to a mastectomy, the PEIA will also cover replacement of the silicone implant with a non-silicone implant or reconstruction surgery. If the silicone implant was originally placed for cosmetic reasons in a normal, healthy breast, the replacement of the implant is not a covered expense.

Radiation Therapy. Treatment by radiation, on either an inpatient or outpatient basis, is covered when prescribed by a physician. The TPA-UM must be notified for case management when inpatient radiation therapy is being recommended as a treatment for cancer or a similar disease.

Diagnostic testing, lab and x-rays, provided in conjunction with a routine physical are covered, if mandated under the PPACA or if medically necessary and billed with a medical diagnosis. PPACA screenings are covered at 100%. The deductible and applicable coinsurance will apply to other testing billed with a medical diagnosis. Only the screenings specifically required under PPACA and specifically listed in this Plan Document or the PEIA SPD, will be covered as routine screenings. To the extent 100% coverage is not mandated by PPACA the screenings will be subject to copayments.

X Skilled Nursing Facility Services. The PEIA covers care in a skilled nursing facility. This is a facility that provides care similar to that given in a hospital to meet the medical needs of a seriously ill patient. This benefit is limited to 100 days per member per year and is subject to a copayment.

When medically necessary, the following items provided in a skilled nursing facility are covered expenses:

- Prescription drugs;
- Physician visits;
- Diagnostic X-rays and lab work;
- Oxygen; and
- Therapy services.

Services provided in a skilled nursing facility at the custodial or intermediate care level are not covered. Care at this level may include some minor medical services but is primarily for support in the tasks of daily living. Skilled nursing care for patients with a primary diagnosis of Alzheimer's disease is not covered.

X Sleep Management Services. The PEIA PPB Plans cover services for the diagnosis and treatment of sleep apnea and other sleep-related conditions that can affect your health. To ensure compliance and to administer prescribed sleep services at the highest quality, a precertification process has been established to qualify services as medically necessary and appropriate. PEIA requires that the ordering physician request approval from UMR prior to a member receiving sleep services that include in-lab sleep testing and sleep therapy. In-home sleep studies do not require pre-certification, but therapy recommended as a result of the sleep study will require pre-certification.

Using evidence-based guidelines, UMR will review the request for an in-lab sleep study and make recommendations for those studies that can be performed in the member's home.

In addition to managing sleep testing services, UMR also manages PAP therapy services by providing prior approval for PAP therapy requests. The servicing provider will provide comprehensive support for members' prescribed PAP therapy to provide assistance with adherence to therapy UMR will monitor compliance for the first 90 days before the equipment is purchased.

To obtain prior authorization for sleep services, call UMR at 1-888-440-7342.

X Specialty Medications. Coverage is provided for treatments utilizing specialty drugs through Express Scripts. Specialty medications covered under the medical benefit plan are subject to applicable coinsurance after the deductible is met. Specialty medications covered under the prescription drug program are covered with a $100 copay if on the West Virginia Preferred Drug List and a $150 copay if not on the West Virginia Preferred Drug List, after the prescription drug deductible is met. Many specialty medications are associated with manufacturer programs and foundation programs which may financially assist patients in the purchase of the medication. PEIA encourages members to participate in such specialty medication manufacturer or foundation financial assistance programs if available. Only your actual out-of-pocket payments

will count toward your drug deductible; and annual out-of-pocket maximum. Amounts discounted off the price by the manufacturer or seller of the specialty medication do not count.

Speech Therapy. When speech therapy is ordered by a physician, it will be covered under the Outpatient Therapy Benefit (see above). The benefit for the combined therapies is limited to 20 visits per member per year. Additional therapy may be covered if it is recommended as medically necessary by the TPA-UM. Speech therapy for voice modulation, language training, elimination of a lisp, or similar training is not covered.

Single Photon Emission Computed Tomography (SPECT). Of the brain or lung requires precertification. All other SPECT is covered with applicable coinsurance after the deductible is met.

Surgery. To assure an insured has the right type of care and full benefits under the Medical Benefits Plan, some surgeries must be reviewed in advance by the TPA-UM.

Precertification is required for these surgeries:

- Hysterectomy;
- Artificial Disc surgery;
- Cataract surgery;
- Cochlear implants;
- Colonoscopy (out-of-state only);
- Discectomy with spinal fusion surgery;
- Knee arthroscopy;
- Laminectomy;
- Insertion of implantable devices including, but not limited to vascular access, implantable pumps spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators;
- Uvulopalatopharyngoplasty;
- Elective and cosmetic surgeries including, but not limited to breast reduction, blepharoplasty, abdominoplasty, breast reconstruction, Panniculectomy, Penile implants/vascular procedures otoplasty, rhinoplasty, scar revision, testicular prosthesis, and surgery for varicose veins;
- Bariatric surgery (including, but limited to: gastric bypass, lap-band, sleeve gastrectomy, etc.);
- Spinal fusion surgery;
- Total joint replacement;
- TTE Transthoracic Echocardiogram;
- Transplants;
- Vertebroplasty, Kyphoplasty, Scroplasty; and
- All admissions to out-of-state hospitals/facilities.

Covered expenses generally include:

- Inpatient, outpatient, or office surgery;

- Cosmetic and reconstructive surgery needed to correct a birth defect or for treatment due to an accident or illness;
- Second and third surgical opinions;
- Medically necessary gastric stapling or bypass;
- Medically necessary oral surgery; and
- Medically necessary assistant surgeon fees.

These surgical expenses are not covered:

- Cosmetic or reconstructive surgery other than to correct a birth defect or the effects of an accident or illness; and
- Surgery to relieve a patient of emotional stress or a psychological disorder.

Other special provisions

- If two or more surgical procedures are performed on the same day, the allowance for the second through fifth procedure is covered at 50% of the allowed amount. The sixth procedure requires special review by the TPA-UM.
- Certain surgeries require precertification by the TPA-UM. These are listed above.
- If an assistant surgeon is medically necessary, the allowance for the second surgeon is 16% of the allowed amount for the first procedure, and 8% after that.
- If a second surgical opinion is required by the TPA-UM, it will be covered at 100% of the PEIA fee schedule allowance after the annual deductible is met. If it is voluntary, it will be paid at the normal rate. Third surgical opinions are paid at the normal rate.

Telehealth. Services of a telehealth physician provided through PEIA's telehealth vendor, Revive Health (formerly iSelectMD), are covered at 100% after a $10 copayment. To reach Revive Health, 24/7 call 844-433-8123.

Therapies. Specific therapies (i.e., speech therapy, occupational therapy, etc.) are addressed under their own heading in this section. Inpatient rehabilitation therapies must be reviewed in advance by the TPA-UM.

These therapies and supplies are not covered:

- Devices used in sports-related activities;
- Educational or cognitive medical rehabilitation;

- Therapy for a patient showing no progress;
- Daily living skills training;
- Stimulation therapy;
- Orientation therapy; and
- Aqua therapy.

Tobacco Cessation Program. PEIA PPB Plans A, B, & D provide benefits for participants who wish to quit smoking or using smokeless tobacco products. Only those members who have been paying the Standard (tobacco-user) premium are eligible for the Tobacco Cessation benefit. if you signed an affidavit claiming to be tobacco-free, you will be declined the Tobacco Cessation benefit.

To access the benefits, simply visit your primary care provider. PEIA will cover an initial and follow-up visit to your physician or nurse practitioner. PEIA covers both prescription and non-prescription tobacco cessation medications if they are dispensed with a prescription.

PEIA will cover a total of two 12-week cycles of drug therapy, even if more than one type of therapy is used. If extended therapy is required, the provider must submit a written appeal to the Director of PEIA with proof of medical necessity.

You can use the benefit (office visits and prescriptions) twice per year (rolling 12-month period).

For pregnant participants, PEIA will provide 100% coverage for the tobacco cessation benefit during any pregnancy.

Vision Therapy. Vision therapy is included in the Outpatient Therapy Benefit (see above) and is limited to a maximum of 20 visits per person per year for the combined benefit. vision therapy is covered when it is ordered by a physician for correction a covered medical condition. Preauthorization is recommended, but precertification is required beyond the 20 visit Outpatient Therapy Benefit amount. Coverage is with applicable coinsurance after the in-network deductible is met.

Face-To-Face Weight Management Program. PEIA offers a facility-based weight management program for PEIA PPB members who meet the program qualifications and are willing to make the necessary commitment to the program. Members will be subject to monthly program compliance checks and must meet certain goals to continue in the program. To participate in the PEIA Weight Management Program, PPB Plan Members must have a Body Mass Index of 25 or greater; or a waist circumference of 35 inches or greater (for women) or 40 inches or greater (for men). The program includes comprehensive services from registered and licensed dietitians, degreed exercise physiologists and personal trainers at approved fitness centers. The current list of participating facilities is on PEIA's website at peia.wv.gov. This is a three year or three attempt per lifetime benefit with a maximum of 36 months. The program

requires a copayment of $30 per month. Members who previously participated in the PEIA Weight Management Program for fewer than 18 months may be eligible for a second program attempt. Members who have exhausted the lifetime benefit or are under age 18, are not eligible for this benefit. To enroll, you must complete the online application, which includes some medical information. For more information, or to enroll in the program, go to peia.wv.gov under Wellness Tools.

New Voluntary Wellness Program – Virgin Pulse. PEIA's newest wellness program, powered by Virgin Pulse, will help our policyholders live better and achieve their health goals through a fun and engaging experience. Virgin Pulse is one of the top health, wellbeing, and navigation platforms available today, and PEIA is excited to share this newest wellness tool with our policyholders who wish to participate.

In accordance with West Virginia Code §5-16-8, PEIA is required to provide certain health benefits and services which require PEIA to disclose and/or share PEIA member information with third parties for the administration and management of said services. PEIA has contracted with Virgin Pulse to be the State's Wellness Program provider. You may receive phone calls, e-mails, or texts from Virgin Pulse informing you of this new benefit.

Online Weight Management Program through Wondr. The program is delivered online to your smartphone or computer and doesn't include starving, counting calories or spending hours prepping 'approved' foods. Instead, it will teach you how to eat your favorite foods while losing weight, looking and feeling better and reducing your risk for major health conditions, like diabetes or heart disease.

The program starts with ten weekly lessons, approximately 30 – 45 minutes in length, to teach you the core principles. Each lesson is broken up into small videos so you can watch the entire lesson in one sitting or break it up into multiple sittings when it is convenient for you. After the first ten weeks, another ten weekly personalized lessons are provided. At this point, you will have learned the core principles so lessons will focus on reinforcing those skills and helping you apply them in your everyday life. After that, you will have new lessons to choose from to help with your long-term weight maintenance.

Policyholders (employees and non-Medicare retirees) and adult dependents (over age 18) enrolled in the PEIA PPB Plans are eligible to apply. Quarterly open enrollments for this program are announced on the PEIA website and Facebook page. Members who have previously completed this program will be eligible for a second attempt.

Well Child Care. For children through age 16, the plan covers routine office visits for preventive care as recommended by the American Academy of Pediatrics. These visits are covered at 100% of allowed charges and are not subject to coinsurance or deductible. This office visit, generally, includes, but is not limited to:

- Height and weight measurement;
- Blood pressure check;
- Vision and hearing screening;
- Developmental/behavioral assessment; and physical examination.

Well Child Care office visits are recommended by the American Academy of Pediatrics at the following ages:

- Infancy: 1 month, 2 months, 4 months, 6 months, 9 months and 12 months.
- Early childhood: 15 months, 18 months, 24 months, 30 months, 3 years and 4 years.
- Late childhood: Annually from ages 5 through 12.
- Adolescence: annually from ages 13 through 16.

Adolescents over the age of 16 receive the Annual Routine Physical and Screening Exam benefit described above.

Exclusions. In addition to exclusions listed in the Specific Benefits Section, the following services are not covered by the PEIA regardless of medical necessity. As it would be practically impossible to list all possible exclusions, this is not intended to be a complete listing. If the service is not one of the services listed in the Specific Benefits Section, the insured should contact the TPA-C to determine if the service is covered. The following are specifically excluded from coverage:

1. Acupuncture
2. Autopsy and other services performed after death, including transportation of the body or repatriation of remains
3. Biofeedback
4. Coma stimulation
5. Cosmetic or reconstructive surgery when not required as the result of accidental injury or disease, or not performed to correct birth defects. Services resulting from or related to these excluded services also are not covered
6. Custodial care, domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living, or for behavioral modification, including applied behavior analysis (ABA), except to the extent ABA is mandated to be covered for treatment of autism spectrum disorder by federal law.
7. Dental implants, whether medically indicated or not
8. Dental services including dental implants, routine dental care, x-rays, treatment of cysts or abscesses associated with the teeth, dentures, bridges, or any other dentistry and dental procedures
9. Daily living skills training
10. Duplicate testing, interpretation or handling fees
11. Education, training and/or cognitive services, unless specifically listed as covered services
12. Elective abortions
13. Electronically controlled thermal therapy
14. Emergency evacuation from a foreign country, even if medically necessary
15. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts
16. Experimental, investigational or unproven services, unless pre-approved by UMR
17. Family or Group therapy when the patient is not present.
18. Fertility drugs and services
19. Foot care. Routine foot care including:

- Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or irritation), hyperplasia (overgrowth of the skin), or hypertrophy (growth of tissue under the skin);
- Cutting, trimming, or partial removal of toenails;
- Treatment of flat feet, fallen arches, or weak feet; and
- Hygienic or other preventative maintenance, like cleaning and soaking of feet

20. Gender reassignment surgery
21. Genetic testing for screening purposes is generally not covered, unless needed to diagnose or treat a condition and precertified.
22. Glucose monitoring devices or test strips, except OneTouch Verio Reflect, OneTouch Verio Flex, FreeStyle Lite, FreeStyle Freedom Lite, and Precision Xtra monitors and OneTouch Ultra, OneTouch Verio, FreeStyle Lite, FreeStyle Freedom Lite, and Precision Xtratest strips covered under the prescription drug benefit
23. Homeopathic medicine
24. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery
25. Hypnosis
26. Incidental surgery performed during medically necessary surgery
27. Infertility Treatment including, but not limited to, the following:
    - Surgical reversal of a sterilized state that was a result of a previous surgery
    - Direct attempts to cause pregnancy by any means, including, but not limited to, hormone therapy or drugs
    - Artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT)
    - Embryo transfer
    - Freezing or storage of embryo, eggs or semen
    - Donor services
    - Genetic testing

    This exclusion does not apply to services required to diagnose infertility.

28. Maintenance outpatient therapy services, including, but not limited to:
    - Chiropractic
    - Massage Therapy
    - Occupational Therapy
    - Osteopathic Manipulations
    - Outpatient Physical Therapy
    - Outpatient Speech Therapy
    - Vision Therapy
29. Marriage counseling
30. Medical and pharmaceutical claims for persons while in the custody of a civil or criminal state or federal authority. The state or federal authority having custody of the person shall be responsible for payment of all healthcare costs.
31. Medical equipment, appliances or supplies of the following types:
    - Augmentative communication devices

- Bathroom scales
- Educational equipment
- Environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters
- Dust extractors
- Equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs (including Hoyer lifts); recliners; contour chairs; adjustable beds; or tilt stands
- Support devices which are widely available over the counter such as prophylactic wrist, ankle and knee supports
- Exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines
- Out-of-Network services unless an emergency or medically necessary
- Hearing aids
- Hygienic equipment such as bed baths, commodes, and toilet seats
- Motorized scooters
- Nutritional supplements, over-the-counter (OTC) formula (with the exception of amino acid-based formula for the treatment of severe protein allergic conditions or absorption disorders or infant formula administered through a feeding tube), food liquidizers or food processors
- Orthopedic shoes, unless attached to a brace
- Professional medical equipment such as blood pressure kits or stethoscopes
- Replacement of lost or stolen items
- Supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags
- Standing/tilt wheelchairs
- Traction devices
- Vibrators
- Whirlpool pumps or equipment
- Wigs or wig styling

32. Medical examinations, vaccinations, inoculations, and/or other procedures required prior to immigration and/or re-entry into the United States.
33. Medical rehabilitation and any other services that are primarily educational or cognitive in nature
34. Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning
35. Optical services:
    - Routine eye examinations, refractions, eyeglasses, contact lenses and fittings
    - Glasses and/or contact lenses following cataract surgery
    - Low-vision devices, including magnifiers, telescopic lenses and closed-circuit television systems
36. Orientation therapy
37. Orthodontia services

38. Orthotripsy
39. Out of network services except in an emergency or if approved in advance by UMR.
40. Physical examinations and routine office visits except those covered under the Periodic Physicals benefit
41. Personal comfort and convenience items or services (whether on an inpatient or outpatient basis) such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician
42. Physical conditioning and work hardening. Expenses related to physical conditioning programs and work hardening such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation
43. Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered under the plan, when such services are:
    - conducted for purposes of medical research;
    - for participation in athletics;
    - needed for marriage or adoption proceedings;
    - related to employment;
    - related to judicial or administrative proceedings or orders;
    - to obtain or maintain a license or official document of any type; or
    - to obtain or maintain insurance
44. Provider charges for phone calls or prescription refills (Telemedicine visits are payable as any other visit)
45. Radial keratotomy, Lasik procedure and other surgery to correct vision. Surgery to prevent legal blindness or restore vision from legal blindness is covered, if not correctable by lenses or other more conservative means
46. Reversal of sterilization and associated services and expenses
47. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities
48. Screenings, except those specially listed as covered benefits
49. Service/therapy animals and the associated services and expenses, including training
50. Services rendered by a provider with the same legal residence as a participant, or who is a member of the policyholder's family. This includes spouse, brother, sister, parent, or child
51. Services rendered outside the scope of a provider's license or certification
52. Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit
53. Sensory stimulation therapy
54. Take-home drugs provided at discharge from a hospital or any facility
55. TMJ. Treatment of temporomandibular joint (TMJ) disorders. Including intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for temporomandibular joint dysfunction not caused by documented organic disease or acute physical trauma
56. The difference between private and semi-private room charges
57. Therapy and related services for a patient showing no progress

58. Therapies rendered outside the United States that are not medically recognized within the United States
59. Transportation other than medically-necessary emergency ambulance services, or as approved under the Organ Transplant Network benefit or the Travel Benefit
60. War-related injuries or illnesses. Treatment in a State or Federal hospital for military or service-related injuries or disabilities
61. Weight loss. Health services and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight-control programs, weight-control drugs, screening for weight-control programs, and services of a similar nature, except those services provided through the Weight Management Program offered by PEIA
62. Work-related injury or illness
63. Services provided for any injury incurred during or resulting from the commission of, or an attempt to commit, a felony or injury and/or related illness incurred while engaging in an illegal act or occupation or participation in a riot.
64. Services of a private-duty nurse or other private-duty attendant are not covered

V.6. Utilization Management Program

The PEIA's utilization management program includes requirements governing hospital pre-admission review, post-admission review of emergency admissions, weekend admissions, optional second surgical opinions, mandatory outpatient procedures review, and medical case management. The intent of this program is to control claims cost by insuring the medical necessity and appropriateness of certain high-cost and over-utilized benefits.

Precertification/Notification Requirements.

Precertification of Inpatient (Admissions Mandatory). For providers participating in the PEIA Plan, precertification is the responsibility of the provider for both inpatient and outpatient services requiring precertification. **See Section V.5. Covered Services.** The PEIA PPB Plan requires that certain services and/or types of services be reviewed to determine whether they are medically necessary and to evaluate the necessity for Complex Condition CARE. Some services require "precertification," and other services require notification." Precertification is performed to determine if the admission/services are medically necessary and appropriate based on the patient's medical documentation. Notification to the TPA-UM is required to evaluate the admission/service in order to determine if the patient's medical condition will require case management, such as discharge planning for home health care services. Admissions for partial hospitalizations and day programs also require prior approval.

Notification:

Notification to the TPA-UM is required to evaluate the admission/service to determine if the patient's medical condition will require Complex Condition CARE, such as discharge planning for home health care services. Notification to UMR is required for the following services in WV:

1. Inpatient medical (non-surgical),

2. Inpatient surgical admissions (except those specifically listed as requiring precertification),
3. Inpatient mental health and substance abuse treatment
4. Maternity and newborn, and
5. Partial/day mental health or substance abuse treatment programs

Failure to pre-certify or notify TPA-UM of an admission within the timeframes specified in the chart below will result in a reduction of benefits under the PPB plan of 30%. This 30% penalty will be the responsibility of network providers. For all non-network providers in-state, this 30% penalty will be the responsibility of the insured in addition to any applicable copayment, coinsurance, deductible, and amounts that exceed PEIA's maximum allowance.

If the insured feels that TPA-UM inappropriately denied an admission, or that extenuating circumstances existed that prevented notification to TPA-UM within the timeframes set forth, the insured may file an appeal.

The TPA-UM will verify the medical necessity of the admission or procedure and determine the appropriate length of stay, when appropriate.

Timely Precertification/Notification Requirements	
Type of Admission	**Advance Notice Required**
Scheduled:	
Planned inpatient admission	Within 2 business days of admission
Inpatient or outpatient elective surgery or procedure	3 business days in advance for procedures requiring precertification. For inpatient notification only, see above.
Maternity (notify UMR during your first trimester)	
Term pregnancy	Within 2 business days of admission
Caesarean section (planned)	Within 2 business days of admission
Caesarean section (emergency)	Within 2 business days of admission
Other Admissions	
Urgent/Emergency service or procedure	Within 2 business days of admission

The insured is responsible to notify his/her provider or the admitting facility that he/she is a member of the PEIA, and that the PEIA has certain pre-certification requirements. For purposes of pre-certification, the insured's provider or the admitting facility must contact the TPA-UM. In circumstances when notice to the TPA-UM must be made within the above timeframes of admission, a family member or Authorized Individual must notify the TPA-UM if the provider is a non-participating provider. Participating providers will make the notification to the TPA-UM.

The TPA-UM may be notified of the admission by telephone or by letter. In either circumstance, the notice must be received by the TPA-UM in accordance with the time frames listed above. The request should be made no more than thirty days prior to the admission.

If the TPA-UM is notified by telephone during office hours, the decision to certify the admission may be made at that time, unless additional information is needed to make the decision. Once all information is received, the TPA-UM will make its decision within two (2) working days.

Whether approved or denied, the TPA-UM will send a letter to the insured, the physician, and the facility advising them of the approval or denial of the pre-certification request. This letter will be sent no later than one (1) working day after the decision by the TPA-UM has been made.

When a proposed admission is approved, the TPA-UM will notify the provider of the number of days approved for the insured. The participating provider must contact the TPA-UM to request additional days. It is the responsibility of the insured to request additional days if the provider is a non-participating provider. When determining whether additional days should be allowed, the TPA-UM will review the health care services delivered during the admission to determine if additional days at the facility are medically necessary. The TPA-UM will notify the insured and provider by telephone and will follow up with a confirming letter within one working day of making its decision.

If the insured is transferred to another facility, admission to the second facility requires precertification in accordance with this Section.

Failure to pre-certify an admission in accordance with the above timeframes will result in a thirty percent (30%) reduction of benefits under the Medical Benefits Plan. This thirty percent penalty will be the obligation of the insured for in-state non-participating providers and of the provider when the provider is participating. If the insured or provider feels that the TPA-UM inappropriately denied an admission or the extension of an admission, or that extenuating circumstances existed that prevented the insured from notifying the TPA-UM within the timeframes set forth in this Section, the insured or provider may appeal the decision in accordance with the procedures set forth herein.

Preauthorization. Preauthorization is a voluntary program which allows insureds to determine whether or not the charges for a procedure that has been recommended are covered under the Medical Benefit Plan. Obtaining preauthorization from the TPA-UM assures that the medical claim will be paid upon submission. Requests for preauthorization should be submitted to the TPA-C and should include the following information: insured's name, address, telephone number, Social Security number, information available about the procedure that has been recommended, and the name and address of the provider who has recommended the service. If a request for preauthorization is denied, the insured will be responsible for payment of the service if performed. To obtain preauthorization, the provider must submit the request electronically through UMR's iExchange portal or send the request to:

UMR
P.O. Box 30541
Salt Lake City, UT 84130-0541

Prior Approval of Out-of-State Services. Non-network out-of-state services are not covered. When West Virginia resident PEIA insureds receive care from out-of-state providers even if they do not participate in the PEIA PPO, the TPA-C must prior approve these services. Prior approval for access to out-of-state providers at the higher level of benefit will usually not be granted if the care is available at in-state providers. Prior approval may be requested by contracting the TPA-C. prior approval for access to non-network out-of-state providers will not be granted if the care is available in-state or in-network.

To be covered, prior approval is required for all non-emergency out-of-state (beyond the bordering counties to West Virginia) medical care that is provided to a PEIA insured who resides within the State of West Virginia or in a bordering county. Care provided outside of the state beyond counties with prior approval from UMR is covered at the higher level of benefit for insureds living within West Virginia or in a bordering county. PEIA insureds who reside beyond the bordering counties of West Virginia may seek medical care from any provider who participates in the UnitedHealthcare Choice Plus PPO without prior approval. Any services from a non-PPO out-of-state provider without prior approval are not covered. In-network, out-of-state care provided without prior approval from the TPA-C is only covered at the lower level of benefit, unless the person receiving the care also lives more than one county beyond the borders of West Virginia. For a detailed explanation, see Out-of-State Provider Networks in this Section. PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-network coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

Medical Complex Condition CARE. The TPA-UM provides medical case management services in cases involving expensive, serious, or long-term illness or injury and in maternity cases. This program assists the insured and/or provider in identifying available resources and containing the cost of long-term care while maintaining quality care and outcomes. The insured or participating provider, must notify the TPA-UM three (3) business days, where possible, prior to receiving any of the following covered services:

- Home health care for more than twelve (12) visits, including but not limited to skilled nursing visits, I.V. therapy in the home; physical, speech or occupational therapy done in the home, hospice care and medication provided or administered by a home health agency;
- Skilled nursing facility services of more than (7) seven visits;
- Durable medical equipment if $1, 000 or more for purchase and/or rental;
- Rehabilitation services;
- Physical, occupational or speech therapy in excess of the amount allowed under the Medical Benefits Plan;
- Mental health visits (outpatient) in excess of the amount allowed under the Medical Benefits Plan; and

- Pregnancy. Insureds (employee and employee spouse) who are pregnant must contact the TPA-UM within the first trimester of pregnancy or as soon as pregnancy is confirmed.

Transition of Care Program. To assist insureds that have been receiving treatment for serious medical conditions from out-of-state or out-of-network providers prior to their effective date of coverage in the PEIA PPB Plan, PEIA has a Transition of Care (TOC) program. Insureds who qualify for TOC can continue to receive medical treatment from an out-of-state non-PPO provider during a transition period and be covered at the in-network benefit level.

Following this transition period or after treatment is complete, medical care must be provided by a network provider to be eligible for the higher in-network level of benefits. Not all conditions will qualify for the TOC program.

Medical conditions likely to qualify include:

- Acute heart attack that occurred recently;
- Acute trauma such as a bone fracture;
- Cancer diagnosed recently requiring surgery, chemotherapy or radiation therapy;
- Pregnancy;
- Psychiatric treatments or substance abuse programs that qualify;
- Surgical procedures performed recently with complications; and
- Total joint replacement requiring physical therapy.

Medical conditions which are *not likely* to qualify for TOC benefits include:

- Allergies;
- Arthritis;
- Asthma;
- Diabetes; and/or
- Hypertension.

In most cases, an in-state provider can successfully treat these chronic conditions. If there is not an in-state provider available to treat a specific illness or condition, PEIA will work with the insured to provide that care. Conditions limited or excluded from coverage are not eligible for TOC benefits. A separate application for each TOC provider must be completed and submitted.

Insureds do not need to apply for TOC benefits if the treating physician participates in the PPB PPO. Applications can be obtained by contacting the TPA-C.

V.7. Claims

In-State Claims. As one of West Virginia's state health care programs, the PEIA uses an electronic claim clearing house for claims submitted by West Virginia providers.

Providers may submit claims electronically using ASAP-AP software (if submitting to the claims clearing house) or other software if compatible with the TPA-C's system, or manually by use of a HCFA 15 form (professional providers) or UB-92 form (facilities). Actual claims processing is performed by the TPA-C.

The PEIA pays directly to providers. An insured that pays for a covered service and wishes reimbursement may contact the TPA-C or the PEIA and obtain a PEIA claim form. This form, along with a copy of the receipt for services and itemized bill, must be forwarded to the TPA-C for processing. Cash register receipts and canceled checks are not sufficient proof of payment. A HCFA 1500 or UB-92 signed by the provider and indicating the amount paid by the insured will also be acceptable.

Insureds will be provided a medical/prescription drug identification card that must be presented to the provider at the time of service. This card will identify insureds with the PEIA PPB Plan and will allow insureds access to Out-of-State Provider Network benefits. The identification cards will be issued within 30 days of the date of enrollment. Additional cards may be acquired by contacting the TPA-P. If the insured is enrolled in a managed care plan, that plan will issue the medical identification card.

If the insured has other insurance that is primary, including Medicare, an Explanation of Benefits (EOB) form from the primary insurer must be submitted with the claims. The EOB form is usually submitted with the claim by the provider. The TPA-C will not process the claim until the EOB from the primary insurer is received.

Providers and insureds (if the insured paid the claim and is seeking reimbursement) must file claims within six months of the date of service. If Medicare is the primary insurer, the provider and insured will have six months from the date of the EOB to file claims. Failure to file a claim in a timely manner will result in the denial of the claim by the PEIA, and the PEIA will have no further obligation to pay the claim.

Out-of-State Claims. Claims for services from out-of-state providers will be processed differently than in-state claims, depending on whether the provider participates in the Out-of-State Provider Network. Non-network out-of-state claims are not covered.

PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-network coverage. For policyholders who are West Virginia residents but who have dependents who

reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

Out-of-State Provider Networks. Under the current TPA-C contract PEIA insureds have access to the PEIA/UMR Network. These networks allow a PEIA insured access to provider discounts on a national basis. Before obtaining the service, the insured should determine whether the provider is a member of the PEIA/UMR Network. The insured must pay any copayment, coinsurance and/or deductible due under the Medical Benefits Plan. A more detailed description of these networks is contained in Appendix F. Non-network out-of-state claims are not covered.

PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-state coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside west Virginia. All other services must be provided within West Virginia.

Out-of-State Waiver Program. Out-of-state, non-network services are not covered unless approved in advance by the TPA-C. However, PPB Plan insureds who receive services out-of-state from a provider that does not participate in the UnitedHealthcare Choice Plus PPO with prior approval of the TPA-C or in an emergency, may be subject to balance billing. In such circumstances, the insured may apply to PEIA requesting that the PEIA pay amounts exceeding the allowable charges under the Plan. The insured may request an Out-of-State Waiver form from the PEIA, complete the form and return it to the PEIA. The program is not available for air-ambulance fees in excess of the PEIA allowance.

PEIA PPB Plan D is the West Virginia ONLY plan. Members enrolling in this plan must be West Virginia residents, and all care provided under this plan must be provided in West Virginia. The only care allowed outside the State of West Virginia will be emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. The benefits (copayments, coinsurance, deductible and out-of-pocket maximum) of Plan D are identical to PEIA PPB Plan A, but there is no out-of-state coverage. For policyholders who are West Virginia residents but who have dependents who reside outside West Virginia (such as students attending college out-of-state), PEIA PPB Plan D will cover those out-of-state dependents for emergency care to stabilize the patient, and a limited number of procedures that are not available from any health care provider inside West Virginia. All other services must be provided within West Virginia.

The Director, has sole discretion, to grant the out-of-state waiver under the following circumstances:

1. The PEIA is the primary payor;
2. The insured is billed for amounts that exceed the PEIA allowable charge;
3. It was necessary for the insured to receive the service for one of the following reasons:
   *an emergency arises and out-of-state care can be reached more quickly;
   * the insured lives or is traveling out of state; or
   * the medically necessary service is not available in West Virginia; or
   * is not available within a reasonable travel time in West Virginia; and

4. If the insured has secondary insurance, an EOB from the secondary insurance must be submitted with the request.

If granted, the PEIA will pay the balance owed for covered services to the out-of-state provider, subject to an additional $500 annual deductible that will be applied against any amount over the allowable charge. This deductible, determined on a Plan Year, can be accumulated by an individual or a family. Under the PEIA PPB Plan, waivers will not be approved for amounts applied to the OOSINNA deductible or coinsurance, copayments, or non-covered services, or for penalties.

Claims Incurred Outside of the U.S. Insureds who incur medical or pharmaceutical expenses while traveling outside the United States may be eligible to receive reimbursement from the PEIA. The insured must forward a completed copy of the appropriate PEIA claim form along with the itemized bill to the TPA-C or TPA-P. The TPA will process the claim and determine the applicable exchange rate.

Court-Ordered Dependents. The legal custodian of a child covered under the non-custodial parent's plan as a result of a court order may submit claims for reimbursement directly to the TPA-C and TPA-P. The legal custodian must submit a certified copy of the divorce order requiring that coverage be provided by the non-custodial parent. The custodial parent must obtain a Court Ordered Dependent Claim Form and submit this form with an itemized bill. Reimbursement for claims will be processed and paid to the custodial parent if the claim indicates payment by the custodial parent. If the provider is paid, the custodial parent will receive the EOB. Ex-spouses are not eligible regardless of Court Order. PEIA is required by law to comply with National Medical Support Orders and may be compelled to administratively add coverage(s) for dependents listed in these Orders.

Assignment of Benefits. In accordance with W.Va. Code § 16-29D-4, any West Virginia provider who elects to see a PEIA insured must accept assignment of benefits. The provider may collect any copayment, coinsurance, or deductible that would be due under the Medical Benefits Plan at the time of service, if the provider knows the current allowed amount. Any provider who renders emergency medical service necessary to treat a life-threatening situation of a PEIA insured is not bound to accept assignment of benefits; however, once the patient is stabilized, any further services by the provider are subject to this provision. Providers who contract directly with the PEIA or with the PEIA's contracted TPA-C or TPA-P must accept assignment at all times.

V.8. Cost Controls

Coordination of Benefits (COB). In an effort to control health care costs, the PEIA has a coordination of benefits (COB) provision. Under this provision, when a PEIA insured also has coverage under another policy or policies, the rules described in Appendix G will determine how the PEIA will pay benefits. With respect to automobile medical payment policies, PEIA will pay as the primary plan and exercise its right of subrogation and full reimbursement against the medical payment insurance coverage.

Medicare Coordination. The PEIA PPB Plan will reimburse the difference between the amount allowed by Medicare and the amount paid by Medicare under Medicare Part A and Part B, if the balance is not more than the PEIA PPB Plan would have paid as the primary plan.

When Medicare is your primary insurer, all services are considered in-network and are processed at the higher benefit level.

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

Medicare Order of Determination. For retirees covered by PEIA and Medicare, regardless of age (see exception below), Medicare is the primary insurer under Medicare Part A and Part B, and PEIA is the secondary insurer. All medical claims must be submitted to Medicare and then to PEIA along with an Explanation of Medicare Benefits (EOMB). Generally, claims are submitted to Medicare and then to PEIA by your provider or by Medicare through the Medicare Crossover program.

When you become an eligible beneficiary of Medicare, you must enroll in Medicare Part A and Medicare Part B. Part A is an entitlement program and is available without payment of a premium to most individuals. Part B is the supplementary medical insurance program that covers physician services, outpatient laboratory and x-ray tests, durable medical equipment and outpatient hospital care. Part B is a voluntary program that requires payment of a monthly premium. You DO NOT need to enroll in Medicare Part D, the prescription drug program, since PEIA continues to provide prescription drug coverage for retirees with Medicare.

If you do not enroll in Medicare Part B, PEIA will process your claims as if you did have the Part B coverage. In other words, PEIA will pay only the amount we would have paid if Medicare had processed your claim and made a payment.

If you or your dependents have other coverage in addition to PEIA and Medicare, contact UMR or PEIA to determine what coverage will be primary, secondary or tertiary (third) and whether you need to enroll in Medicare Part B.

Exception: If you are entitled to Medicare as an End Stage Renal Disease (ESRD) beneficiary, call UMR or PEIA to determine who the primary insurer will be.

Subrogation and Reimbursement. If the PEIA pays an insured's medical expenses for an illness, injury, disease or disability for which another person's is legally liable, the PEIA has the right of subrogation and reimbursement. This right of subrogation allows the PEIA to be fully reimbursed for the expenses it has already paid, if the responsible person pays the insured, or pays a provider on the insured's behalf. The PEIA can only collect amounts that are related to that illness, injury, disease or disability.

The PEIA has the right to seek full and complete repayment of expenses from, among others, the party that caused the sickness, injury, disease, or disability, his or her liability carrier or the insured's own auto insurance carrier in cases of uninsured, underinsured medical payment coverage.

Subrogation and the right to full reimbursement applies, but it is not limited to, the following circumstances:

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

This right of subrogation and full reimbursement constitutes a lien against any settlement or judgment obtained by or on behalf of an insured for recovery of such benefits. Any such settlement or lien shall not preclude PEIA from enforcing its rights under this section.

When an insured incurs medical expenses for which the PEIA has a right of subrogation, the insured must:

- Notify the PEIA in writing of any injury, sickness, disease, or disability for which the PEIA has paid medical expenses on the insured's behalf that may be attributable to the wrongful or negligent acts of another person;

- Notify the PEIA in writing if the insured retains services of an attorney, and of any demand made or lawsuit filed on the insured's behalf, and on any offer, proposed settlement, accepted settlement, judgement, or arbitration award;

- Accept that the PEIA has the right to seek full repayment of expenses from, among others, the party that caused the sickness, injury, disease or disability, his or her liability carrier or the insured's own auto insurance carrier in cases of uninsured, underinsured or medical payment coverage; and

- Promptly and fully reimburse the PEIA for benefits paid on the insured's behalf attributable to the sickness, injury, disease, or disability, once the insured has obtained money through settlement, judgment, award, or other payment.

- Notify medical providers that they are covered by PEIA and provide their PEIA I.D. card,
  Failure to comply with any of these requirements may result in:

- PEIA's withholding payment of further benefits or recovery of payment from the provider; and

- The insured being obligated to pay attorney's fee and/or other expenses incurred by the PEIA in obtaining the required information or full reimbursement.

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

As with any claim, the claims resulting from an accident or other incident which may involve subrogation, must be submitted within the PEIA'S filing requirement. It is not necessary that any settlement, judgment, award, or other payment from a third-party have been reached or received before filing a claim with the PEIA.

Balance Billing. When PEIA is the primary payor, physicians, facilities, and other health care providers located within the State of West Virginia must as a matter of State law accept as payment in full the maximum allowed amount established by the PEIA for covered services. This provision is not subject to waiver by the insured. Such providers are prohibited from billing members for any charges other than deductibles, coinsurance, copayments, and for services not covered by the Plan. Where the services are provided outside of the State of West Virginia or where PEIA is the secondary payor, the above balance billing prohibition does not apply. In addition, the insured cannot be balance billed if the service is provided by participating UnitedHealthcare Choice Plus PPO Provider.

Balance billing prohibitions do not apply to air ambulance services without regard to geographic location of the provided service. However, while West Virgina law does not prohibit balance billing for air ambulance services, under federal law, balance billing for air ambulance services is prohibited unless notice and consent requirements are satisfied pursuant to the No Surprises Act. Balance billing prohibitions do not apply to pharmacists and pharmacies, outpatient oral surgery and other dental services in West Virginia.

Recovery of Overpayment, Incorrect Payments, or Payments Made for Which a Third-Party is Responsible. The PEIA has the right to recovery from any insured, provider or any other person or entity for benefits paid which are subsequently determined to be excessive, for non-covered services, are paid by PEIA when another party is responsible for the claim, or are otherwise improperly or incorrectly made. Failure of an insured or provider to cooperate fully with the PEIA to secure recovery of any such overpayments or incorrect payments from the insured or an entity to whom such overpayment has been made will result in either the amount of the overpayment being deducted from other benefits which are, or may become, payable to or on behalf of the insured, or from benefits payable to the provider, or the PEIA withholding benefits entirely. By agreeing to provide care, services, or products to a PEIA enrollee a provider agrees that it will cooperate with PEIA auditing of claims records.

This provision shall not limit the PEIA with respect to any other remedy provided by law.

Fraud or Misrepresentation. Insureds who intentionally provide false or misleading information to the PEIA or its TPAs or who fail to provide relevant information such as a divorce

or remarriage are subject to termination of coverage. PEIA may term the coverage(s) of dependents determined to be ineligible for coverage(s). In addition, PEIA may proceed with civil or administrative proceedings to recover any moneys expended and may report such activities to the appropriate law enforcement agency.

Providers who knowingly provide false or misleading information to the PEIA or its contracted benefit administrators will be reported to the appropriate law enforcement agency and/or licensing board. PEIA reserves the right to block, ban, or refuse payment to any provider identified as engaging in potentially fraudulent activity. In addition, the PEIA may proceed with civil or administrative proceedings to recover any moneys owed it.

In accordance with W.Va. Code § 5-16-12, the PEIA may withhold any payments due an insured or provider, or may directly offset any payments owed an insured or provider for whom it has evidence that the insured or provider has received an overpayment or unauthorized payment through fraud or misleading information.

PEIA Administrative Proceeding Procedures

Definitions

An "administrative proceeding" held by PEIA is authorized by W.Va. Code §§5-16-12 or 5-16-12a and a "hearing" may be held as part of the overall administrative proceeding.

The "Administrative Law Judge (ALJ)" is the person who conducts an administrative proceeding pursuant to W.Va. Code §§5-16-12 or 5-16-12a. The ALJ must be impartial and may not be someone who has had prior personal involvement with the material substance of the administrative proceeding.

A "party" in an administrative proceeding refers to PEIA and a person or entity to be heard in the administrative proceeding, typically a PEIA member or employer of a PEIA member, who:

(1) is requested by the PEIA Director to appear and participate at an administrative proceeding pursuant to W.Va. Code §§5-16-12 or 5-16-12a; or

(2) fails to respond to a request by the PEIA Director to appear and participate at an administrative proceeding pursuant to W.Va. Code §§5-16-12 or 5-16-12a, in which case such an administrative proceeding may proceed against the party in absentia.

Contacting the ALJ

Parties may contact the ALJ with questions regarding how the administrative proceeding will be conducted and the rules they must follow, but one party may not discuss information or facts regarding the substance of the case with the ALJ without the other party or the party's representative present, unless the administrative proceeding is being conducted in absentia due to failure of the party to respond to the notice of the administrative proceeding. All communication, both verbal and written, made to the ALJ must include the other party or the party's representative, unless the administrative proceeding is being conducted in absentia. A party against whom an administrative proceeding is being conducted in absentia will have written communications relating to the administrative hearing sent to their last known address (and email, if any) on record with PEIA. Such party is solely responsible for updating their address and email in PEIA's records.

Right to Representation

Parties have the right to be represented during the administrative proceeding by an attorney. If they decide to be represented, it is their responsibility to choose their own attorney. Neither PEIA nor the ALJ may recommend an attorney. PEIA will be represented by legal counsel at all times in the administrative proceeding. Each party will bear the cost of their respective attorney.

The Administrative Proceeding Process

An administrative proceeding may begin with a decision by the PEIA Director to hold an administrative proceeding under W.Va. Code §§5-16-12 or 5-16-12a. If, after notice of an administrative proceeding, it is determined the person has violated the article, the person is liable for any overpayment or improper receipt of benefits, which may be further enforced to the fullest extent of the law, including but not limited to, garnishment of wages, retirement benefits, tax returns, or other payments which may be enforced by the West Virginia State Auditor's Office or other authority, or in any court of competent jurisdiction. The Director may withhold and set off any payment of any benefits or other payment due to or on behalf of that person until any overpayment is recovered, and the Director may prevent additional coverage added to the member's current benefits or may ultimately terminate benefits for failure to pay the determined liability based upon an order issued by the ALJ. Appearances at any level may be in-person at PEIA's offices or virtually via telephone or an approved video conferencing platform.

Notice

PEIA is required to provide notice of an administrative proceeding and any hearing. The parties will receive notice of the first step in the administrative proceeding no less than thirty (30) days prior to the Counsel Conference via certified mail to their last known address (and email, if any) on record with PEIA. The responsive parties may waive the thirty (30) day notice but PEIA may not be able to accommodate a hearing on a shorter time frame. All parties must agree to any waiver of the thirty (30) day notice. Notice of a hearing may be sent by certified mail, by e-mail with a delivery confirmation, to counsel of record, or by certified service, e.g. the Sheriff or licensed process server.

Counsel Conferences

The initial notice to the party beginning the administrative proceeding will be for the required scheduling of a Counsel Conference. A Counsel Conference is a meeting between PEIA and the party designed and intended to resolve the matter at hand and allow for discovery by the non-PEIA party. Should the non-PEIA party fail to appear at the Counsel Conference, a formal prehearing conference with the ALJ will be scheduled.

Prehearing Conferences

PEIA will hold prehearing conferences with the ALJ following the scheduled Counsel Conference, even in cases where a tentative settlement agreement has been reached at the Counsel Conference. All parties are required to appear at the scheduled prehearing conference. Failure of the non-PEIA party to appear will result in a decision by the ALJ to immediately proceed from the prehearing conference to a final hearing without further scheduling, where the absent

party will be in "default" and the ALJ will interpret their absence to be an admission that all of the allegations contained in the complaint are true. In that event, the ALJ will enter an in absentia order in favor of the other party. If it is known that a party cannot appear, they must contact the ALJ promptly to ask for a change.

The purposes of a prehearing conference are to:

- clarify any misunderstandings;
- agree on as many of the undisputed facts as possible;
- identify the real disagreements to be addressed;
- set a timetable to prepare for and schedule the hearing.
- work toward agreeing to settle the administrative proceeding prior to hearing.

Settlement

Administrative proceedings may be settled by agreement on liability and successful payment in full acknowledged by PEIA or by an agreement and ALJ's order without a hearing. If payment in full is successfully made, PEIA will issue notice that the full amount of the liability has been resolved and the administrative proceeding is complete. All parties are free to respond to or to contact the other party or that person's attorney to discuss the possibility of settlement without involving the ALJ. If the parties are close to reaching a tentative settlement agreement as the prehearing conference or hearing approaches and need more time, they should ask the ALJ for a continuance to postpone the prehearing conference or hearing so they can continue to work on tentatively settling the administrative proceeding.

Unsuccessful settlement discussions are usually not disclosed to the ALJ. If the case goes to hearing, the content of unsuccessful settlement discussions cannot be mentioned at the hearing unless the parties agree to disclose such discussions.

When parties successfully agree to tentatively settle the matter, they may sign an agreement (called a "stipulation", "settlement agreement" or "compromise") setting forth the terms of the tentative settlement. Successful, tentative settlement may be finalized via a prehearing conference before the ALJ and the ALJ may issue an order, which is a command to the parties, accepting and implementing the settlement as the final result of the administrative proceeding. At such a time, the administrative proceeding is completed, and the order regarding settlement will be enforced by PEIA to the fullest extent of the law, including but not limited to, garnishment of wages, retirement benefits, tax returns, or other payments which may be enforced by the West Virginia State Auditor's Office or other authority, or in any court of competent jurisdiction. Settlement offers intended to avoid a final order from the ALJ which formally completes the administrative proceeding will not be considered.

Discovery and Documentary Evidence

Parties may want to use documents or other evidence to support their position. All parties should also understand that, prior to the hearing, each party has a right to know the other party's evidence. The process to find out about the other party's case is called "discovery." In the administrative proceeding, the parties are encouraged to fully and freely exchange medical

records and other documents. However, there is no formal discovery in PEIA cases, except as the ALJ may order.

Witnesses and Subpoenas

Parties may want to have one or more witnesses testify for them in the hearing. If so, they are responsible for having them appear. They may arrange for witnesses to appear voluntarily at the hearing or, they may request that PEIA issue a subpoena for the appearance of their witness. Parties may use a subpoena to order their requested witnesses to appear. Parties must arrange to have the subpoena served on their witness. Parties can do this themselves, as long as they prepare an affidavit of service. They also may have a subpoena served by the Sheriff's office or a private process-server. Along with a subpoena, the parties requesting the witness must include payment to the witness of a daily fee and mileage for appearing. They should also attach a map or directions to the hearing location, if needed. Because each party has a right to know what evidence will be presented by the other party, the ALJ will order each party to provide a list of their witnesses and to send copies of any documents the party may use in a hearing to the other party. The ALJ may make this order in a prehearing conference or issue a written order. The parties are required to exchange witness lists for PEIA hearings.

Rescheduling, Continuing, and Adjourning

Prior to the hearing, if a good reason is shown by either party, the ALJ can reschedule the hearing. The ALJ is not required to honor rescheduling request and may deny them if repeated requests are made. Once a hearing has started, the ALJ may continue it if more time is necessary. If a case settles, the ALJ will usually adjourn the hearing, not canceling it entirely but taking it off the calendar until the settlement is approved by the final decision-maker.

Appearing at the Hearing

If a case is not settled or rescheduled all parties must appear on the date specified in the notice of hearing. Parties may appear:

- in person representing themselves – "pro se."
- in person represented by counsel.
- via telephone representing themselves.
- via telephone represented by counsel.
- via an approved video conferencing platform.

If a party does not appear at a scheduled hearing, the party will be in "default" and the ALJ will interpret their absence to be an admission that all of the allegations contained in the complaint are true. In that event, the ALJ will enter an in absentia order in favor of the other party.

How a Hearing Is Conducted

The hearing will be conducted similar to a bench trial (without a jury). The ALJ will oversee the hearing and rule on procedure, the evidence which may be presented, and objections.

Each party may make an opening statement, as the ALJ may allow. If one is made, a party should briefly summarize their side of the story for the ALJ. For PEIA hearings, the usual practice does not include opening or closing statements.

Each party may then present evidence. Usually, the party who files the complaint or requests the appeal presents his or her evidence first. That party presents all their witnesses and other evidence and then the other party may do the same. Each witness can be questioned by both parties: first the party who called the witness (direct examination), then the other party (cross examination). Each party then gets a second opportunity to ask follow-up questions (re-direct and re-cross examination).

Evidence at the Hearing

The evidence may be in documents or oral testimony from witnesses. Witnesses will be sworn to tell the truth. A person may testify themselves and they may be called as a witness by another party. Refusal to answer questions only if their testimony might subject them to criminal prosecution is permitted.

Generally, witnesses can testify only about matters of which they have personal knowledge. Although the ALJ might allow a person to testify about what someone else told them, their case will be stronger if they call that person as a witness. If a problem is anticipated, such as whether a certain document will be admitted or certain testimony allowed, the issue can be discussed in a prehearing conference, or a party should advise the ALJ and the other party of this need as soon as possible.

Closing Statement

After all the evidence has been presented, each side may make a closing statement, as the ALJ may choose to allow. If allowed, a party may summarize or comment on the evidence that has been presented. They may also argue how the case should be decided. For PEIA hearings, the usual practice does not include opening or closing statements.

The Record

Each hearing is recorded by electronic means. Anybody may purchase a copy of the audio recording burned onto a CD or other media, or a written copy of the recording (called a "transcript"), if a transcript is made. The party requesting a written transcript shall bear the cost of such transcription.

Written Statements After the Hearing

Following the hearing, a party may be allowed to write a document which sets forth the facts and laws they believe are relevant. They may also argue for a particular outcome and against the other party's position. The ALJ will discuss with the parties whether they wish to submit such documents and the timetable for submitting them. Submission of such documents is not typical for PEIA hearings, but on occasion the parties may file briefs upon request of the ALJ.

If a complaint has been filed against a party, they do not have to "prove their case." PEIA has the burden of proving the allegations against the other party. This means that, for each

disagreement, PEIA must have the preponderance of evidence in its favor in order to prevail in that disagreement.

The Decision

The final decision-maker after a hearing is completed is the ALJ. Once the hearing is completed, the ALJ is responsible for preparing a Proposed or a Final Decision which sets out all the facts of the case, recites the law that governs the case, and applies the law to the facts. The most important questions to be answered are who prevailed on each disagreement and what the final outcome should be. Any Proposed or Final Decision must be in writing.

If the ALJ issues a Proposed Decision, it will be sent to all parties. They will be notified of a time in which to file written objections which will be considered by the ALJ. The Final Decision can be changed from the Proposed Decision, based upon the decision-maker's independent review of the evidence and the parties' objections.

Right to Appeal

A Final Decision will be sent to all parties. It will be accompanied by a notice of appeal rights. An appeal may be made by any party who disagrees with any outcome in the decision. The notice will explain how to make an appeal.

V.9. Appeals

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Participant is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, and the Participant will owe any amount to the provider, the Participant will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Participant to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Participant may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Participant of that fact. The Participant has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

PEIA PPB Plans

If you are a PEIA PPB Plan participant or provider and think that an error has been made in processing your claim or reviewing a service, the first step is to call the Third-Party Administrator to verify that a mistake has been made. All appeals must be initiated within one hundred and eighty (180) days of claim payment or denial.

Type of Error	Who to Call	Where to Write
Pre-Service Medical claim or Complex Condition CARE denial	UMR Appeals **1-888-440-7342**	UHC Appeals – UMR P.O. Box 400046 San Antonio, TX 78229 Fax: **1-888-615-6584** Attn: UMR Appeals
Post-Service Medical claim	UMR **1-888-440-7342**	UMR P.O. Box 30541 Salt Lake City, UT 84130-0541
Out-of-state care denial or denial of precertification	UMR **1-888-440-7342**	UMR P.O. Box 30541 Salt Lake City UT 84130-0541
Prescription drug claim	Express Scripts **1-877-852-4070**	Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588
Common Specialty Medications claim	Express Scripts **1-877-852-4070**	Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588
Specialty Injectable Drugs	UMR **1-888-440-7342**	UMR P.O. Box 30541 Salt Lake City, UT 84130-0541

How to appeal an adverse benefit decision (denied claims): This is a mandatory appeal level. The Covered Person must exhaust internal procedures before taking any outside legal action.

- If your medical claims or service has been denied, or if you disagree with the determination made by one of the Third Party Administrators, the second step is for you or your Authorized Individual to appeal in writing to the Third-Party Administrator at the address listed above. The Participant must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Participant received the EOB form seven days after the Plan mailed the EOB form. Explain what you think the problem is, and why you disagree with the decision. Please have your physician provide any additional relevant clinical information to support your request.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision and may not have been supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be

identified upon the Participant's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

- After the claim has been reviewed, the Participant will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Participant. The notification will provide the Participant with the information outlined under the "Adverse Benefit Determination" section above.

Filing a Second Appeal: This is a mandatory appeal level. The Participant must exhaust internal procedures before taking any outside legal action.

Your Plan offers two internal levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from PEIA. The Participant or their Authorized Individual must file the appeal within 60 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume the covered person received the EOB form seven days after the Plan mailed the EOB form. Appeals should be directed to the Director of the PEIA. Facts, issues, comments, letters, Explanation of Benefits (EOBs), and all pertinent information about the case should be included and mailed to: **Director, Public Employees Insurance Agency, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345**

When your request for review arrives, PEIA will reconsider the entire case, considering any additional materials which have been provided. If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with the medical director. This health care professional may not have been involved in the original denial decision or first appeal and may not have been supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Participant's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the Participant or his or her Authorized Individual. If additional information is required to make a decision, this information will be requested in writing. The additional information must be received within sixty (60) days of the date of the letter. If the additional information is not received, the case will be closed.

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Participant of it's decision within the following timeframes, although Participants may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide You with a reasonable opportunity

to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

URGENT CLAIM APPEALS THAT REQUIRE IMMEDIATE ACTION

A request by a Participant or their Authorized Individual for the review and reconsideration of coverage that requires notification or approval prior to receiving medical care may be considered an urgent claim appeal. Urgent claim appeals must meet one or both of the following criteria to be considered urgent in nature:

- A delay in treatment could seriously jeopardize life or health or the ability to regain maximum functionality.
- In the opinion of a Physician with knowledge of the medical condition, a delay in treatment could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

UMR must respond to the urgent claim appeal request as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receiving the request for review.

- Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 10 business days after the Plan receives the request for review for the first appeal, and another 10 business days for the second appeal.
- Post-Service Claims: Within a reasonable period of time, but no later than 30 calendar days after the Plan receives the request for review for the first appeal, and another 30 calendar days for the second appeal, or a maximum of 60 calendar days for the two appeal levels.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, you are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
  - Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;

- Whether a claim for items and services was furnished by a non-network provider at a network facility;
- Whether an individual gave informed consent to waive the protections under the No Surprises Act;
- Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
- Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or PEIA fails to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR nor PEIA will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request as indicated below.

In compliance with the No Surprises Act, the Plan covers ancillary non-emergency services provided by a nonparticipating provider, with respect to a visit at a participating facility, at a participating facility benefit level.

Notice of the right to external review for Pre-Service appeals should be sent to:

UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

Alternatively, You may fax Your request to 888-615-6584, ATTN: UMR Appeals

Notice of the right to external review for Post-Service appeals should be sent to:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Participant's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or PEIA. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by UMR and/or PEIA in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or PEIA.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or PEIA with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the claims administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

VI: PRESCRIPTION DRUG PLAN

VI.1. Introduction

The PEIA Prescription Drug Plan works in coordination with Medical Benefits Plan to assist in the payment of health care costs for PEIA insureds. The PEIA Prescription Drug Plan is available to all Participants in the PEIA PPB Plan. Participants in the PEIA PPB Plan B are subject to higher copayments and deductibles.

Both the claims-processing and utilization-review functions of the Prescription Drug Plan are administered by the TPA-P.

PEIA PPB Plan C

This plan is a High Deductible Health Plan that is different than the more traditional PEIA Plans A, B, & D. While the core benefits of Plan C are similar to Plans A and B, & D, the deductibles, copayments, coinsurance, and out-of- pocket expenses are very different. Certain benefits are also treated differently or are not available under Plan C. The Plan C section of the PEIA Summary Plan Description sets out the details of Plan C and should be referred to for Plan C information.

VI.2. Deductibles, Copayments and Plan Maximums

Deductibles. Before the PEIA pays for the cost of covered prescription drugs, the insured must have met an annual deductible. This deductible is $75 per person and $150 per family for Plans A and D, and $150 per person and $300 per family for Plan B for each Plan Year. Covered prescription drug purchases will be counted toward the annual deductible in the Plan Year of purchase, not the Plan Year they are billed to the PEIA. Only allowed expenses will be counted toward the deductible. Expenses that should be billed through the Medical Benefits Plan, including certain prescription drugs such as Hyalgan, Synvisc, immunizations and immune globulins will not be counted toward the Prescription Drug Plan deductible.

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

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

Copayments. Once an insured's annual deductible has been met, the Prescription Drug (PD) Plan will pay a portion of the cost of the insured's covered prescription drugs. The amount exceeding the deductible that the insured is responsible to pay is known as the copayment amount. PEIA's portion of the covered prescription cost is dependent on the type of drug and whether it is dispensed by a Network Pharmacy, a non-Network Pharmacy, or through the TPA-P's mail order service. A chart showing the current copayments under the Prescription Drug Plan (PD) is contained in Appendix H.

If a prescription is filled at a non-Network Pharmacy, the insured is responsible for the entire cost of the medication at the time of purchase and the claim can later be submitted to the TPA-P for payment. The insured will be reimbursed PEIA's allowed amount for the drug, which is based on the TPA-P contracted rate plus the dispensing fee, and minus the insured's responsibility. The Insured will be responsible for any difference in the submitted amount and the allowed amount. The allowed amount is usually less than the submitted amount. All prior authorization, step therapy, and quantity limits will still apply.

If you purchase a Maintenance Medication at a non-network pharmacy, you will not be reimbursed for your purchase. Maintenance Medications must be purchased from Retail Maintenance Network pharmacies or using the Express Scripts Mail Service Pharmacy Program.

VI.3. Copayments (Retiree Drug Copay Assistance)

Medicare-eligible retired employees who are in the MAPD with fifteen (15) years of service, whose total annual income is less than 250% of the current federal poverty level, may receive assistance in paying a portion of their drug copayments. Applicants must be enrolled in PEIA MAPD or The Medicare Special Plan. Managed care members are not eligible for this program. Applications are mailed to all retired PPB Plan members annually. (See Appendix H).

Prescription Out-of-Pocket Maximum. PEIA has an out-of-pocket maximum on drugs. The maximum is $1,750 for an individual and $3,500 for a family. The maximum is $250 for an individual Medical-eligible retired employee meeting the above requirements for Retiree Drug Copay Assistance. Once insureds have met the out-of-pocket maximum, PEIA will cover the entire cost of the insureds' prescriptions for the balance of the plan year. The out-of-pocket maximum only includes actual copays, not deductibles or other charges, and is separate from the medical plan out-of-pocket maximum.

Brand v. Generic. If an insured's doctor prescribes any generic drug, the copayment at a network drug store is $10.00 for up to a 30-day supply. If the medication is a brand-name and is included on the Preferred Drug List (PDL), the copayment at a Network Pharmacy is $25.00

($30.00 for PEIA PPB Plan B). However, if the medication is a Non-Preferred brand-name drug, the insured will pay a 75% coinsurance amount. Maintenance medications will only be covered for 90-day supplies when purchased from Retail Maintenance Network Pharmacies or Express Scripts Mail Service Pharmacy.

Non-Preferred Drugs. Non-preferred (tier 3) drugs are brand name drugs that do not appear on the PDL. Non-preferred drugs require 75% coinsurance after the prescription drug deductible.

If your doctor prescribes a non-preferred brand name drug, and you have tried and failed on the generic and preferred brand name alternatives offered by Express Scripts, your provider may file an appeal to lower your out-of-pocket cost. To file the appeal, your provider must submit medical justification, in writing, to:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588

Your tier appeal, if approved by Express Scripts, will lower your out-of-pocket cost from 75% of the cost of the drug to the $25 preferred drug monthly copay. For more information about tier appeals, you may contact Express Scripts at 1-855-224-6247.

VI.4. Providers

Pharmacy Network.

In order to control costs and ensure quality service, the PEIA utilizes the services of a pharmacy network. Services from a Network Pharmacy include:

- a controlled price on the cost of prescriptions;
- electronic claims filing; and
- the insureds' only having to pay the copayment at the time of the dispensing of the medication, providing that their prescription drug deductible has been met.

PEIA PPO Network pharmacies should display a sign indicating that they are part of the Network. An insured who has a question whether a pharmacy is in the PEIA PPO Network may contact either the specific pharmacy or the TPA-P. The network includes most pharmacies in West Virginia and large chain pharmacies out of state. The PEIA will include Plan incentives to encourage the use of the Network by PEIA insureds.

Maintenance medications must be purchased in 90-day supplies at either a Retail Maintenance Pharmacy or from the Express Scripts Mail Service Pharmacy Program.

Non-Network Providers.

The PEIA will pay for covered prescriptions filled at a non-Network Pharmacy, however, a higher out-of-pocket expense will apply (see Appendix H). The insured must pay the full price of the non-Network claim at the time of the dispensing of the medication and seek reimbursement from PEIA for the covered amount (see **Filing Claims** in this section). The insured will be reimbursed PEIA's allowed amount for the drug, which is based on the TPA-P contracted rate plus the dispensing fee, and minus the insured's responsibility. The allowed amount is usually less than the submitted amount.

A non-Network Pharmacy may not be familiar with prescription drugs covered under the PEIA Prescription Drug Plan. The non-Network Pharmacy or the insured may contact the TPA-P to determine whether the prescription drug will be a covered expense by the PEIA. Determining whether the prescription is covered under the PEIA Prescription Drug Plan is the ultimate responsibility of the insured, and the PEIA will not reimburse the insured for any prescription drugs not covered, even if the insured mistakenly thought the prescription was a covered expense.

Mail Order Service or Retail Maintenance Pharmacies

Through the current TPA-P, PEIA insureds have access to a prescription mail order service or retail maintenance pharmacies. Drugs prescribed by a physician that are included on the Maintenance Drug List must be filled by mail or at a participating retail maintenance pharmacy in a 90-day supply for the price of two copayments (See Maintenance Medications section in the SPD) for generic and brand-preferred medications only. The insured may check with local pharmacies to verify participation in the retail maintenance program.

If using the mail order service, the insured must submit a prescription from the physician written for a 90-day supply along with a completed Mail Service Pharmacy Order Form and payment to the TPA-P. The insured should notify the TPA-P of any changes in prescription information by submitting a new form. Refills of maintenance medications can be placed over the phone by contacting the TPA-P's customer service department. Any prescriptions submitted to the TPA-P that are not available by mail order will be returned to the insured.

VI.5. Covered Prescriptions

Specific Prescriptions.

The following prescription drugs and medical items are covered under the Prescription Drug Plan when prescribed by a provider authorized by law to prescribe the medication:

- Aerochamber spacers;
- One Touch Ultra test strips, One Touch Verio test strips, One Touch strips, One Touch Blue test strips;
- Compound medication that received prior authorization and approval;
- Disposable needles/syringes;
- Glucose elevating agents;

- Inspirease spacers;
- Insulin;
- Lancets;
- Legend contraceptives, oral and injectable contraceptives may be dispensed in up to a 90-day supply. Pursuant to W.Va. Code §5-16-28, PEIA provides coverage for a 12-month refill of contraceptive drugs obtained at one time after the insured has completed the initial supply of the drugs, unless the insured requests a smaller supply or the prescribing provider instructs that the insured must receive a smaller supply;
- Legend drugs. Exceptions: See Exclusion list in this Section; and
- Tretinoin topical (e.g., Retin-A) for individuals through the age of 35 years.

Preferred Drug List.

The current TPA-P for PEIA offers a listing of brand-name and generic medications that have been proven to be safe, effective treatments and is available at a reduced cost. The copayments for drugs listed on the Preferred Drug List (PDL) are $10.00 for generic and $25.00 ($30.00 for PEIA PPB Plan B) for brand-name drugs.

The PDL includes drugs to treat the following conditions:

- Asthma – beta agonist and corticosteroid inhalers, corticosteroid nasal sprays;
- Immunosuppressant's – alkylating agents, antimetabolites, androgens, and hormones;
- Anxiety – anxiolytics;
- Arthritis – non-steroidal anti-inflammatory drugs (NSAIDs);
- Cardiovascular – ACE inhibitors, angiotensin II receptor blockers, alpha – 1 blockers, beta blockers and calcium channel blockers for high blood pressure; HMG Co -A reductase inhibitors for high blood cholesterol;
- Central Nervous System – narcotic analgesics, anxiolytics, sedative/hypnotics, anticonvulsants, antivertigo, antiemetics, antiparkonism agents, antipsychotic drugs, CNS stimulants;
- Depression – antidepressants;
- Dermatological/Topical – corticosteroids, anesthetics and acne;

- Diabetes – insulin, blood glucose strips, sulfonylureas, insulin sensitizers, oral hypoglycemic;
- Gastrointestinal conditions – H^2 antagonists, proton pump inhibitors to treat ulcers and reflux;
- Glaucoma – alpha agonist, beta blockers, carbonic anhydrase inhibitors, prostaglandin;
- Infections – antibiotics, antifungals, and antivirals to treat common infections like bronchitis, ear infections, toenail and fingernail infections, herpes;
- Migraine – selective serotonin – 1 receptor agonists;
- Topical – anesthetics, corticosteroids, anti-acne drugs, keratolytics, anti-psoriasis and anti-eczema drugs, drugs affecting the ear, nose, throat and mouth;
- Urological – anticholinergics, antispasmodics and benign prostatic hyperplasia therapy;
- Vitamins – prenatal and multi-vitamins; and
- Women's health conditions – hormone replacement (menopause), oral contraceptives, selective estrogen receptor modulators (osteoporosis prevention);

A PDL is distributed to all insureds and is also available by contacting the TPA-P or on-line at peia.wv.gov.

Prior Authorization.

The PEIA PPB Plan prescription drug program provides coverage for **some** drugs only if they are prescribed for certain uses and amounts, so those drugs require prior authorization for coverage. If a medication must be authorized, the pharmacist or physician can initiate the review process for you. The prior authorization process is typically resolved over the phone; if done by letter, it can take up to two business days. If the medication is not approved for plan coverage, the insured will have to pay the full cost of the drug.

PEIA will cover, and the pharmacist can dispense, up to a five-day supply of a medication requiring prior authorization for the applicable copayment. This policy applies when the prescribing doctor is either unavailable or temporarily unable to complete the prior authorization process promptly. If the prior authorization is ultimately approved, the pharmacist will be able to dispense the remainder of the approved amount with no further copayment for that month's supply if the insured has already paid the full copayment.

The medications listed below require prior authorization:

1. Adrenal Hormones* (Acthar, Cortrophin, Tarpeyo)

2. Akylating Agents* (Temodar, Temozolomide)

3. Antiasthmatics (Advair, Airduo, Breo ellipta, Daliresp, Dulera, Roflumilast, Symbicort, Wixela)

4. Antifungals – Oral (Cresemba, Noxafil, Vfend, Voriconazole)

5. Colony Stimulating factors* (Aranesp, Epogen, Neupogen, Procrit, Retacrit)

6. Compounded medications

7. Continuity of Care (requested drug dispensed within the last 90 days approved for

coverage previously by a prior plan)

8. Diuretics* (Jynarque, Samsca, Tolvaptan)

9. . Eye Preparations - Tears (Cequa, Cyclosporine, Restasis, Verkazia)

10.. Fentanyl drugs (Actiq®, Duragesic®, Fentora®, Lazanda®, Subsys)

11. Forteo*

12. Gastrointestinal* (Bylvay, Livmarli, Ocaliva, Xermelo)

13. GLP-1 Agonists/ Incretin Mimetics Combination (Adlyxin, Byetta, Bydureon, Mounjaro, Ozempic, Rybelsus, Trulicity, Victoza)

14. Growth Hormones* (Gemnotropin,Humatrope, Norditropin Flexpro, Omnitrope, Skytrofa)

15. Hepatitis-C medications* (Harvoni, Epclusa)

16. Increlex*

17. Immunosuppressants* (Dupixent, Kevzara, Skyrizi, Stelara)

18. Lidocaine Patches

19. Lupron*

20. Medications to treat cancer*

21. Medications to treat Inflammatory Conditions

22. Medications to treat Prostate Cancer*

23. Omnipod

24. Ophthalmic Prostaglandin (Latanoprost, Lumigan, Xalatan , Travatan Z, Zioptan)

25. Opioids - Short and Long-acting, MEQD, and day limit rules

26. Pulmonary Arterial Hypertension* (Bosentan, Tracleer, Tyvaso)

27. Revlimid*

28. Sedative/Hypnotics (Ambien, Belsomra, Dayvigo, Edluar, Intermezzo, Lunesta, Rozerem, Quviviq, Silenor, Zaleplon, Zolpimist)

29. Sickle Cell Anemia* (Endari, Oxbryta)

30. Specialty medications*

31. Testosterone products (Androderm, AndroGel, Depo-Testosterone, Fortesta, Natesto, Striant, Testim, Vogelxo, Xyosted)32. Vacation supplies of medication for foreign travel (allow 7 days for processing)

33. V-go

34. Vitamin A derivatives – Topical Tretinoins (Altreno, Atralin, Avita, Retin-A, Retin-A Micro, Tazorac, Tretin-X)

35. Xyrem*, Xywav*

*These drugs must be purchased through the Common Specialty Medications Program.

1 PEIA will honor a prior authorization approved by your previous insurer for the first 3 months of your enrollment in PEIA if the services are provided within the state to allow time for your provider's office to work through any prior authorizations and appeals. The medication is still subject to all prior authorization, step therapy, and quantity limits. It is important your provider's office let the Rational Drug Therapy Program (for non-specialty medications) or Express Scripts (for specialty medications) know you are new to PEIA.

2 PEIA will cover any prescription requiring a prior authorization written for an inpatient at the time of discharge for three days: Provided, That the cost of the medication does not exceed $5,000 per day and the provider has noted on the prescription or notified the pharmacy that the prescription is being provided at the time of discharge. After the three-day time frame, a prior authorization shall be obtained.

This list is subject to change during the plan year if circumstances arise which require adjustment, and notice will be provided no later than 60 days prior to the date on which the modification will become effective.

VI.6. Drugs with Special Limitations

Step Therapy

Step Therapy promotes appropriate utilization of first-line drugs and/or therapeutic categories. Step Therapy requires that participants receive one or more first-line drug(s), as defined by program criteria before prescriptions are covered for second-line drugs in defined cases where a step approach to drug therapy is clinically justified. To promote use of cost-effective, first-line therapy, PEIA uses step therapy in the following therapeutic classes:

Examples of medications with step therapy are listed below. This list is not all-inclusive.

1. Acne agents - Topical (Aczone, Avar, Cleocin, Epiduo, Plexion, Rosula)
2. ADHD (Adhansia XR, Concerta, Daytrana, Focalin XR, Methylphenidate, Quillichew, Ritalin)
3. Amphetamines (Adderall XR, Adzenys, Dexedrine, Dyanavel, Mydayis, Vyvanse)
4. Antibiotics - Topical (Altabax, Mupirocin, Xepi)
5. Antifungals - Topical (Ciclodan, Penlac)

6. Angiotensin II Receptor Blockers & Renin Inhibitors (Atacand, Avapro, Benicar, Cozaar, Diovan, Edarbi, Edarbyclor, Hyzaar, Micardis)
7. Anticonvulsants (Depakote, Keppra, Lamictal, Namenda, Neurontin, Spritam, Topamax, Vimpat)
8. Antidepressants (Cymbalta, Drizalma, Effexor, Fetzima, Pristiq)
9. Antihistamines (Carbinoxamine Maleate, Karbinal, Ryvent)
10. Antihypertensive Combinations (Azor, Exforge, Twynsta, Tribenzor)
11. Antiparkinson drugs (Azilect, Xadago)
12. Antipsoriatic / Antiseborrheic (Dovonex, Pramosone, Sorilux, Taclonex, Wynzora)
13. Benign Prostatic Hyperplasia (Flomax, Rapaflo, Uroxatral)
14. Corlanor
15. Corticosteroids – Topical (Apexicon, Cordran, Halog, Nucort, Topicort, Triderm, Tridesilon)
16. Diabetes - Oral (Actos, Avandia, Farxiga, Fortamet, Glucophage XR, Glumetza ER, Invokana, Jardiance, Metformin ER, Riomet, Steglujan, Synjardy, Trijardy)
17. Eye Anti-inflammatory agents (Acular, Alrex, Durezol, Flarex, Lotemax, Maxidex, Pred mild)
18. Gout therapy (Colcrys, Colchicine, Febuxostat, Uloric)
19. Immunosuppressants (Astagraf, Envarsus)
20. Intranasal Steroids (Beconase, Dymista, Mometasone Furoate, Nasonex, Qnasl, Zetonna)
21. Lipid/Cholesterol Lowering agents (Crestor, Lescol, Lipitor, Livalo, Pravachol, Vytorin, Zocor)
22. Narcolepsy and sleep disorder (Armodafinil, Nuvigil, Provigil, Sunosi)
23. Neurological therapy (Aricept, Exelon, Namenda, Razadyne)
24. NSAIDS (Arthrotec, Cambia, Celebrex, Celecoxib, Daypro, diclofenac potassium, Feldene, Flector, ketoprofen capsules, Meloxicam, Mobic, Naproxen, Relafen, Sprix, Tivorbex, Vivlodex, Voltaren, Zorvolex)
25. Osteoporosis (Actonel, Binosto, Boniva, Fosamax)
26. Overactive Bladder (Detrol, Ditropan, Enablex, Oxytrol, Toviaz, Vesicare)
27. Proton Pump Inhibitors (Aciphex, Dexilant, Dexlansoprazole, Esomeprazole, lansoprazole ODT, Nexium, Prevacid, Prilosec, Protonix, Zegerid)
28. Rheumatological agents (Otrexup, Rasuvo, Reditrex, Savella)
29. Selective Serotonin Reuptake Inhibitors (Celexa, Lexapro, Paroxetine, Paxil, Prozac, Zoloft)

This list is subject to change during the plan year if circumstances arise which require adjustment, and notice will be provided no later than 60 days prior to the date on which the modification will become effective.

Quantity Limits (QL)

Under the PEIA PPB Plan Prescription Drug Program, certain drugs have preset coverage limitations (quantity limits). Quantity limits ensure that the quantity of units supplied in each

prescription remains consistent with clinical dosing guidelines and PEIA's benefit design. Quantity limits encourage safe, effective and economic use of drugs and ensure that members receive quality care. If you are taking one of the medications listed below and you need to get more of the medication than the plan allows, ask your pharmacist or doctor to call RDT or Express Scripts to discuss your refill options.

This list is subject to change during the plan year if circumstances arise which require adjustment, and notice will be provided no later than 60 days prior to the date on which the modification will become effective.

Examples of medications with quantity limits are listed below. This list is not all-inclusive.

THERAPEUTIC CATEGORY	QUANTITY LIMIT
ANDROGENIC AGENTS	ANDRODERM IS LIMITED TO 30 PATCH PER FILL
ANDROGENIC AGENTS	NATESTO IS LIMITED TO 22 GRAM PER FILL
ANDROGENIC AGENTS	TESTOSTERONE IS LIMITED TO 75 GRAM PER FILL
ANTIEMETIC/ANTIVERTIGO AGENTS	APREPITANT IS LIMITED TO 1 UNIT PER FILL
ANTIEMETIC/ANTIVERTIGO AGENTS	GRANISETRON HCL IS LIMITED TO 6 UNIT PER FILL
ANTIEMETIC/ANTIVERTIGO AGENTS	ONDANSETRON ODT IS LIMITED TO 9 UNIT PER FILL
ANTIEMETIC/ANTIVERTIGO AGENTS	ONDANSETRON HCL IS LIMITED TO 100 UNIT PER FILL
ANTIEMETIC/ANTIVERTIGO AGENTS	VARUBI IS LIMITED TO 2 TABLET PER FILL
ANTIHYPERGLYCEMICS	BYETTA IS LIMITED TO 1 PEN PER 23 DAYS

ANTIHYPERGLYCEMICS	MOUNJARO IS LIMITED TO 2 MILLILITERS (4 PENS) IN 21 DAYS
ANTIHYPERGLYCEMICS	OZEMPIC IS LIMITED TO 1 PEN PER 21 DAYS
ANTIHYPERGLYCEMICS	RYBELSUS IS LIMITED TO 30 TABLETS IN 23 DAYS
ANTIHYPERLIPIDEMIC	EZETIMIBE-SIMVASTATIN IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	AMLODIPINE-ATORVASTATIN IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	ATORVASTATIN CALCIUM IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	FLUVASTATIN SODIUM IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	LOVASTATIN IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	LIVALO IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	PRAVASTATIN SODIUM IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	ROSUVASTATIN CALCIUM IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	SIMVASTATIN IS LIMITED TO 30 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	ALMOTRIPTAN MALATE IS LIMITED TO 12 UNIT PER FILL

ANTIMIGRAINE PREPARATIONS	DIHYDROERGOTAMINE MESYLATE IS LIMITED TO 8 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	ELETRIPTAN HBR IS LIMITED TO 6 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	AIMOVIG AUTOINJECTOR IS LIMITED TO 1 UNIT IN 23 DAYS
ANTIMIGRAINE PREPARATIONS	AJOVY AUTOINJECTOR IS LIMITED TO 3 UNIT IN 68 DAYS
ANTIMIGRAINE PREPARATIONS	FROVATRIPTAN SUCCINATE IS LIMITED TO 9 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	EMGALITY IS LIMITED TO 1 UNIT IN 23 DAYS
ANTIMIGRAINE PREPARATIONS	NARATRIPTAN HCL IS LIMITED TO 9 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	RIZATRIPTAN IS LIMITED TO 18 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	SUMATRIPTAN IS LIMITED TO 6 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	SUMATRIPTAN SUCC-NAPROXEN SOD IS LIMITED TO 9 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	SUMATRIPTAN SUCCINATE IS LIMITED TO 1 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	ZOLMITRIPTAN IS LIMITED TO 6 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	ZOMIG IS LIMITED TO 6 UNIT PER FILL

ANTIPSYCHOTIC,ATYPICAL	ASENAPINE MALEATE IS LIMITED TO 60 TABLET PER FILL
ANTIPSYCHOTIC,ATYPICAL	LATUDA IS LIMITED TO 30 TABLET PER FILL
ANTIPSYCHOTIC,ATYPICAL	OLANZAPINE IS LIMITED TO 30 TABLET PER FILL
ANTIPSYCHOTIC,ATYPICAL	PALIPERIDONE ER IS LIMITED TO 30 TABLET PER FILL
ANTIPSYCHOTIC,ATYPICAL	QUETIAPINE FUMARATE ER IS LIMITED TO 30 TABLET PER FILL
ANTIPSYCHOTIC,ATYPICAL	RISPERIDONE IS LIMITED TO 60 TABLET PER FILL
ANTIPSYCHOTIC,ATYPICAL	ZIPRASIDONE HCL IS LIMITED TO 60 CAPSULE PER FILL
ANTIPSYCHOTICS, ATYPICAL	ARIPIPRAZOLE IS LIMITED TO 30 TABLET PER FILL
INHALERS	SYMBICORT IS LIMITED TO 11 UNIT PER FILL
INHALERS	ADVAIR HFA IS LIMITED TO 12 UNIT PER FILL
INHALERS	FLUTICASONE-SALMETEROL IS LIMITED TO 1 UNIT PER FILL
INHALERS	WIXELA INHUB IS LIMITED TO 1 UNIT PER FILL
INHALERS	BREO ELLIPTA IS LIMITED TO 60 UNIT PER FILL

INHALERS	DULERA IS LIMITED TO 1 UNIT PER FILL
INHALERS	BREZTRI AEROSPHERE IS LIMITED TO 10.7 GRAM PER FILL
INHALERS	TRELEGY ELLIPTA IS LIMITED TO 60 UNIT PER FILL
ESTROGENS	DOTTI IS LIMITED TO 8 PATCH IN 21 DAYS
ESTROGENS	ESTRADIOL IS LIMITED TO 4 PATCH IN 21 DAYS
ESTROGENS	LYLLANA IS LIMITED TO 8 PATCH IN 21 DAYS
ORAL INHALERS	QVAR REDIHALER IS LIMITED TO 11 GRAM PER FILL
ORAL INHALERS	BUDESONIDE IS LIMITED TO 120 UNIT PER FILL
ORALINHALERS	ARNUITY ELLIPTA IS LIMITED TO 1 INHALER PER FILL
ORAL INHALERS	ARMONAIR RESPICLICK IS LIMITED TO 1 INHALER PER FILL
ORAL INHALERS	FLOVENT DISKUS IS LIMITED TO 1 UNIT PER FILL
ORAL INHALERS	FLOVENT HFA IS LIMITED TO 12 UNIT PER FILL
ORAL INHALERS	ASMANEX IS LIMITED TO 1 UNIT PER FILL
ORAL INHALERS	ASMANEX HFA IS LIMITED TO 13 GRAM PER FILL

LOCAL ANESTHETICS	GLYDO IS LIMITED TO 60 MILLILITER IN 23 DAYS
LOCAL ANESTHETICS	LIDOCAINE HCL IS LIMITED TO 60 MILLILITER IN 23 DAYS
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	BUPROPION XL IS LIMITED TO 30 TABLET PER FILL
OPHTHALMIC ANTI-INFLAMMATORY	RESTASIS IS LIMITED TO 60 UNIT PER FILL
OPHTHALMIC ANTI-INFLAMMATORY	RESTASIS MULTIDOSE IS LIMITED TO 6 MILLILITER PER FILL
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	CITALOPRAM HBR IS LIMITED TO 30 TABLET PER FILL
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	ESCITALOPRAM OXALATE IS LIMITED TO 30 TABLET PER FILL
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	FLUVOXAMINE MALEATE IS LIMITED TO 60 CAPSULE PER FILL
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	PAROXETINE HCL IS LIMITED TO 30 TABLET PER FILL
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	SERTRALINE HCL IS LIMITED TO 60 TABLET PER FILL
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	DESVENLAFAXINE SUCCINATE ER IS LIMITED TO 30 TABLET PER FILL
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	DULOXETINE HCL IS LIMITED TO 60 CAPSULE PER FILL
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	FETZIMA IS LIMITED TO 28 CAPSULE PER FILL

SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	VENLAFAXINE HCL ER IS LIMITED TO 30 CAPSULE PER FILL
TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY,STEROID AGENT	CLOTRIMAZOLE/BETAMETHASONE IS LIMITED TO 45 GRAM IN 21 DAYS
TOPICAL ANTIFUNGALS	NYSTATIN IS LIMITED TO 30 GRAM IN 21 DAYS
TOPICAL ANTIFUNGALS	NYSTATIN W/TRIAMCINOLONE IS LIMITED TO 60 GRAM IN 21 DAYS
TOPICAL LOCAL ANESTHETICS	LIDOCAINE IS LIMITED TO 50 GRAM IN 21 DAYS

Exclusions. The following prescriptions, in addition to those listed in the Summary Plan Description (SPD) are excluded from the Prescription Drug Plan:

1. Abortifacient (i.e., Mifeprex)
2. Anorexiants (any drug used for the purpose of weight loss)
3. Anti-wrinkle agents (e.g. Renova®)
4. Arestin
5. Bleaching agents (e.g., Eldopaque®, Eldoquin Forte®, Melanex®, Nuquin®, Solaquin®)
6. Bulk ingredients (i.e. bulk chemicals, bulk powders, bulk compounding ingredients, hormone replacement bulk ingredients, high cost bases, compound kits, etc.)
7. CeQur, Finesse® and all other disposable insulin delivery systems, except Omnipod and VGo.
8. Charges for the administration or injection of any drug
9. Compounds containing one or more ingredients which are commercially available in alternate medications, are an over-the-counter (OTC) product or lack clinical evidence in compounded dosage forms. This list is subject to change throughout the Plan Year.
10. Contraceptive devices and implants
11. Diagnostic agents
12. Drugs dispensed by a hospital, clinic or physician's office
13. Drugs excluded from the formulary by Express Scripts. You can find a list of these medications at https://peia.wv.gov/prescription_drug_lists/Documents/Formulary_Exclusions.pdf
14. Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs not approved by the FDA, even though a charge is made to the individual.
15. Drugs requiring prior authorization when prescribed for uses and quantities not approved by the FDA
16. Drugs requiring a prescription by State law, but not by federal law (State controlled) are not covered
17. Erectile dysfunction medications
18. Fertility drugs
19. Fioricet® with Codeine (butalbital/acetaminophen caffeine with codeine)
20. Fiorinal® with Codeine (butalbital/aspirin caffeine with codeine)

21. Hair growth stimulants
22. Homeopathic medications
23. Hypoactive Sexual Desire Disorder (HSDD) Agents
24. Immunizations, biological sera, blood or blood products, Hyalgan®, Synvisc®, Remicade®, Synagis®, Xolair®, Amevive®, Raptiva®, Vivitrol®, (these are covered under the medical plan)
25. Latisse™
26. Medical or therapeutic foods
27. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, sanitarium, or extended care facility
28. Medications for which the cost is recoverable under any Workers' Compensation or occupational disease law, or any State or governmental agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
29. Newly released prescription medications that have been on the market less than 4 months
30. Non-legend drugs
31. Nutritional Supplements (that require a prescription, i.e., Metanx, Limbrel, Deplen)
32. Pentazocine/Acetaminophen (Talacen®)
33. Prescription drug charges not filed within 6 months of the purchase date, if PEIA is the primary insurer, or within 6 months of the processing date on the Explanation of Benefits (EOB) from the other plan, if PEIA is secondary.
34. Products unapproved by the FDA.
35. Replacement medications for lost, damaged or stolen drugs
36. Requests for less than a 90-day supply of maintenance medications, or requests for more than a 30-day supply of short-term medications.
37. Respiratory Therapy Supplies: Nebulizers
38. Respiratory Therapy Supplies: Peak Flow Meters
39. Stadol® Nasal Spray (butorphanol)
40. Select medical devices and artificial saliva products (e.g., Avenova, Beau Rx, Eletone, Epiceram, HPR Plus, PromiseB, NetraSal, SalivaMAX)
41. Select medications with clinically appropriate, cost-effective alternatives (e.g., Absorica, Absorica LD, almotriptan, Aplenzin, carvediol ER (extended release only), citalopram capsule, dihydroergotamine injection/nasal spray, doxycycline 40mg, Duexis, frovatriptan, Jublia, Kerydin, metformin ER modified/osmotic, naratriptan, Nascobal, Onzetra, pramipexole ER, Sitavig, sumatriptan STAT dose injection (auto injector only), sumatriptan/naproxen, Tosymra, Trudhesa, venlafaxine ER tablet, Vimovo, Xerese, Zavzpret, Zipsor, zolmitriptan ODT, zolmitriptan 5mg spray, zolmitriptan tablet, Zomig 2.5mg nasal spray, Zyflo)
42. Specialty Mental Health Category (e.g., Spravato, Zulresso)
43. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those listed above.
44. Unit dose medications
45. Vacation supplies, unless leaving the country. If you are leaving the country, and want PEIA to cover a vacation supply, you must submit documentation (copy of an airline ticket, travel agency itinerary, etc.) to substantiate your international travel arrangements. Please allow seven (7) days for processing.

46. Services provided for any injury incurred during or resulting from the commission of, or an attempt to commit, a felony or injury and/or related illness incurred while engaging in an illegal act or occupation or participation in a riot.

Dispensing Limits

Acute Medications. Reimbursement for medication taken for short periods to treat acute medical conditions will be limited to a 30-day supply when the prescription is filled, and each time it is refilled. If a larger supply is purchased, the insured will be responsible for the charge in excess of the cost of the 30-day supply.

Maintenance Medications. A maintenance drug is taken for a long-term condition such as high blood pressure or diabetes. Maintenance medications can be purchased in a 90-day supply through the TPA-P's mail order service or participating retail maintenance pharmacies at the price of only two copayments for generic and brand-preferred medications only.

All Maintenance Medications must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through Express Scripts mail service. You must receive a 90-day supply of the medications and classes listed below. Maintenance medications dispensed in quantities less than 90 days are not covered by the plan. If you are starting on a new maintenance medication, you may receive up to two 30-day fills to be sure you tolerate the medication and that your dosage is correct. After the second 30-day fill, the maintenance medication will be covered only in a 90-day supply, and only when filled at a Retail Maintenance Network pharmacy or using the Express Scripts Mail Service Pharmacy Program. Pursuant to W.Va. Code §5-16-28, PEIA provides coverage for a 12-month refill of covered contraceptive drugs obtained at one time after the insured has completed the initial supply of the drugs, unless the insured requests a smaller supply or the prescribing provider instructs that the insured must receive a smaller supply. Such contraceptive coverage shall allow the insured to receive the contraceptive drugs on-site at the providers's office, if available, and prescribing and dispensing guidelines must be followed to ensure the health of the patient while maximizing access.

VI.7. Prescription Drug Formulary

The PEIA maintains an open drug formulary to allow members access to most medications available. It follows a three-tier copayment schedule: a generic copayment, a brand-preferred copayment, and a brand non-preferred coinsurance. The TPA-P will publish and distribute a list of preferred medications, known as the Preferred Drug List (PDL). These medications are clinically appropriate alternatives while also being the most cost effective. Insureds are not limited to PDL medications, but may take advantage of the discounts available on the drugs that are included in the listing.

Specialty Drug Program

PEIA's Specialty Drug Program has two components:
1. **Specialty Injectable Drugs** are administered by injection or infusion and are managed by UMR through the medical benefit.

2. **Common Specialty Medications** are self-administered, and are managed by the Express Scripts Accredo Pharmacy and some local retail pharmacies participating in the Specialty Precision Network.

Specialty Injectable Drugs are prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory

bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring. The PEIA PPB Plans cover specialty injectable drugs through a program managed by UMR. The program provides comprehensive direction to policyholders and their dependents for treatments utilizing specialty drugs. If your physician prescribes a specialty drug, that physician, you, or the pharmacist must call UMR at 1-888-440-7342. The Specialty Injectable Drug list is located at https://www.umrwebapps.com/SpecialtyInjectable/77700000. To obtain a paper copy, call 1-888-680-7342. UMR will review the drug for medical necessity. If denied, UMR will contact your physician for additional information which may allow approval of the requested medication.

Common Specialty Medications are self-administered specialty injectable or oral drugs purchased through the Express Scripts Accredo Pharmacy and some local retail pharmacies participating in the Specialty Precision Network. Through such pharmacies, specialists will check in to see what you need and how they can help moving forward. They'll also make arrangements for injection training, as needed. If your physician prescribes a specialty drug, they can call 1-800-803-2523, fax 1-888-302-1021, or e-prescribe the specialty drug to the Accredo Specialty Pharmacy or to a local retail Specialty Precision Network pharmacy. These pharmacies will then work with your doctor to obtain prior authorization for the specialty medication. Once approved, you can have your specialty medications delivered directly to you.

PEIA participates in the SaveOnSP program which includes many specialty medications. SaveOnSP accesses many manufacturer programs which will assist patients and PEIA financially in the purchase of these specialty medications. If your medication is included in the SaveOnSP list, PEIA requires you to participate in the program. Only your actual out-of-pocket payments will count toward your drug deductible and annual out-of-pocket maximum; not amounts discounted off the price by the manufacturer or seller of the specialty medication. Specialty drugs have the following key characteristics:

- Need frequent dosage adjustments
- Cause more severe side effects than traditional drugs
- Need special storage, handling and/or administration
- Have a narrow therapeutic range
- Require periodic laboratory or diagnostic testing

After you have met your prescription drug deductible, the copayment on these medications will generally be $100 for any Common Specialty Medications on the WV Preferred Drug List and $150 for any Common Specialty Medications not on the WV Preferred Drug List if it is not on the SaveOnSP list. Only your actual out-of-pocket payments will count toward your drug deductible and annual out-of-pocket maximum, not amounts discounted off the price by the manufacturer or seller of the specialty medications. Contact Express Scripts to verify copayments. These drugs are not available in 90-day supplies. If you are prescribed one of these common specialty medications, call Express Scripts at 1- 855-224-6247.

SaveOnSP Copay Assistance Benefit

West Virginia Public Employees Insurance Agency offers members access to a copay assistance benefit, administered by SaveOnSP, which helps members save money on certain specialty medications. SaveOn reaches out when it identifies eligible members taking the drugs that are included. Enrollment in the SaveOnSP manufacturer assistance program is now required for specialty prescriptions. Members can get their specialty medications filled for $0 cost if the specialty medication is on the SaveOnSP list. If a member does not enroll in the program, the member cost of the drug will be 30% coinsurance.

Common Specialty Medications

Examples of specialty medications are listed below. This list is not all-inclusive.

DRUG NAME	CATEGORY
ACTEMRA (QLL)	RHEUMATOLOGICAL AGENTS
ACTIMMUNE	INTERFERONS
ALECENSA (QLL)	ANTINEOPLASTIC DRUGS
AUBAGIO (QLL)	NEUROLOGICAL THERAPY
BALVERSA	ANTINEOPLASTIC DRUGS
CINRYZE	PULMONARY AGENTS
DARAPRIM	ANTIMALARIALS
EGRIFTA	GROWTH HORMONES
ENBREL (QLL)	RHEUMATOLOGICAL AGENTS
FORTEO (QLL)	OSTEOPOROSIS THERAPY
GENOTROPIN	GROWTH HORMONES
LUPRON DEPOT-PED	ANTINEOPLASTIC DRUGS
NUPLAZID (QLL)	ANTIDEPRESSANTS
OFEV (QLL)	PULMONARY AGENTS
OTEZLA (QLL)	RHEUMATOLOGICAL AGENTS
PROCRIT	ERYTHROID STIMULANTS
SKYRIZI (QLL)	ANTIPSORIATIC / ANTISEBORRHEIC
STELARA (QLL)	ANTIPSORIATIC / ANTISEBORRHEIC
TYMLOS (QLL)	OSTEOPOROSIS THERAPY
XYREM (QLL)	PSYCHOTHERAPEUTIC AGENTS
ZEPOSIA (QLL)	NEUROLOGICAL THERAPY

All Common Specialty Medications require Prior Authorization from Express Scripts.

[QLL] This drug is subject to Quantity Level Limits (QLL). This list is not all-inclusive and is subject to change throughout the Plan Year.

Diabetes Management

PEIA covers diabetes management items under its Maintenance Medication benefit, which means that needles, syringes, lancets and test strips must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through Express Scripts mail service. For patients just

starting use of needles, syringes, lancets or test strips, PEIA will permit two 30-day fills of the new prescription at a network pharmacy, but after that, all items must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through Express Scripts mail service.

Cost-sharing Limits: There are limits on the amount of cost-sharing a member with diabetes must pay for a 30-day supply of some medications and devices for treating diabetes.

Diabetes devices include blood glucose test strips, glucometers, continuous glucose monitors (CGM), lancets, lancing devices, or insulin syringes, but not insulin pumps. Cost sharing for a 30-day supply of covered devices may not exceed $100 in aggregate, even if the member is prescribed more than one device per 30-day supply.

Prescription insulin drugs' cost-sharing cannot exceed $35 in aggregate for a 30-day supply, even if the member is prescribed more than one insulin drug, per 30-day supply, regardless of the amount or type of insulin needed to fill the member's prescription.

Omnipod insulin delivery systems are covered under the Prescription Drug Program at the preferred drug copay of $25 per 30-day supply or $50 per 90-day supply in Plans A and D, or $30 per 30-day supply or $60 per 90-day supply in Plan B. The standard Express Scripts quantity limit (QL) for Omnipod is 15 pods per thirty-day supply or 45 pods per ninety-day supply. Quantities greater than this will require prior authorization from the Rational Drug Therapy Program (RDTP).

UMR will no longer precertify Omnipod, but all other Insulin pumps will still require pre-certification through UMR and be covered under the medical benefit. All diabetic supplies (including continuous glucose monitors (CGMs), CGM supplies, lancets, and test strips) are covered under the pharmacy benefit plan administered by Express Scripts. Diabetic supplies will no longer be covered through the medical benefit plan. Traditional insulin pumps and their supplies are not affected and will continue to be a medical benefit only.

Blood Glucose Monitors: Covered diabetic insureds can receive a free OneTouch Verio, OneTouch Reflect, FreeStyle Lite, FreeStyle Freedom Lite, or Precision Xtra blood glucose monitor with a current prescription. All major chain pharmacies and some doctor's offices have vouchers for the OneTouch meters. Take your prescription to them or call the Express Scripts Diabetic Meter Program at **1-855-224-6247** to request a meter.

Glucose Test Strips: The plan covers only OneTouch Ultra, OneTouch Verio, FreeStyle Lite, FreeStyle Freedom Lite, and Precision Xtra test strips at the preferred copayment of $50 per 90-day supply for PPB Plans A and D, and $60 per 90-day supply for PPB Plan B. Other brands require a 100% copayment.

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

Diabetes Management Copayments				
	PEIA PPB Plan A or D		**PEIA PPB Plan B**	
	Up to 30-day supply	**90-day supply***	**Up to 30-day supply**	**90-day supply***

OneTouch, FreeStyle, and Precision Xtra test strips, as noted above	Not Covered	$50	Not Covered	$60
BD needles/syringes	Not Covered	$20	Not Covered	$20
Lancets	Not Covered	$20	Not Covered	$20

*You must purchase all Diabetes Management items in 90-day supplies through a Retail Maintenance Network pharmacy or through Mail Service.

PEIA insureds must have a diabetes diagnosis in order to receive diabetic supplies and/or medications.

VI.8. Tobacco Cessation Program

PEIA has a tobacco cessation program that includes coverage for both prescription and over-the-counter (OTC) tobacco cessation products. The drugs are covered under your prescription drug program.

What is Covered?

PEIA will cover prescription and OTC tobacco cessation products if they are dispensed with a prescription. Toll-free numbers are provided by the manufactures of most of these products for phone coaching and support.

Coverage is limited to two twelve-week cycles per rolling twelve-month period. Tobacco-cessation products are available at no cost to the member; both the deductible and the copayment are waived when prescribed by a physician and purchased at a network pharmacy.

Who is Eligible for Tobacco Cessation?

Only those members who have been paying the Standard (tobacco-user) premium are eligible for this benefit. If you have signed an affidavit claiming to be tobacco-free, and then you attempt to use the tobacco cessation benefit, you will be declined services. Pregnant women will be offered 100% coverage during any pregnancy.

VI.9. Utilization Review

The TPA-P shall be responsible for the utilization review function of the Prescription Drug Plan. The purpose of utilization review is to ensure that medications prescribed for insureds are medically appropriate. When possible, the TPA-P will inform the dispensing pharmacy of a contraindicated drug before the drug is dispensed. While the TPA-P shall review prescriptions for over-utilization and contraindicated prescriptions, neither the PEIA nor the TPA-P assumes any responsibility for the medical care or treatment of an insured. The insured should consult with his/her treating provider and the dispensing pharmacist concerning the medication that has been prescribed.

The utilization review program will focus on the following issues of prescription drug utilization:

- Over-utilization;

- Under-utilization;
- Duplicate claims;
- Excessive daily dose;
- Insufficient daily dose;
- Therapeutic duplication;
- Drug-to-drug interaction;
- Drug/age contraindication; and
- Drug/pregnancy contraindication.

By participation in the Prescription Drug Program, the insured has authorized the PEIA and the TPA-P to provide and receive information related to an insured's prescription from providers and pharmacies.

VI.10. Filing Claims

The TPA-P is responsible for processing all prescription drug claims. In order to be paid under the Prescription Drug Program, the claim must be received by the TPA-P within six months of the date that the prescription was filled, if PEIA is the primary insurer, or within six months of the processing date on the Explanation of Benefits (EOB) from the other plan, if PEIA is secondary.

Network Pharmacies. Claims for prescription dispensed by a Network Pharmacy will be submitted electronically to the TPA-P. Claims will be approved prior to dispensing. The insured will be responsible for any copayment, coinsurance, deductible amount, or ancillary charges at the time the prescription is dispensed.

Non-Network Pharmacies. Claims from non-Network pharmacies must be filed using the PEIA Prescription Drug Claim Form. This form, which can be obtained from the PEIA or the TPA-P, must be filled out by the dispensing pharmacist or the insured and forwarded by either the pharmacist or the insured to the TPA-P. The prescription receipt must be attached to the form. When using a non-Network Pharmacy, the insured is responsible for paying the full amount at the time the prescription is dispensed, unless the insured and the pharmacy reach a different agreement. All prior authorization, step therapy, and quantity limits still apply.

Filing Claims for Court-Ordered Dependents. Prescription drug claims for court-ordered dependents will be processed using the PEIA identification number of the policyholder currently on file with PEIA.

Claims Incurred Outside the U.S. Claims for prescriptions filled outside the U.S. will be processed in the same manner as such claims are handled under the Medical Benefits Plan, except that prescription drug claims must be sent to the TPA-P and the PEIA prescription drug

claim form must be completed, and accompanied by a receipt (see **Section V, Medical Benefit Plan, Claims**).

VI.11. Coordination of Benefits

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

1. **Commercial Insurance:** As a secondary payor, PEIA will pay only if the other insurance plan's benefit is less than what PEIA would have provided as the primary insurer. If PEIA is the secondary insurer, either your pharmacy can process the prescription claim as a secondary claim to PEIA or you must submit the following documentation to the TPA-P to have the secondary claim processed:

    a. a completed TPA-P claim form;
    b. the receipt from the pharmacy; and
    c. an Explanation of Benefits from the primary plan or a pharmacy printout that shows the amount paid by the primary plan.

You will usually be reimbursed within 30 days from receipt of your claim form.

If you need claim forms, call Express Scripts' Member services at 1-855-224-6247 or visit their website at www.express-scripts.com/wvpeia.

Medicare Part D

Medicare offers prescription drug coverage through Medicare Part D. Please be aware that you should NOT purchase a separate Medicare Part D plan. PEIA will provide prescription drug coverage to its Medicare members through a Medicare Part D Plan administered by Humana. If you are a Medicare Advantage plan member and enroll in a separate Medicare Part D plan, you will be disenrolled from all medical and prescription benefits from PEIA. You will have only original Medicare A & B for medical coverage and your Medicare Part D plan with no secondary coverage.

Medicare Part D Creditable Coverage Notice

The coverage you have now through West Virginia PEIA is considered by Medicare to be creditable coverage, or coverage as good as or better than that offered under Medicare's standard Part D benefit. If you are eligible for Medicare and decide to opt out of this plan's coverage, you should consider joining another plan as soon as possible to avoid having to pay a late enrollment penalty. If you choose to leave this plan and do not join another plan within 63 days of the termination date of this coverage, you will be charged a late enrollment penalty of at least 1% per month you went without coverage as good as or better than that offered under Medicare Part D.

When Can You Change to a Different Plan?

Generally, Medicare-eligible members can change plans during the yearly enrollment period (called the "annual coordinated election period") from October 15 through December 7, 2011. Generally, this is the only time of year to choose a different Medicare plan. Certain individuals, such as those with Medicaid, those who get "Extra Help" paying for their drugs, or those who move out of the geographic service area, can make changes at other times.

VI.12. Appeals

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Participant is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, and the Participant will owe any amount to the provider, the Participant will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Participant to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Participant may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Participant of that fact. The Participant has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

PEIA PPB Plans

If you are a PEIA PPB Plan participant or provider and think that an error has been made in processing your prescription drug claim or in a prescription benefit determination or denial, the first step is to reach out to Express Scripts or RDT to verify that a mistake has been made. All appeals must be initiated within one hundred and eighty (180) days of claim payment or denial.

Type of Error	Who to Call	Where to Write
Prior Authorization error or denial	RDT **1-800-847-3859**	Rational Drug Therapy Program WVU School of Pharmacy P.O. Box 9511 HSCN Morgantown, WV 26506
Prescription drug claim payment error or denial	Express Scripts **1-855-224-6247**	Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588
Appealing a Specialty Drug Claim	Express Scripts **1-855-224-6247**	Express Scripts Attn: Clinical Appeals Department

		P.O. Box 66588 St. Louis, MO 63166-6588

How to appeal an adverse benefit decision (denied claims): This is a **mandatory** appeal level. The Covered Person must exhaust internal procedures before taking any outside legal action.

If your pharmacy claim has been denied, or if you disagree with the determination made by RDT or Express Scripts, the second step is for you or your Authorized Individual to appeal in writing to RDT or Express Scripts at the address listed above. The Participant must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Participant received the EOB form seven days after the Plan mailed the EOB form. Explain what you think the problem is, and why you disagree with the decision. Please have your physician provide any additional relevant clinical information to support your request.

If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision and may not have been supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Participant's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

After the claim has been reviewed, the Participant will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Participant. The notification will provide the Participant with the information outlined under the "Adverse Benefit Determination" section above.

Filing a Second Appeal: This is a **mandatory** appeal level. The Participant must exhaust internal procedures before taking any outside legal action.

Your Plan offers two internal levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from PEIA. The Participant or their Authorized Individual must file the appeal within 60 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume the covered person received the EOB form seven days after the Plan mailed the EOB form. Appeals should be directed to the Director of the PEIA. Facts, issues, comments, letters, Explanation of Benefits (EOBs), and all pertinent information about the case should be included and mailed to:
Director, Public Employees Insurance Agency, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345

When your request for review arrives, PEIA will reconsider the entire case, considering any additional materials which have been provided. If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with the medical director. This health care professional may not have been involved in the original denial decision or first appeal and may not have been supervised by the health care professional who was involved. If the Plan has

consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Participant's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the Participant or his or her Authorized Individual. If additional information is required to make a decision, this information will be requested in writing. The additional information must be received within sixty (60) days of the date of the letter. If the additional information is not received, the case will be closed.

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Participant of it's decision within the following timeframes, although Participants may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

URGENT CLAIM APPEALS THAT REQUIRE IMMEDIATE ACTION

A request by a Participant or their Authorized Individual for the review and reconsideration of coverage that requires notification or approval prior to receiving medical care may be considered an urgent claim appeal. Urgent claim appeals must meet one or both of the following criteria in order to be considered urgent in nature:

- A delay in treatment could seriously jeopardize life or health or the ability to regain maximum functionality.
- In the opinion of a Physician with knowledge of the medical condition, a delay in treatment could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The Plan must respond to the urgent claim appeal request as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receiving the request for review.

  - Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 10 business days after the Plan receives the request for review for the first appeal, and another 10 business days for the second appeal.
- Post-Service Claims: Within a reasonable period of time, but no later than 30 calendar days after the Plan receives the request for review for the first appeal, and another 30 calendar days for the second appeal, or a maximum of 60 calendar days for the two appeal levels.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
  - Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
  - Whether a claim for items and services was furnished by a non-network provider at a network facility;
  - Whether an individual gave informed consent to waive the protections under the No Surprises Act;
  - Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
  - Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if Express Scripts, RDT, or PEIA fails to respond to Your appeal within the timelines stated above.

In compliance with the No Surprises Act, the Plan covers ancillary non-emergency services provided by a nonparticipating provider, with respect to a visit at a participating facility, at a participating facility benefit level.

You may request an independent review of the Adverse Benefit Determination. Neither You nor RDT, Express Scripts nor PEIA will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request as indicated below.

Notice of the right to external review for appeals should be sent to:

Director, Public Employees Insurance Agency
601 57th Street, SE, Suite 2
Charleston, WV 25304-2345

Alternatively, you may fax Your request to 877-233-4295, ATTN: PEIA External Appeal

Your written request should include: (1) Your specific request for an external review; (2) the Participant's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by PEIA's Third Party Administrator (UMR) and has no material affiliation or interest with UMR or PEIA. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by RDT, Express Scripts, and/or PEIA in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to RDT, Express Scripts, or PEIA.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or PEIA with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

How to reach Express Scripts

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

By Telephone: For those insureds who do not have access to Express Scripts via the Internet, you can learn more about your program by calling Express Scripts Customer Care at 1-855-224-6247, 24 hours a day, 7 days a week.

Special Services: Express Scripts continually strives to meet the special needs of PEIA's insureds: You may call a registered pharmacist at any time for consultations at 1-855-224-6247.

PEIA's hearing-impaired insureds may use Express Scripts' TDD number at 1-800-759-1089.

Visually impaired insureds may request that their mail service prescriptions include labels in Braille by calling 1-855-224-6247.

VII: MANAGED CARE PLANS

VII.1. Introduction

The PEIA offers to certain policyholders and their dependents the option to participate in one of the managed care plans available through the PEIA.

PEIA will select and contract with qualified managed care plans to offer medical coverage to eligible PEIA insureds. While the managed care plans are non-governmental entities wholly separate and distinct from the PEIA, those members who select the managed care option are still regarded as Participants in the PEIA Plan.

VII.2. Participation

Eligibility. All participating employers in the PEIA Plan must offer to their eligible employees the choice of selecting a PPB Plan or any PEIA-authorized managed care plan. Qualifications for participation in a PEIA-authorized MCO are the same as those requirements set forth in Section II of this Plan, except as specifically noted in this section. By selecting an MCO for medical coverage, the policyholder is agreeing that the insured and the insured's enrolled dependents will receive routine medical care in accordance with the guidelines established by the MCO. In addition to each plan's enrollment area, the Shopper's Guide contains a summary of each plan's benefit offerings, monthly premiums and copayment schedule.

All policyholders and their enrolled dependents are eligible to participate in a PEIA managed care option, unless the policyholder or an enrolled dependent is eligible to have Medicare as their primary insurer. Policyholders or any covered dependents that have Medicare as their primary insurer, may not select an MCO. Should Medicare become the primary insurer for the policyholder or one of the covered dependents during a Plan Year, the policyholder and dependents must enroll in the PPB Plan.

Dependents must participate in the same plan as their sponsoring policyholder. Dependents living outside the enrollment area of the MCO in which they are enrolled must receive all routine medical services through their PCP.

A non-Medicare insured who becomes a policyholder as a surviving dependent or through COBRA eligibility may select either the PPB Plan or a managed care plan during open enrollment, but may not change plans during the Plan Year as a result of their achieving policyholder status.

Prior to each enrollment period, PEIA produces the Shopper's Guide, a reference document developed to assist policyholders in the selection of a medical benefit plan.

VII.3. Enrollment

Open Enrollment Period. Eligible policyholders may select a PEIA-authorized managed care plan during the annual open enrollment period. The open enrollment period is held each year for approximately 30 days. The PEIA will provide policyholders with advance notice of the dates of the annual open enrollment, a copy of the Shopper's Guide, and a transfer form to use to make changes in coverage.

A policyholder already enrolled in a medical plan who does not wish to change coverage will be automatically re-enrolled in that plan for the next Plan Year, unless other instructions are communicated during open enrollment. It is not necessary to complete another enrollment form.

A policyholder who selects a managed care plan must remain in the plan for the full plan Year, unless there is a qualifying event to permit the policyholder to change coverage.

Changes in Coverage Outside Open Enrollment Period. A policyholder enrolled in a managed care plan may changes outside of the open enrollment period only as a result of a qualifying event. Examples of qualifying events are:

Changes in Marital Status Including:

- Marriage or divorce of the employee;
- Death of the employee's spouse or child;
- Death of the employee's spouse or dependent;
- Annulment.

Change in Number of Dependents, Including:

- Birth, death or adoption of the employee's child;
- A dependent loses eligibility due to age or student status.

Changes in Employment Status Including:

- Commencement or termination of employment of the employee's spouse or dependent;

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

- An unpaid leave of absence taken by the employee or spouse;

- A significant change in the health coverage of the employee or spouse attributable to the spouse's employment;

- Change in the residence or work site of the employer, spouse, or dependent;

- Employment change due to strike or lock-out; or

- The employee's spouse changes coverage during open enrollment of the spouse's employer's plan, and the spouse's employer's plan permits the same type mid-year changes, and the spouse's employer's plan year is different than the PEIA Plan Year.

Additions outside of an open enrollment period must be made in the calendar month of or the two calendar months following a qualifying event. Coverage will be effective on the first day of the month following enrollment, or in the case of newborns, on the date of birth. Any additions not made within these time frames may not be made until the next open enrollment. All deletions must be made within 60 days of the qualifying event.

While the PEIA authorizes policyholders to make changes under the above-listed circumstances, those policyholders who participate in an IRS Section 125 Plan must consult their Section 125 Plan and IRS regulations to determine whether such change would be permitted by the IRS.

A physician's departure from a managed care plan does not qualify a managed care plan member to change plans. The member will be offered the opportunity to choose another participating physician from the Plan's network. If the withdrawing physician is the member's primary care physician (PCP), and the member does not choose another PCP, the member will be assigned a PCP by the Plan.

Commencement of Coverage. Coverage for members enrolled during an open enrollment period will begin on the first day of the new Plan Year. Commencement of coverage for members enrolled outside the open enrollment period will be the first day of the calendar month following the enrollment. Coverage for newborns enrolled during the month of or the two calendar months following birth will begin on the date of birth.

Termination of Coverage. A policyholder and dependents must remain in the plan selected by the policyholder for the full Plan Year, unless there is a qualifying event that would allow the policyholder to terminate coverage.

Transfer Between Agencies. A member of a managed care plan who transfers from one participating state agency to another during a Plan Year must remain in the managed care plan for the balance of the Plan Year. The member can only change plans during the Plan Year if the transfer moves him or her out of the enrollment area of the Plan so that accessing care is unreasonable.

In certain extraordinary circumstances, the Director may allow the policyholder to terminate coverage with an MCO outside of an open enrollment period and without having a qualifying event as described in this section. A policyholder may apply to the Director in writing describing why it would create an undue and unreasonable hardship for him/her to remain in the managed care plan through the Plan Year. The decision to allow the policyholder to terminate coverage under this provision is solely at the discretion of the Director. The fact that a policyholder's or their dependent's primary care physician, specialist, or preferred facility voluntarily left the managed care network will not be considered a justifiable reason to terminate the policyholder's coverage with the MCO.

As previously stated, if the policyholder's premium is paid with pre-tax dollars, there are certain IRS Section 125 Plan should consult that Plan to determine whether he/she may terminate or change coverage.

VII.4. Copayments, Deductibles and Plan Maximums.

Copayments due under an MCO plan are payable by the member at the time the service is provided. MCO plans typically do not have medical deductibles.

VII.5. Premiums

State agencies, colleges, universities and county boards of education pay the same "employer" premiums for the same tiers of coverage whether the policyholder participates in the PEIA PPB Plan or a managed care plan. Cost differences among the plans are borne by the employees who participate in the plans. Except with respect for retirees, non-state agencies determine what portion of the premium will be paid by the employer, and what, if any, will be paid by the employee. Premiums are paid to PEIA which, in turn, pays a capitation amount to the MCO for each enrolled policyholder. Premiums are published in the Shopper's Guide each year prior to open enrollment.

VII.6. Capitation Rates

A capitation rate is the amount that the PEIA will pay to an MCO for providing medical care and prescription drug coverage to a PEIA member. The Director will set capitation rates for each coverage tier allowed in the PPB Plan.

VII.7. Administration

In order to administer the managed care offering, the PEIA, MCOs, employers and policyholders all must recognize and fulfill certain responsibilities. The following is not intended to be an exclusive list of those responsibilities. Further responsibilities may be contained in the managed care contracts and on enrollment forms.

Responsibilities of PEIA. The PEIA is responsible for the following:

- Disseminating information regarding managed care options, restrictions and limitations so that policyholders may make informed choices;

- Processing new enrollments, changes in enrollment, terminations of enrollment and verifying eligibility to enroll in a managed care plan;

- Furnishing eligibility data to managed care plans;

- Billing and receiving premiums from employers, retirement plans and individual policyholders, as appropriate; and,

- Paying MCOs those capitation rates as agreed upon in the managed care contracts.

Responsibilities of MCOs. MCOs offering benefits to PEIA members are responsible for the following:

- Providing to PEIA members those benefits set forth in the evidence of coverage;

- Maintaining adequate provider contracts to ensure that PEIA members have appropriate access to services as required by the West Virginia Department of Insurance;

- Providing eligible policyholders with information concerning their plan;

- Providing enrolled members with an identification card and evidence of coverage prior to the commencement of coverage;

- Resolving member grievances in a timely and fair manner; and

- Performing other duties as outlined in the managed care contract.

Responsibilities of Employers. Employers shall be responsible for following:

- Knowing the managed care offerings in their geographic area so they may direct employees to the correct source of information;

- Communicating eligibility and enrollment data to the PEIA as soon as the information becomes available; and

- Collecting and paying to the PEIA by the 25th day of each month the employer and employee share of the premium.

Responsibilities of Policyholders. Policyholders who select one of the managed care plans authorized through the PEIA are responsible for the following:

- Making their selection of a health plan selection for the Plan Year during open enrollment;

- Reviewing and understanding managed care options, limitations and restrictions prior to selecting a plan; and

- Communicating eligibility/enrollment changes to the employer immediately as such information becomes available.

VII.8. Benefits

The benefits package provided to PEIA must be an existing commercial benefit package offered to other clients and approved by the West Virginia Department of Insurance. Benefits, limitations and exclusions in an MCO plan must clearly be set out in the Plan description provided to members.

VII.9. Solicitation

All solicitation material to be sent to PEIA insureds is subject to inspection and prior approval by the PEIA.

VII.10. Communication

All communication materials to be mass-distributed to PEIA insureds are subject to inspection and prior approval by the PEIA.

VII.11. Appeals

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

If your claim has been denied, or if you disagree with the determination made by your managed care plan, refer to the Evidence of Coverage (EOC) provided by your plan for details of your plan's appeals process.

VIII: LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D)

VIII.1. Introduction

The PEIA contracts with a life insurance carrier ("Carrier") to offer term life insurance and AD&D plans to active employees and term life insurance to retired employees through a group life insurance policy. The current carrier is listed in Appendix A. Active and retired employees can choose basic life insurance, optional life insurance, and optional dependent life insurance. Each of these coverages is described below.

All life insurance offered by PEIA is term life insurance coverage with no cash value. The Basic and Optional Life insurance plans are decreasing term coverage, which means premiums increase and the amount of coverage decreases as the policyholder ages. For details, please see your life insurance certificate.

VIII.2. Basic Life and AD&D Insurance

Active employees may select basic life insurance. For active employees, this benefit plan also includes coverage for accidental death and dismemberment. Retired employees are eligible only for the basic life coverage, but not AD&D coverage.

Basic life and AD&D insurance is decreasing term coverage. The amount of benefits depends on the age and employment status of the insured as set forth below.

VIII.3. Basic Life Insurance Benefits

Amount of Benefits. Upon receipt of proof of death of an enrolled employee, the Plan will provide the following Basic Life Insurance benefits:

Active Employees:

	Amount of Life Coverage	Amount of AD&D Coverage
	$ 10,000	$ 10,000

Retired Employees:

	Amount of Life Coverage	Amount of AD&D Coverage
At retirement	$ 5,000	$ 0
At age 67 and older	$ 2,500	$ 0

Disabled Employees (Disabled Prior to Age 60):

	Amount of Life Coverage	Amount of AD&D Coverage
Under age 65	$ 10,000	$0
Age 65 but Under Age 70	$ 5,000	$0
Age 70 or older	$ 2,500	$0

VIII.4. Optional Life and Accidental Death and Dismemberment (AD&D) Insurance

Active employees can elect optional life and an equal amount of AD&D coverage. Retired employees can elect optional life insurance, but not the AD&D coverage. The employee can choose from eighteen levels of decreasing term coverage for active and ten levels of decreasing term coverage for retired employees, depending on the age and employment status of the employee as follows:

Active Employee – Optional Life and AD&D

Age	Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII	Plan VIII	Plan IX	Plan X
Under 65	$5,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$75,000	$80,000	$100,000
65-69	$3,250	$6,500	$13,000	$19,500	$26,000	$32,500	$39,000	$48,750	$52,000	$ 65,000
70 & over	$2,250	$4,500	$9,000	$13,500	$18,000	$22,500	$29,000	$33,750	$36,000	$ 45,000

Age	Plan XI	Plan XII	Plan XIII	Plan XIV	Plan XV	Plan XVI	Plan XVII	Plan XVIII
Under 65	$150,000	$200,000	$250,000	$300,000	$350,000	$400,000	$450,000	$500,000
65-69	$ 97,500	$130,000	$162,500	$195,000	$227,500	$260,000	$292,500	$325,000

Retired Employee – Optional Life with no AD&D

Age	Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII	Plan VIII	Plan IX	Plan X
Under 65	$5,000	$10,000	$15,000	$20,000	$30,000	$40,000	$50,000	$75,000	$100,000	$150,000
65-69	$3,250	$ 6,500	$ 9,750	$13,000	$19,500	$26,000	$32,500	$48,750	$ 65,000	$ 97,500
70 & over	$2,500	$ 5,000	$ 7,500	$10,000	$15,000	$20,000	$25,000	$37,500	$ 50,000	$ 75,000

Increasing the Optional Life Insurance Benefit. An employee who wants to increase the Optional Life Insurance benefit will be required to submit a statement of insurability form. A medical examination, paid for by the employee, may be required.

Continuation of Coverage during Leave of Absence. An employee on an approved leave of absence may continue Optional Life Insurance by paying the required premiums if coverage under Basic Life Insurance Plan is continued through the period of the leave of absence.

Optional Dependent Life and AD&D

In addition to the Optional Life AD&D coverages, active employees may elect Optional Life with AD&D Insurance for their dependents. Retirees may elect Optional Life Insurance without AD&D coverage for their dependents.

- If a retiree elects option II or above, the retiree must provide evidence of insurability for each dependent to be insured.

- Retirees may elect Dependent Life Insurance only during the calendar month of or the two calendar months following their date of retirement. After this time, no initial elections or increases will be permitted.

Active Employee's Dependent Life and AD&D Insurance
Plan 1 ($5,000 Spouse/$2,000 Child)
Plan 2 ($10,000 Spouse/$4,000 Child)
Plan 3 ($15,000 Spouse/$7,500 Child)
Plan 4 ($20,000 Spouse/$10,000 Child)
Plan 5 ($40,000 Spouse/$15,000 Child)

Retired Employee's Dependent Life Insurance
Plan 1 ($5,000 Spouse/$2,000 Child)
Plan 2 ($10,000 Spouse/$4,000 Child)
Plan 3 ($15,000 Spouse/$7,500 Child)
Plan 4 ($20,000 Spouse/$10,000 Child)
Plan 5 ($40,000 Spouse/$15,000 Child)

A statement of insurability will be required if
Optional Dependent Life is elected at any time after the enrollment period.

Dependent life insurance benefits will be available for newborns that die before discharge from the hospital when they are added to the policy within the allotted time frames for enrollment of dependents, and if they meet the guidelines of an eligible dependent. They cannot be enrolled for an amount greater than the amount for which the policyholder has previously elected.

VIII.5. Enrollment

Enrollment in Basic, Optional or Dependent Life and AD&D coverage is accomplished by completing enrollment forms obtained from the employee's place of employment or through the retirement system. Enrollment will authorize the employer or retirement system to deduct the premiums for the coverages from the employee's salary or pension.

New Employees. The enrollment period for new employees is the calendar month in which employment begins and the following two calendar months. No statement of health will be required during this time, for any amount not exceeding $100,000. Coverage will become effective the first day of the month following enrollment, (or approval, if required).

In order for coverage to begin on the first day of the month following enrollment, the employee must be actively at work on the date the coverage would become effective. If the

employee enrolls before he/she is actively at work, coverage will begin on the first day of the month following the employee's first day of active employment.

If the employee chooses to enroll in Basic, Optional, or Dependent Optional Life Insurance after the enrollment period, a statement of insurability will be required. Coverage will become effective the first day of the month following approval.

Basic Life coverage or an increase in the amount of Optional Life Insurance coverage will be effective on the date the policyholder becomes eligible provided the policyholder has completed:

(a) a full day of Active Work on that date; or
(b) a full day of Active Work on the last regularly scheduled workday and is able to work on the date he/she becomes eligible.

If the policyholder does not meet the requirements of (a) and (b) above, the coverage will become effective on the date the policyholder returns to Active Work.

Active Work and Actively at Work means: performing regular duties for a full workday for the Policyholder.

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

Additional Dependents. If you wish to add new dependents, such as a new spouse, your biological newborn or adopted child, you must complete enrollment forms to add them to your coverage. Their coverage will become effective the first day of the month following enrollment. Coverage is not automatic, even if you have an existing family plan.

Retired Employees. The enrollment period for retired employees wishing to elect new, or continue or increase Optional Life Insurance is the calendar month of, and the two calendar months following, their retirement. A statement of insurability will be required for retirees wishing to elect new, increase their coverage, or who elect plan two. New or increased coverage will be effective the first day of the month following approval. The retired employee cannot elect to enroll in or increase Optional Life Insurance after this initial period. The retired employee cannot enroll for or continue AD&D insurance.

VIII.6. Benefits for Accidental Death and Dismemberment Insurance

For active employees, the amount of the AD&D coverage is equal to the amount of the basic and/or optional insurance coverage.

To qualify for an AD&D benefit payment, the death or dismemberment must be the result of an injury caused by external and purely accidental means. The accident must occur while the employee or dependent is insured, or the loss of life or body part must occur within 90 days after the accident. AD&D insurance is paid as follows:

100% - Accidental loss of life

100% - Accidental loss of both hands, both feet, the sight of both eyes, or one hand or one foot and the sight of one eye.

50% - Accidental loss of one hand, one foot, or the sight of one eye.

No more than the full amount of coverage will be paid for multiple injuries resulting from one accident.

No AD&D benefits will be paid for losses caused directly or indirectly by, resulting from, or where there is a contribution from, any of the following:

1. Suicide or attempted suicide, whether sane or insane; or
2. The insured's participation in or attempt to commit a felony; or
3. Bodily or mental infirmity, illness or disease; or
4. The abuse of drugs, or the use of poisons, gases or fumes, voluntarily taken, administered, absorbed, inhaled, ingested or injected, except as administered by a licensed medical professional; or
5. Bacterial infection, other than infection occurring simultaneously with, and as a result of, the accidental injury; or
6. War or any act of war, whether declared or undeclared.

VIII.7. Statement of Insurability

A statement of insurability will be required for any employee who does not elect Basic, Optional, or Dependent Optional Life Insurance during the enrollment period or who wishes to increase the coverage amount. The life insurance carrier may require a medical examination at the employee's expense and will make the final determination of whether or not to issue coverage.

VIII.8. Designating and Changing Beneficiaries

Designation. The employee may indicate the individual, individuals, or entity to receive the proceeds of the benefits under the life insurance plan.

The employee may designate more than one person as the beneficiary and may indicate the portion of the proceeds for each beneficiary by listing the beneficiary and the percentage of proceeds each beneficiary is to receive. If no percentage is listed, the proceeds will be divided equally among all beneficiaries. If a beneficiary has died, the remaining beneficiaries will share the portion that would have been paid to the deceased beneficiary.

Failure to Designate a Beneficiary. If the employee fails to designate a beneficiary or if the beneficiary does not survive the employee, benefits will be paid to the first surviving class of beneficiaries:

- Widow or widower;
- Surviving children;
- Surviving parents;

- Surviving brothers and sisters; and
- The employee's estate.

Minor Beneficiary. If the beneficiary is a minor for whom no legal guardian has been appointed, the Plan will request that a guardian be appointed so that the entire benefit can be paid. The benefit will not be paid until the appointment, or the life insurance carrier will place the money into an interest-bearing account, in the minor's name, to be held until the minor turns age 18.

Multiple Beneficiaries. If more than one (1) beneficiary is named, the form should indicate the proportion to be paid to each beneficiary. If the share that each beneficiary is to receive is not stated on the designation form, the beneficiaries will be paid equal shares.

If one or more of the named beneficiaries dies before the employee, the remaining beneficiaries will share equally the amount which would have been distributed to the deceased beneficiary or beneficiaries. If only one beneficiary survives the employee, that beneficiary will receive the entire benefit.

Beneficiary for Optional Dependent Life Insurance. The employee will always be the beneficiary of Optional Dependent Life Insurance benefits.

Changing a Beneficiary. The employee may change the beneficiary of the Basic or Optional Life Insurance and AD&D coverage by completing a Change of Beneficiary form obtained from the employee's benefits coordinator or the retirement system.

VIII.9. Premiums

Basic Life Insurance Coverages. All costs of Basic Life Insurance coverage for employees and totally disabled employees are paid by the employer, except for non-state agencies. The premium rates are set forth in Appendix B.

Optional Life Insurance. The employee is responsible for paying the full applicable premium for Optional Life Insurance. The premium rates are set forth in Appendix B.

Optional Dependent Life Insurance. The employee is responsible for payment of all applicable premiums for Optional Dependent Life Insurance. The premium rates are set forth in Appendix B.

All premium rates are subject to change as determined by the WV PEIA's Life Insurance Carrier.

Basic Life Insurance for Disabled Employees (Waiver of Premium). If an active employee with Basic Life Insurance becomes totally disabled before reaching age 60, the Basic Life Insurance may be continued at no cost to the employee through a waiver of premium while the employee remains totally disabled. To qualify for this waiver of premium, the employee must furnish proof of total disability within one year after the date of disability, and, the employee must have been covered under Basic Life Insurance when the disability began. The date of disability is the employee's last day of active work.

"Total Disability" exists when the employee is completely unable, due to sickness or injury or both, to engage in any gainful occupation which the employee is reasonably capable of performing by education, training or experience. The employee will not be considered totally disabled while capable of working at any gainful occupation.

Application for waiver of premium is made through the employee's benefits coordinator. Proof of continuing disability will be required three months before each anniversary of the initial date of disability. The employee may be asked by the life insurance carrier to submit to periodic medical exams. AD&D coverage does not continue under the waiver of premium.

If the waiver of premium application is approved, the Basic Life Insurance will remain at $10,000 with no premium cost to the employee. At age 65, the Basic Life Coverage will decrease to $5,000, and further reduce to $2,500 at age 67. All active employees with basic life insurance retain $10,000 in coverage, regardless of age.

This coverage will end at the earliest of these events:

- the end of disability;
- the failure to provide proof of continued disability; or
- the failure to submit to a physical examination when required by the life insurance carrier.

Refund of Individual Policy Premiums. If the employee had converted his/her life insurance under the Group Policy to an individual policy while totally disabled, the employee must return the individual policy to the insurance company with the first proof of total disability for a refund of any premiums paid.

Medical Examinations. The insurance company has a right to have its medical representative examine the employee when necessary, but not more than one (1) time each year after the employee has been totally disabled for a period of two (2) years.

Optional Life Insurance for Disabled Employees (Direct Payment of Premiums). If an active employee who has Optional Life Insurance becomes totally disabled before reaching age 60, the same or lower level of Optional Life Insurance may be continued while the employee remains totally disabled if the employee pays the entire premium for the Optional Life Insurance directly to PEIA. To qualify for this benefit, the employee must furnish proof of total disability and, the employee must have been covered under Basic Life Insurance and Optional Life Insurance when the disability began. The date of the disability is the employee's last day of active work. The employee must meet the definition of "total disability" and qualify for "waiver of premium" of their Basic Life Insurance as more fully set out in the "Basic Life Insurance for Disabled Employees (Waiver of Premium) section immediately above. The employee must also qualify as totally disabled with the Public Employees Retirement System.

VIII.10. Conversion

Basic and Optional Life Insurance Coverage.

Termination of Employment. If an employee leaves employment, the life insurance protection will continue for thirty-one (31) days from the date of termination of employment. The

Accidental Death and Dismemberment coverage will end on the date of termination of employment.

During the thirty-one (31) day period, the employee may elect to convert all or a part of the group life insurance coverage to an individual policy by making an application and paying the first premium during the thirty-one (31) day period. No medical examination or statement of health is required. The employee may only choose a type of coverage available from the Carrier.

The amount which may be converted is an amount equal to or less than the prior level of coverage. The level of premium is based upon the age, occupation and type of policy selected. The policy will take effect at the end of the thirty-one (31) day period.

Conversion for Spouse or Dependent. If a dependent loses coverage due to attaining the age of twenty-six (26), the dependent may convert the Dependent Life Insurance into an individual policy. The application and payment of the first month's premium must be made within thirty-one (31) days after the termination of coverage.

If coverage on the spouse of the employee ends due to employee's loss of eligibility, the dependent may, within thirty-one (31) days after the insurance ends, apply to convert the coverage to an individual policy.

The spouse may elect term insurance for a period of not more than one (1) year before the conversion coverage. No medical exam is required. The converted policy will take effect thirty-one (31) days after the coverage under the group policy ends as long as proper application is made and the first monthly payment is paid in that period.

If the employee coverage on the spouse ends because the group policy has terminated or is amended, the employee may apply to convert the coverage to an individual policy in the manner described above. However, he/she must have been insured under the group policy for at least three (3) consecutive years and the group policy must have been in force at least five (5) consecutive years. The sum of coverage is reduced by any other group policy for which he/she is eligible within the thirty-one (31) day conversion period.

If a dependent's coverage under the Optional Dependent Life Insurance ends because the employee's class of employment is no longer classified as eligible and the dependent dies within thirty-one (31) days of that event, the benefit will be paid in the amount for which the dependent was last insured.

If a dependent die within thirty-one (31) days after the insurance ends because the group policy is discontinued or amended, a benefit will be paid in the amount for which the dependent was last insured under the group policy. The employee must have been insured under the group policy for at least three (3) consecutive years and the group policy must have been in force for at least five (5) consecutive years. This amount will be reduced by any amount for which a person became insured under any other group policy within thirty-one (31) days after the coverage under this plan ended.

No Payments will be made under the provisions of the last 2 paragraphs above if: (1) at the time of the dependent's death, he/she is eligible for insurance as an employee under the Plan; or (2) at a child's death, he/she is married or has reached the age limit.

Totally Disabled Employees. When the life insurance coverage for a totally disabled employee ends, the totally disabled employee will have the same rights to covert the group life insurance to an individual policy as apply to an employee. This right of conversion applies only if the totally disabled employee does not become insured again under the group policy.

Termination of Group Coverage or no Longer Eligible to Participate. If the group policy terminates or the employee is no longer employed in an eligible class of employees, the employee may convert coverage to an individual policy within the thirty-one (31) day period after coverage ends. For this right of conversion to exist, the employee must have been insured under the group policy for at least three (3) consecutive years. The amount which may be converted is reduced by any sum for which the employee was otherwise eligible under any other group policy in the thirty-one (31) days during which the election to convert may be made.

If an employee dies within thirty-one (31) days of the end of coverage, and the coverage ended because the group policy terminated, or the employee was employed in a class of employees which is no longer eligible to participate, the employee's beneficiary will be paid a benefit if the employee had been insured under the group policy for at least three (3) consecutive years and the group policy had been in force at least five (5) consecutive years.

The amount of the benefit will be the amount of life insurance for which the employee was last insured less any sum for which the employee became insured under any other group policy within thirty-one (31) days of the date the coverage ended under the group policy.

The individual policies for all life insurance policies are issued by PEIA's life insurance carrier. The individual policy is not the same as provided through PEIA, and may be substantially different. The employee may obtain a Life Insurance Conversion Application Form by calling the PEIA. The completed form is provided by PEIA's life insurance carrier which will explain the coverage options and costs to the employee.

VIII.11. Filing Claims

In General. Upon the death of the insured, the following steps are to be followed:

1. the insured's payroll location or retirement system should be notified by the family of the insured;

2. the payroll location or retirement system will initiate the process for the payment of the claim by completing the employer's statement on the notice of death form and sending it to PEIA;

3. PEIA will then notify the beneficiary by sending out a Proof of Death claim form and requesting a court-certified death certificate with a raised seal;

4. the beneficiary completes the Proof of Death claim form and returns these materials to:

   Public Employees Insurance Agency
   Attn: Life Insurance Supervisor

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

5. upon receipt of these materials, PEIA completes the final preparation of the claim; and

6. PEIA forwards all materials to the Carrier for processing;

7. the proceeds will be paid to the beneficiary(ies).

Retired Employees. Retired employees using sick and/or annual leave to extend insurance coverage must contact their former employers to file life insurance claims. All other retired employees must file life insurance claims through their retirement system.

Accidental Death and Dismemberment Claims. Within ninety (90) days after the date of the loss for which a claim is being made, written notices of the event must be provided to the PEIA. Failure to provide notice within this ninety (90) day period will not invalidate or reduce the claim as long as it can be shown that it was not reasonably possible to provide notification within that time frame and that notice was provided as soon as reasonably possible.

Upon receipt of notice, the forms for filing a proof of claim will be provided by the PEIA. If the claimant does not receive the forms for filing a proof of claim from the PEIA within fifteen (15) days of providing notification, the claimant will be deemed to have complied with the proof of claim requirements. If the claimant submits written proof covering the occurrence and the character and extent of loss for which the claim is being made to the PEIA, this written statement must be received within ninety (90) days after the date of the loss unless it can be shown that it was not reasonably possible to furnish the proof within the required time, and that proof was provided as soon as reasonably possible.

Upon receipt of the proof of claim, the AD&D benefits will be paid to the employee, if living, or to the beneficiary.

VIII.12. Disputed Claims

All disputed claims for benefits under the Plan shall be submitted to PEIA, or its representative within 60 days of the receipt of the denial notice from Carrier. Written notice of the decision on each such claim shall be furnished within sixty (60) days of the decision of the Carrier to the claimant.

If the claim is wholly or partially denied, such written notice shall set forth an explanation of the specific findings and conclusions on which such denial is based. A claimant may review all pertinent documents and may request a review by the Carrier of such a decision denying the claim. Such a request shall be made in writing and filed with the Carrier, within 30 days after delivery to the claimant of written notice of decision. Such written request for review shall contain all additional information which the claimant wishes the Carrier to consider in rendering its decision, and the decision on review shall be made within ninety (90) days of the date all information is received by the Carrier.

Written notice of the decision of the Carrier, shall be furnished within sixty (60) days to the claimant and shall include specific reasons for such decision. For all purposes under the Plan, such decisions on claims (where no review is requested) and decisions on review (where review is requested) shall be final, binding, and conclusive on all interested persons as to participation and benefit eligibility and as to any other matter of fact or interpretation relating to the Plan.

VIII.13. Termination or Reduction of Coverage

Employee. Coverage ends when the employee is no longer eligible or when the group coverage terminates, whichever happens first. In the case of a voluntary termination of employment, the employee's coverage terminates immediately upon termination of employment is involuntary but not due to gross misconduct, the employee may continue to be covered for three (3) months after the end of the month in which the employee is taken off the payroll.

Dependents. A dependent's coverage will end at the earlier of the following events:

- The dependent is no longer an eligible dependent;
- The employee retires and elects not to enroll for optional dependent life insurance;
- The employee dies;
- The employee elects not to participate; or
- The coverage under the group policy ends.

IX: VISION, DENTAL, HEARING BENEFITS, LEGAL AND LONG AND SHORT-TERM DISABILITY PLANS

IX.1. Introduction

In accordance with W.Va. Code § 5-16-15, the PEIA offers a vision, dental and long-term disability plan to eligible insureds. These plans are offered as part of Mountaineer Flexible Benefits administered by a TPA with insurance coverage provided by a third-party. Eligible insureds may elect to participate in any one of these plans separately or in combination.

IX.2. Eligibility

All active employees and their dependents eligible to participate in the Medical Benefits Plan may elect to participate in any of these plans. In the case of County Boards of Education, the board must participate for the employee to be eligible. Non-state (local government and other) agencies are not eligible to participate. All issues concerning eligibility will be determined by the Director.

IX.3. Enrollment

Active employees may enroll in these plans during the PEIA annual open enrollment, or if a new employee, during the calendar month of or the calendar month following their employment. If the active employee enrolls in any of these plans and uses pre-tax dollars to pay premiums, the employee may not voluntarily terminate participation until an open enrollment period, effective the first day of the next Plan Year, unless the employee has a qualifying event as defined by PEIA's Section 125 Plan.

IX.4. Premiums

All administrative and actuarial costs of these plans shall be borne by the premium payments of the Participants, or in the case of employees of county boards of education, pursuant to any agreement between the employee and the agency. Premiums will be determined by the company providing the insurance coverage.

Employers will collect premiums from employees participating in the plans and forward the premiums to the PEIA. Employees on a leave of absence will send premium payments directly to the PEIA. The PEIA will determine the dates premium payments are due at the Agency and provide appropriate notice. The PEIA will collect all premium payments and forward them to the TPA.

IX.5. Administration

The Vision, Dental, Hearing Benefits, Legal, and Long-and Short-Term Disability Plans are administered for the PEIA by the TPA listed in Appendix A.

The Director shall establish separate accounts for the deposit of dental premiums, vision premiums, and short-and long-term disability premiums.

The TPA shall provide to the PEIA such reports as requested by the PEIA and as set forth in the contract between the TPA and the PEIA.

IX.6. Benefits

Each insured who elects coverage from one of these plans will be given a summary of benefits by the carrier describing the benefits covered, the providers participating in the benefit (if applicable) and how to file claims.

X: MEDICAL REIMBURSEMENT PLAN

ARTICLE I – INTRODUCTION

1.1 Purpose of Plan. The purpose of the Plan is to enable Participants to elect to receive payments or reimbursements of Health Care Expenses that are excludable from the Participant's gross income under §105 (b) of the Code and that would be deductible expenses under §162 of the Code.

1.2 Qualification of Plan. This Plan is intended to qualify as an accident and health plan under §105(e) of the Code, as is to be interpreted in a manner consistent with the requirements of §105(e).

1.3 Effective Date. The Plan is amended and restated effective July 1, 2006.

ARTICLE II – DEFINITIONS

The definitions in this Plan shall have the same meanings as set forth in the State of West Virginia Public Employees Insurance Agency Section 125 Plan, unless otherwise indicated below.

2.1 "Benefit" means any amount(s) paid to a Participant in the Plan as reimbursement for Health Care Expenses incurred by a Participant during a Plan Year and/or Grace Period by the Participant, Spouse or Dependents.

2.2 "Effective Date" means this amendment and restatement is effective July 1, 2000.

2.3 "General Purpose Medical Reimbursement Plan" means a Plan that applies to all Health Care Expenses.

2.4 "Grace Period" means the period of two months and fifteen days following the end of the Period of Coverage (Plan Year) during which amounts unused at the end of the Period of Coverage (Plan Year) may be used to reimburse qualifying Health Care Expenses incurred during the Grace Period. All amounts allocated to the Medical Reimbursement Plan that are not used to reimburse qualifying Health Care Expenses incurred during the Period of Coverage (Plan Year) and/or Grace Period shall be forfeited.

2.5 "Health Care Expense" means health care expenses that are (a) deductible under Section 213 of the Code; (b) incurred by the Participant, Spouse, or Dependents during the Period of Coverage in which Contributions were credited to the Participant's Medical Reimbursement Account and/or the immediately following Grace Period; (c) not incurred prior to the date the Employee's participation in the Plan commenced; and (c) not incurred prior to the date the Employee's participation in the Plan commenced; and (d) not reimbursed by the Medical Plan or any other source. Health Care Expenses shall not include an expense incurred for the payment of premiums under a health insurance plan. For purposes of this Plan, expenses are incurred when the Participant or Beneficiary is furnished the health care or services giving rise to the claimed expense. Further, for the purposes of this Plan, if an individual chooses to elect a Limited Purpose Medical Reimbursement Plan, the term "Health Care Expenses" shall mean only dental and vision expenses.

2.6 "Highly Compensated Individual" means a Participant who is (a) one of the 5 highest paid officers, (b) a shareholder owning more than 10 percent in value of the stock of the employer, or (c) among the highest paid 25 percent of all Participants as defined in §105 (h)(5) of the Code.

2.7 "Limited Purpose Medical Reimbursement Plan" means a plan that applies only to Health Care Expenses related to dental and vision expenses.

2.8 "Open Enrollment" means the period prior to or during a Plan Year during which Eligible Employees may make elections to allocate Contributions under the Section 125 Plan. The open enrollment period shall be established from year to year by PEIA.

2.9 "Participant" means each Employee who elects to participate in the Plan in accordance with Article III.

2.10 "Period of Coverage" means the Plan Year. The Period of Coverage will generally be twelve (12) months, except the 1999 Plan Year, or for Periods of Coverage during which an Employee is a Participant for less than the entire Period of Coverage. A Period of Coverage shall not be for a duration which would enable a Participant to defer the receipt of Compensation or to obtain coverage under the Plan only for periods during which a Participant expects to incur Health Care Expenses.

2.11 "Plan" means The State of West Virginia Public Employees Insurance Agency Medical Reimbursement Plan as set forth herein, together with any and all amendments and supplements hereto, which is designed to operate in conjunction with the Section 125 Plan.

2.12 "Plan Year" means the twelve-month period beginning July 1 and June 30.

2.13 "Required Premiums" means the amount of medical reimbursement coverage elected by the Participant for the Period of Coverage divided by the number of pay periods in such Period of Coverage.

2.14 "Run-out-Period" means the 120 days following the close of the Period of Coverage (Plan Year) during which participants may submit for reimbursement those expenses incurred during the Period of Coverage (Plan Year), and incurred during the Grace Period.

2.15 "Section 125 Plan" means The State of West Virginia Public Employees Insurance Agency Section 125 Plan as amended from time to time.

The singular shall include the plural and vice-versa, whenever used herein, unless the context clearly indicates otherwise.

ARTICLE III – PARTICIPATION

3.1 Eligibility to Participate. All Eligible Employees may participate in and enter the Plan and select either a General Purpose Medical Reimbursement Plan or a Limited Purpose Medical Reimbursement Plan. Health Savings Account benefits cannot be elected with a Medical Reimbursement Plan unless the Limited Purpose Medical Reimbursement Plan is selected.

3.2 Commencement of Participation. An Eligible Employee may elect to become a Participant in either the General Purpose Medical Reimbursement Plan or the Limited Purpose Medical Reimbursement Plan by completing a Benefit Election Form and filing it with the Employer. Such individual must elect either the General Purpose Medical Reimbursement

Plan or the Limited Purpose Medical Reimbursement Plan, bot not both; the election will last for the entire plan year. Such an individual will become a Participant upon the effective date of an election to participate in the plan as set forth in Article IV. In order to participate in the Plan during a particular Period of Coverage, an Employee must complete and file a Benefit Election Form during an open enrollment period designated by the Employer, which shall end prior to the first day such Period of Coverage. If an Eligible Employee is hired after open enrollment, the employee must enroll during the month of hire or the following month.

On the Benefit Election Form, the Employee shall designate the amount of Compensation to be contributed to the Medical Reimbursement plan, and thereby agrees to have his/her Compensation reduced by such amount.

3.3 Cessation of Participation. Except as provided in Article VII, a Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates, (b) the date on which the employee ceases to be an Eligible Employee, or (c) the date on which the election under the Section 125 Plan to receive Health Care Expense reimbursement expires or is terminated under the Section 125 Plan.

3.4 Reinstatement of Former Participant. A former Participant will become a Participant again upon meeting the eligibility requirements of Section 3.1 and electing again under the Section 125 Plan to receive Health Care reimbursement under this Plan. However, in the case of a Participant who separates from service with the Employer during a Period of Coverage and elects to revoke existing benefit elections and terminates the receipt of benefits for the remaining portion of the Period of Coverage, if such Participant should return to service within the same Period of Coverage, the Participant will be prohibited from making new benefit elections for remining portion of said Period of Coverage.

3.5 Participation of Spouses or Dependents. To the extent required by law, coverage under this Plan shall be made available to the Spouse or a Dependent of a Participant or Former Participant in lieu of (or in addition to) the Participant. In that event, such Spouse or Dependent shall be treated as a Participant under this Plan, but only to such extent and for such period as the law requires. No Benefit Election Form shall be required for such a Spouse or Dependent, but Required Premiums must be paid to the Employer on a monthly basis (or within such other time limit as may be provided for by law), and coverage shall cease upon nonpayment of any such Required Premium.

3.6 Salary Reduction. By participating in the Plan, each Participant agrees to have his/her annual Compensation reduced by the amount of money the Participant has elected to contribute to the Medical Reimbursement Account under the Section 125 Plan. No Participant shall be entitled to reduce Compensation for Health Care Expenses by more than the maximum amount of Benefits specified in Section 4.3.

ARTICLE IV – ELECTION TO RECEIVE HEALTH CARE REIMBURSEMENTS

4.1 Election Procedure. A Participant may elect to receive reimbursement of his Health Care Expenses under this Plan by filing a Benefit Election Form in accordance with Article IV of the Section 125 Plan. An election to receive reimbursements of Health Care Expenses

shall be irrevocable and remain in effect until the end of the Period of Coverage, subject to a change in family status, as provided in the Section 125 Plan.

4.2 Minimum Reimbursement Election. The minimum amount, which the Participant may elect to receive in any Period of Coverage in the form of reimbursement for Health Care Expenses incurred during any Period of Coverage, is $150.

4.3 Maximum Reimbursement. The maximum amount that the Participant may elect to receive in any Period of Coverage in the form of reimbursement for Health Care Expenses incurred during any Period of Coverage is $2,650 (as indexed for inflation for future years and communicated in enrollment materials) or such lesser amount as is communicated in enrollment materials.

4.4 Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of Highly Compensated Individuals or Key Employees (as defined in Code §105 (h)(5)) as to the eligibility to participate and/or benefits provided under the Plan, and is therefore intended to comply in this respect with the requirements of the Code.

4.5 Maximum Employer Contributions. The maximum amount of Employer Contributions under the Plan for any Participant shall be the maximum amount, which the Participant may elect to receive in the form of Health Care Expense reimbursement under the Plan described in Section 4.3.

ARTICLE V – MEDICAL REIMBURSEMENT ACCOUNTS

5.1 Establishment of Accounts. The administrator will establish and maintain its own books on Medical Reimbursement Account for each Period of Coverage with respect to each Participant who has elected to receive reimbursement of Health Care expenses incurred during the Period of Coverage.

5.2 Crediting of Accounts. There shall be credited to a Participant's Medical Reimbursement Account for each Period of Coverage as of each date Compensation is paid, for the Participant in such Period of Coverage, an amount equal to reduction, if any, to be made in such Compensation in accordance with the Participant's Benefit Election Form under the Section 125 Plan. Contributions shall be credited to Medical Reimbursement Accounts in equal amounts over a period of time established by the Employer. All amounts credited to such Medical Reimbursement Account shall be the property of the Employer until paid out pursuant to Article VI.

{If an Employee's net pay is not sufficient to fully fund his requested salary reduction, the contribution cannot be made up in the future when the Participation has earned salary sufficient to fund such benefits election.}

Debiting of Accounts. A Participant's Medical Reimbursement Account for each Period of Coverage shall be debited from time to time as provided in Section 6.2 hereof in the amount of any payment under Article VI to or for the benefit of the Participant for Health Care Expenses incurred during such Period of Coverage or Grace Period. Amounts debited to each such Medical Reimbursement Account shall be treated as payments of

the earliest amounts credited to the Account and not yet treated paid, under a "first-in, first-out" approach.

5.3 Limitation on Reimbursements or Payments with Respect to Certain Participants. Notwithstanding any other provision of this Plan, the Administrator may limit the amounts reimbursed or paid with respect to any Participant who is Highly Compensated Individual (within the meaning of Code Section 105 (h)(5) or 125(e)) to the extent the Administrator deems such limitation to be advisable to assure compliance with any non-discrimination provision of the Code. Such limitation may be imposed whether or not it results in forfeiture under Section 5.5.

5.4 Forfeiture of Accounts. The amount credited to a Participant's Medical Reimbursement Account for any Period of Coverage shall be used only to reimburse the Participant for Health Care Expenses incurred during such Period of Coverage and Grace Period, and only if the Participant applies for reimbursement on or before the end of the Run-out Period following the close of the Period of Coverage in which such expenses were incurred. If any balance remains in the Participant's Medical Reimbursement Account for a Period of Coverage after all reimbursements hereunder, such balance shall not be carried over to reimburse the Participant for Health Care Expenses incurred during a subsequent Period of Coverage, and shall be forfeited. (Forfeited amounts shall be used to pay the administrative expenses of the Plan).

5.5 If Congressional Action or Treasury/IRS Regulatory Changes modify or rescind the Use it or Lose It Rule, the Employer has the discretion to eliminate or modify the forfeiture provisions of this plan by notifying employees in advance of the Grace Period for any given Plan Year.

ARTICLE VI – PAYMENT OF HEALTH CARE EXPENSE REIMBURSEMENTS

6.1 Claims for Reimbursement. A Participant may apply to the Employer for reimbursement of Health Care Expenses incurred by the Participant during the Period of Coverage and/or Grace Period by submitting a statement in writing to the Employer, in such form as the Employer may prescribe, setting forth:

(a) The amount, date and nature of the expense with respect to which a payment or reimbursement is requested;

(b) The name of the person, organization or entity to which the expense was or is to be paid;

(c) The name of the person for whom the expense was incurred and, if such person is not the Participant, the relationship of such person to the Participant; and

(d) Such other information as the Employer may often require.

Such application shall be accompanied by statements showing the amounts of such expenses, together with any additional documentation, which the Administrator may request. Claims for reimbursement of expense incurred during the Period of Coverage and/or Grace Period may be submitted at any time during the Period of Coverage or within the Run-out Period.

Expenses shall be considered incurred when the health care is provided, not when the Participant is formally billed, charged for, or pays for the expense.

6.2 Reimbursement or Payment of Expenses. The Employer shall reimburse the Participant from the Participant's Medical Reimbursement Account for Health Care Expenses incurred during the Period of Coverage and/or Grace Period, for which the Participant submits a written application and documentation in accordance with Section 6.1. The Employer may, at its option, pay any such Health Care Expense directly to the person providing or supplying the health care in lieu of reimbursing the Participant. Notwithstanding anything herein to the contrary, a claim with respect to a Period of Coverage must be filed by the end of the Run-out Period to be eligible for reimbursement.

Subject to Article VII, the amount available for reimbursement shall, at all time during the Period of Coverage and/or Grace Period, be equal to the amount of coverage purchased by the Participant (the amount the Participant elected to have contributed into his Medical Reimbursement Account for the Period of Coverage), less any previous reimbursements made for the Period of Coverage. In no event may the annual value of Benefits provided hereunder for any Participant pursuant to the Participant's election on his Benefit Election Form exceed the maximum reimbursement amount as described in Section 4.3.

ARTICLE VII – TERMINATION OF PARTICIPATION

7.1 Termination of Participation. (a) In the event that a Participant ceases to be a Participant in this Plan for any reason other than as provided by subsection (b) during a Period of Coverage, the Participant's Benefit Election Form relating to this Plan shall terminate. Except as provided in this Section 7.1 and Section 7.2, the Participant shall be entitled to reimbursement only for Health Care Expenses incurred up to the date of termination, but only for Health Care Expenses incurred up to the date of termination, but only if the Participant (or estate) applies for such reimbursement in accordance with Section 6.1. No such reimbursement shall exceed the remaining balance, if any, at the date of employment termination in the Participant's Medical Reimbursement Account for the Period of Coverage in which the expenses were incurred.

(b) A Participant who terminates employment during a Period of Coverage due to disability or retirement shall be entitled to reimbursement for Health Care Expenses incurred within the same Plan Year as the termination until the Medical Reimbursement Account is exhausted, but only if the Participant (or the participant's estate) applies for such reimbursement in accordance with Section 6.1. No such reimbursement shall exceed the remaining balance, if any, in the Participant's Medical Reimbursement Account for the Period of Coverage in which the expenses were incurred, provided, however, that

such Participant may be entitled to reimbursement up to the maximum amount which the Participant elected to receive in the form of Health Care Expense reimbursement for such Period of Coverage if the Participant continues to pay the Required Premium for such Period of Coverage subsequent to termination.

7.2 Continuation of Coverage. If and to the extent required by law (including, without limitation, Sections 105, 125 and 4980N and regulations there under), in the event a Participant ceases to be an Employee and undertakes to pay Required Premium to the Employer on a monthly basis (or within such other time limit as may be provided for by law), coverage under the Plan shall continue so long as such Required Premiums are paid, but not beyond the end of the period for which such coverage is required by law. In addition, the former Participant shall be treated as a Participant under the Plan to such extent as is required by law, and shall be entitled to reimbursement for Health Care Expenses incurred during such period of continued coverage, subject to Section 7.3.

7.3 Limits on Time and Amount of Reimbursements. Reimbursements shall be made for any Period of Coverage under this Article VII only if the Participant applies for such reimbursement in accordance with Section 6.1 on or before the Run-out Period following the close of the Period of Coverage and/or Grace Period. In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Article VII.

7.4 No reimbursement under this Article VII shall exceed the remaining balance, if any, in the Participant's Medical Reimbursement Account for the Period of Coverage in which the expenses were incurred.

ARTICLE VIII – ADMINISTRATION

8.1 Plan Administrator. The Administrator shall have the sole responsibility for the administration of this Plan. The Administrator shall have the authority to appoint such other person or committee from time to time to supervise the administration of the Plan. The designated representatives of the Administrator shall have only those specific powers, duties, responsibilities and obligations as are specifically given them.

The Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the plan authorizing or providing for such direction, information or action. Furthermore, the Administrator may rely upon any such direction, information or action of another Employee of the Employer as being proper under this Plan, and is not required under this Plan to inquire into the propriety of any such direction, information or action. It is intended under this Plan that the Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Administrator nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

All usual and reasonable expenses of the Administrator that are not properly chargeable to or payable by the Plan (including payment out of forfeitures pursuant to Section 5.5)

shall be paid by the Employer, and any expenses not paid by the Employer shall not be the responsibility of the Administrator personally. The Administrator or any other designated representative of the Employer who is an Employee of the Employer shall not receive any compensation with respect to services hereunder except as such person may be entitled to Benefits under this Plan.

It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

The Administrator will have full power to administer the Plan in all of its details subject to applicable requirements of law.

8.2 Records and Reports. The Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants and the balances, if any, which are maintained under this Plan. The Administrator shall be responsible for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 105(b) plans.

8.3 Examination of Records. The Administrator will make available to each Participant such records as pertain to the participant, for examination at reasonable times during normal business hours.

8.4 Reliance on Tables, etc. In administering the Plan, the Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by the accountant, counsel or other expert who is employed or engaged by the Administrator.

8.5 Rules and Decisions. The Administrator may adopt such rules, as it deems necessary, desirable, or appropriate. All rules and decisions of the Administrator, whether directionally or otherwise, shall be exercised in a uniform and consistent manner so that all persons similarly situated will receive substantially the same treatment. When making a determination or calculation, the Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or the legal counsel of the Employer.

8.6 Facility of Payment. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a Benefit or installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such person or to the person's legal representative or to a relative of such person or such person's benefit, or the Administrator may direct the Employer to apply the payment for the Benefit of such person in such a manner as the Administrator considers advisable. Any payment of a Benefit or installment thereof in accordance with the provisions of this Section 8.6 shall be a complete discharge of any liability for making of such payment under the provisions of the Plan.

8.7 Claims and Review Procedures.

(a) A claim for benefits under the Plan shall first be filed with the TPA. Notice of the decision shall be furnished to the claimant by the TPA within a reasonable period

of time after receipt of the claim by TPA. If a Participant does not receive notice of denial of a claim for benefits under the Plan within 90 days of the filing of such claim, then the claim shall be deemed denied.

(b) A claimant may review all pertinent documents and may request a review by the TPA of any claim. Any such request must be filed in writing with the TPA within 90 days after the earlier of (i) receipt by the claimant of written notice of the decision on the claim or (ii) 90 days after the initial filing of such claim. Such written request for review shall contain all additional information, which the claimant wishes the TPA to consider.

(c) If such claim is denied by the TPA, a claimant may appeal in writing to PEIA. Such appeal must be filed with PEIA within 30 days of receipt of the TPA's decision denying such claim. All information relating to the denial, including a copy of the denial letter from the TPA, must be supplied to PEIA by the claimant. PEIA will, after reviewing the facts, make a final determination and notify the claimant of its decision. Such decision shall be final and binding.

8.8 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

8.9 Indemnification of Administrator. PEIA agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including and Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorneys' fee and amounts paid in settlement of any claims approved by PEIA) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

8.10 Appointment of Agent by Administrator. The Plan Administrator may delegate its duties to a TPA, and such TPA may perform all the duties of the Administrator as set forth in this Article VIII, subject to the terms of the Plan.

ARTICLE IX – AMENDMENT AND TERMINATION OF PLAN

9.1 Amendment of Plan. This Plan may be amended at any time by the PEIA to any extent and in any manner that it may deem advisable, by a written instrument signed by PEIA.

9.2 Termination of Plan. PEIA has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but PEIA will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time without liability. Upon termination or discontinuance of the Plan, all elections and reductions in compensation related to the Plan shall terminate, and reimbursements shall be made in accordance with Article VI and Article VII.

ARTICLE X – MISCELLANEOUS PROVISIONS

10.1 Communication to Employees. Promptly after the Plan is adopted, PEIA will notify all Employees of the availability and terms of the Plan.

10.2 Information to be Furnished. Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

10.3 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Administrator or the Employer, except as expressly provided herein, and in no event, will the terms of employment or service of any Participant be modified or in any way be affected hereby.

10.4 Benefits Solely from General Assets. The Benefits provided hereunder will be paid solely from the general assets of the Employer. The Benefits provided by the Plan are given in exchange for the Participant's salary reduction agreement. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the Benefit of any Participant and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any payment under the Plan may be made.

10.5 Non-assignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his creditors by any process whatsoever, and any attempt to cause such rights to be so subjected will not be recognized, except to such extent as may be required by law.

10.6 Non-alienation of Benefits. Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable hereunder shall be void. The Employer and PEIA shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits hereunder.

10.7 Divestment of Benefits. Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to the benefit to which the participant becomes entitled in accordance with the provisions of this Plan.

10.8 No Guarantee of Tax Consequences. Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under Article VI will be excludable from the Participant's gross income tax purposes, or that any other Federal or state treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under Article VI is excludable from the Participant's gross income for Federal or state income tax

purposes, and to notify the Employer if the Participant has reason to believe that any such payments is not so excludable.

10.9 Indemnification of Employer by Participants. If any Participant's receives one or more payments or reimbursement under Article VI that are not for Health Care Expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal or state income tax or Social Security tax from such payment or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and state income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.10 Governing Law. The Plan will be construed, administered and enforce according to the laws of the state of West Virginia.

10.11 Execution of Documents. Each Employee, family member or beneficiary, does, by the acceptance of potential benefits under this Plan, agrees to execute any documents, which may be necessary or proper in the carrying out of the purpose and intent of the Plan.

10.12 Election Not to Participate. Each eligible Participant shall have the right to elect not to participate in this Plan.

10.13 Not a Contract of Employment. This Plan shall not be deemed to constitute a contract between the Employer and the Participant or to be a consideration or an inducement for the employment of any Participant. Nothing contained in the Plan shall be deemed to give any Participant the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant at any time regardless of the effect which said discharge shall have upon the employee as a Participant of the Plan.

10.14 Severability. If any provisions of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

10.15 Construction of the Plan. PEIA and/or Administrator may construe any ambiguous provisions of the Plan, correct any defect, supply any omission, or reconcile any inconsistency, in such manner and to such extent as PEIA in its discretion may determine, any such action of PEIA shall be binding and conclusive upon all Participants.

ARTICLE XI – CONTINUATION COVERAGE

11.1 Right to Elect Continuation Coverage. To the extent required by COBRA, a Participant, the Participant's Spouse, ex-spouse, and the Participant's dependent child can elect continuation coverage of such optional benefits under the Employer's Medical Plan and Medical Reimbursement Plan.

XI: DEPENDENT CARE REIMBURSEMENT PLAN

ARTICLE I – INTRODUCTION

1.1 Purpose of Plan. The purpose of the Plan is to enable Participants to elect to receive payments of reimbursements of their dependent care expenses that are excludable from the Participant's gross income under Section 129 of the Code.

1.2 Qualification of Plan. This Plan is intended to qualify as a dependent care assistance program under Section 129 of the Code, and is to be interpreted in a manner consistent with the requirements of Section 129.

1.3 Effective Date. The Plan is amended and restated effective July 1, 2006.

ARTICLE II – DEFINITIONS

The definitions in this Plan shall have the same meanings as set forth in the State of West Virginia Public Employees Insurance Agency Section 125 Plan, unless otherwise indicated below.

2.1 "Benefits" means any amount(s) paid to a Participant in the Plan as reimbursement for Dependent Care Expenses incurred by a Participant during a Period of Coverage and/or Grace period by the Participant, Spouse, or Dependent.

2.2 "Dependent" means any individual who is (a) dependent (as defined in Code Section 152) of the Participant who is under the age of 13 and with respect to whom the Participant is entitled to an exemption under Section 151 (c) of the Code, or (b) a dependent as defined in Code Section 152(c) or Spouse of the Participant who is physically or mentally incapable of caring for him or herself.

2.3 "Dependent Care Expenses" means expenses incurred by a Participant which (a) are incurred for the care of a Dependent of the Participant or for related household services, (b) are paid or payable to a Dependent Care Service Provider, and (c) are incurred to enable the Participant to be gainfully employed for any period of which there are one or more Dependents with respect to the Participant. "Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is described in Section 2.2(a) above or regularly spends at least eight (8) hours each day in the Participant's household.

Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses related are rendered.

2.4 "Dependent Care Reimbursement Account" means the account described in Article V hereof.

2.5 "Dependent Care Service Provider" means a person who provides care or other services described in Section 2.3 above, but shall not include (a) a dependent care center (as defined in Section 21 (b)(2)(D) of the Code), unless the requirements of Code Section 21 (b)(2)(C) are satisfied, or (b) a related individual described in Section 129(c) of the Code.

2.6 "Earned Income" means all income derived from wages, salaries, tips, self-employment and other employee compensation (such as disability benefits) but such term does not include any amounts received (i) under the Plan or any other Dependent Care program under Code Section 129 (ii) as pension or annuities; or (iii) as unemployment or Workers' Compensation.

2.7 "Effective Date" means this amendment and restatement is effective July 1, 2006.

2.8 "Eligible Expenses" means all Dependent Care Expenses incurred by a Participant or by his Spouse which are paid to a Dependent Care Service Provider.

2.9 "Grace Period" means the period of two months and fifteen days following the end of the Period of Coverage (Plan Year) during which amounts unused at the end of the Period of Coverage (Plan Year) may be used to reimburse qualifying Dependent Care Expenses incurred during the Grace Period. All amounts allocated to the Dependent Reimbursement Plan that are not used to reimburse qualifying Dependent Care Expenses incurred during the Period of Coverage (Plan Year) and/or Grace Period shall be forfeited.

2.10 "Highly Compensated Individual" means a Participant who is (a) a 5 percent owner, (b) received compensation from the Employer in excess of $75,000 (as adjusted), (c) received compensation from the Employer in excess of $50,000 (as adjusted) and was in the top-paid group of Employees for such year, or (d) an officer who received compensation greater than 50 percent of the amount in effect under Section 415(b)(1)(A) of the Code for such year.

2.11 "Participant" means each Employee who elects to participate in the Plan in accordance with Article III.

2.12 "Period of Coverage" means the Plan Year. The Period of Coverage will be twelve (12) months, except for the periods of Coverage during which an Employee is a Participant for less than the entire Period of Coverage. A Period of Coverage shall not be for a duration which would enable a Participant to defer the receipt of Compensation or to obtain coverage under the Plan only for periods during which a Participant expects to incur Dependent Care Expenses.

2.13 "Plan" means The State of West Virginia Public Employees Insurance Agency Dependent Care Reimbursement Plan as set forth herein, together with any and all amendments and supplements hereto, which is designed to operate in conjunction with the Section 125 Plan.

2.14 "Plan Year" means the twelve-month period beginning July 1 and ending June 30.

2.15 "Run-out Period" means the 120 days following the close of the Period of Coverage (Plan Year) during which participants may submit for reimbursement those expenses incurred during the Period of Coverage (Plan Year), and incurred during the Grace Period.

2.16 "Section 125 Plan" means The State of West Virginia Public Employees Insurance Agency Section 125 Plan as amended from time to time.

The singular shall include the plural and vice-versa, whenever used herein, unless the context clearly indicates otherwise.

ARTICLE III – PARTICIPATION

3.1 Eligibility to Participate. All Eligible Employees may participate in and enter the Plan.

3.2 Commencement of Participation. An Eligible Employee may elect to become a Participant in the Plan by completing a Benefit Election Form and filing it with the Employer. Such an individual will become a Participant upon the effective date of an election to participate in the Plan as set forth in Article IV. In order to participate in the Plan during a particular Period of Coverage, an Employee must complete and file a Benefit Election Form during an open enrollment period designated by the Employer, which period shall end prior to the first day of such Period of Coverage. An Eligible Employee hired after open enrollment, must enroll during the month of hire or the following month.

On the Benefit Election Form, the Employee shall designate the amount of Compensation to be contributed to the Dependent Care Reimbursement Account, and thereby agrees to reduced Compensation by such amount.

3.3 Cessation of Participation. Except as provided in Article VII, a Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates, (b) the date on which the participant ceases to be an Eligible Employee, or (c) the date on which the election under the Section 125 Plan to receive Dependent Care Expense reimbursement expires or is terminated under the Section 125 Plan.

3.4 Reinstatement of Former Participant. A Former Participant who is eligible under Section 3.1 elects again under the Section 125 Plan to receive reimbursement of Dependent Care Expenses under this Plan, will again become a Participant in this Plan on the effective date of such election. However, in the case of a Participant who separates from service with the Employer during a Period of Coverage and elects to revoke existing benefit elections and terminates the receipt of Benefits for the remaining portion of the Period of Coverage, such a Participant who returns to service within the same Period of Coverage, will be prohibited from making new benefit elections for the remaining portion of such Period of Coverage.

3.5 Salary Reduction. By participating in the Plan, each Participant agrees to have annual Compensation reduced by the amount of money the participant has elected to contribute to his Dependent Care Reimbursement Account under the Section 125 Plan. No Participant shall be entitled to reduce Compensation for Dependent Care Benefits by more than the aggregate maximum amount of Benefits specified in Section 4.4.

ARTICLE IV – ELECTION TO RECEIVE DEPENDENT CARE REIMBURSEMENTS

4.1 Election Procedure. A Participant may elect to receive Dependent Care Expense Reimbursement under this Plan by filing a Benefit Election Form in accordance with the procedures set forth in the Section 125 Plan. An election to receive Dependent Care Expense Reimbursement shall be irrevocable and remain in effect until the end of the

Period of Coverage, unless there is a change in family status, as provided in the Section 125 Plan.

4.2 Maximum Dependent Care Reimbursement. The maximum amount which the Participant may receive in any Period of Coverage in the form of Dependent Care Expense Reimbursement under this Plan shall be the lesser of (a) the Participant's Earned Income for the Period of Coverage (after all reductions in compensation including the reduction related to Dependent Care Reimbursement), (b) the actual or deemed Earned Income of the Participant's Spouse for the Period of Coverage, or (c) $5,000 ($2,500 where a separate return is filed by a married individual). In the case of a Spouse who is a full-time student at an education institution or is physically or mentally incapable of caring for him or herself, such spouse shall be deemed to have Earned Income of not less than $200 per month if the Participant has one Dependent and $400 per month if the Participant has two or more Dependents.

4.3 Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of Highly Compensated Individuals or Key Employees (as defined in Code Section 414(q)) as the eligibility to participate, contributions and/or benefits, and to comply in this respect with the requirements of the Code. If, in the judgment of the Plan Administrator, the operation of the Plan in any Period of Coverage would result in such discrimination, then such Plan Administrator shall select and exclude from coverage under the Plan such Highly Compensated or Key Participants and/or reduce contributions and or Benefits under the Plan for such Participants, as shall be necessary to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate.

4.4 Maximum Employer Contributions. The maximum amount of Employer contributions under the Plan for any Participant shall be the maximum amount, which the Participant may receive in the form of Dependent Care Expense Reimbursement under the Plan.

ARTICLE V – DEPENDENT CARE REIMBURSEMENT ACCOUNTS

5.1 Establishment of Accounts. The Administrator will establish and maintain on its books a Dependent Care Reimbursement Account for each Period of Coverage with respect to each Participant who has elected to receive reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

5.2 Crediting of Accounts. There shall be credited to a Participant's Dependent Care Reimbursement Account for each Period of Coverage as of each date Compensation is paid, for the Participant in such Period of Coverage, an amount equal to the reduction, if any, to be made in such Compensation in accordance with the Participant's Benefit Election Form under the Section 125 Plan. Contributions shall be credited to Dependent Care Reimbursement Accounts in equal amounts over a period of time established by the Employer. All amounts credited to such Dependent Care Reimbursement Account shall be the property of the Employer until paid out pursuant to Article VI.

{If an Employee's net pay is not sufficient to fully fund the requested salary reduction, the contribution cannot be made up in the future when the Participant has earned salary sufficient to fund such benefit election}.

5.3 Debiting of Accounts. A Participant's Dependent Care Reimbursement Account for each Period of Coverage shall be debited from time to time as provided in Section 6.2 hereof in the amount of any payment under Article VI to or for the benefit of the Participant for Dependent Care Expenses incurred during such Period of Coverage and Grace Period. Amounts debited to each such Dependent Care Reimbursement Account shall be treated as payments of the earliest amounts credited to the Account and not yet treated as paid under this Section 5.3, under a "first-in, first-out" approach.

5.4 Forfeiture of Accounts. The amount credited to a Participant's Dependent Care Reimbursement Account for any Period of Coverage shall be used only to reimburse the Participant for Dependent Care Expenses incurred during such Period of Coverage and Grace Period, and only if the Participant applies for reimbursement on or before the end of the Run-out Period following the Period of Coverage in which the expenses were incurred. If any balance remains in the Participant's Dependent Care Reimbursement Account for a Period of Coverage after all reimbursement hereunder, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Period of Coverage, but shall be forfeited. (Forfeited amounts shall be used to pay the administrative expenses of the Plan).

If Congressional Action or Treasury/IRS Regulatory Changes modify or rescind the Use it or Lose It Rule, the Employer has the discretion to eliminate or modify the forfeiture provisions of this Plan by notifying employees in advance of the Grace Period for any given Plan Year.

ARTICLE IV – PAYMENT OF DEPENDENT CARE EXPENSE REIMBURSEMENTS

6.1 Claims for Reimbursement. A Participant may apply to the Employer for reimbursement of Dependent Care Expenses incurred by the Participant during the Period of Coverage and Grace Period by submitting an application in writing to the Employer, in such form as the Employer may prescribe, setting forth.

(a) The amount, date and nature of the expense with respect to which a payment or reimbursement is required.

(b) The names, address and tax identification number of the person, organization, or entity to which the expense was or is to be paid.

(c) Such other information as the Employer may from time to time require.

Such application shall be accompanied by a receipt showing the amounts of such expenses, together with any additional documentation, which the Administrator may request. Claims for reimbursement may be made at any time during the Period of Coverage or within the Run-out Period.

Expenses shall be considered incurred when the dependent care is provided, and not when the Participant is formally billed, charged for, or pays for the expense.

6.2 Reimbursement or Payment of Expenses. The Employer shall reimburse the Participant from the Participant's Dependent Care Reimbursement Account for Dependent Care Expenses incurred during the Period of Coverage and Grace Period, for which the

Participant submits a written application and documentation in accordance with Section 6.1. No Reimbursement or payment shall at any time exceed the balance of the Participant's Dependent Care Reimbursement Account for the Period of Coverage at the time of the Reimbursement or Payment. The amount of Dependent Care Expense not reimbursed or paid as a result of the preceding sentence will be carried over and reimbursed if and when the balance in the Participant's Dependent Care Reimbursement Account permits such reimbursement or payment. Notwithstanding anything herein to the contrary, a claim with respect to a Period of Coverage must be filed by the end of the Run-out Period to be eligible for reimbursement. In no event may the annual value of Benefits provided hereunder for any Participant pursuant to the Participant's election on his Benefit Election Form exceeds the maximum reimbursement amount as described in Section 4.2.

6.3 Limitation on Amount of Benefits. The average Benefits provided to Non-Highly Compensated Individuals must be at least 55% of the average Benefits provided to Highly Compensated Individuals under all Dependent Care Reimbursement Plans of the Employer. For purposes of this limitation, in the case of any Benefits provided through a salary reduction agreement, the Plan may disregard any Participant whose Compensation is less than $25,000. For purposes of the above paragraph, there shall be excluded from consideration Employees who are described in Code Section 129(d)(9).

6.4 Principal Shareholders Limitation. Not more than 25 percent of the amounts paid or reimbursed by and Employer for Dependent Care Expenses incurred during a period of Coverage may be provided for the class of Participants, each of whom (on any day of such Period of Coverage) owns more than 5 percent of the stock or of the capital or profits interest in such Employer. The ownership of stock in an Employer shall be determined in accordance with the rules provided under Section 1563(d) and (e) of the Code (without regard to Section 1563(e)(3)(C)). The Administrator shall reduce the Dependent Care for such Participants to the extent that it reasonably believes necessary to prevent this limitation from being exceeded.

6.5 Officers, Owners, and Highly Compensated Individuals. The Administrator shall also reduce the Dependent Care Benefits for Officers, Owner, and Highly Compensated Individuals and their Dependents, to the extent that absent such reduction, the Program would be discriminatory within the meaning of Section 129 (d)(2) of the Code.

6.6 Verification of Information.

(a) Limitations. Participants shall furnish to the Administrator such information as the Administrator shall reasonably require to satisfy itself that the limitations contained in Sections 6.3, 6.4 and 6.5 are not violated. The Administrator may, but shall not be required to, require verification of such information, and refuse to pay Benefits unless and until it is satisfied that none of the limitations contained in Article IV and VI would be violated by such payment.

(b) Dependent Care Expenses. The Administrator may, but shall not be required to, require verification of Dependent Care Expenses for which Benefits are claimed and refuse to pay Benefits unless and until it is satisfied that such Benefits have

been incurred. A Participant shall cooperate fully with such verification if the Administrator requires him to do so.

(c) Service Provider Identifying Information. No amount paid or incurred by the Employer for Benefits provided to a Participant shall be excluded from the gross income of a Participant unless:

(1) the name, address and taxpayer identification number of the facility or name, address, Social Security number and signature of the person performing the services are included on the Reimbursement Claim Form to which the exclusion relates; or

(2) if such person is an organization described in Section 501 (c)(3) of the Code and exempt from tax under Section 501(a), the name and address of such person are included on the Reimbursement Claim Form to which the exclusion relates.

The preceding sentence shall not apply if the Participant can show that due diligence was exercised in attempting to provide the required information in the case of a failure to provide such information.

6.7 Limitation on Dependent Care Benefits. Notwithstanding anything herein to the contrary, no benefit shall be paid under this Article VI to the extent otherwise reimbursed.

ARTICLE VII – TERMINATION OF PARTICIPATION

7.1 Termination of Participation. In the event that a Participant ceases to be a Participant in this Plan for any reason, the Participant's election with respect to the Dependent Care Reimbursement Plan shall terminate. However, the Participant (or estate) shall be entitled to reimbursement for Dependent Care Expenses incurred within the same Plan Year of termination until the Dependent Care Reimbursement Account is exhausted, but only if the Participant (or estate) applies for such reimbursement in accordance with Section 6.1. No such reimbursement shall exceed the remaining balance, if any, in the Participant's Dependent Care Reimbursement Account for the Period of Coverage in which the expenses were incurred.

7.2 Leave of Absence. Upon termination of employment, Participants may no longer contribute to their Dependent Care Reimbursement Accounts. However, Participants who take an unpaid leave during a Period of Coverage may continue to contribute to their Dependent Care Reimbursement Accounts using after-tax dollars.

ARTICLE VIII – ADMINISTRATION

8.1 Plan Administrator. The Administrator shall have the sole responsibility for the administration of this Plan. The Administrator shall have the authority to appoint such other person or committee from time to time to supervise the administration of the Plan. The designated representatives of the Administrator shall have only those specific powers, duties, responsibilities and obligations as are specifically given them.

The Administrator warrants that any directions given, information furnished, or action by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. Furthermore, the Administrator may rely upon such direction, information or action of another Employee or Employer as being proper under this Plan, and is not required under this Plan to inquire into the propriety of any such direction, information or action. It is intended under this Plan that the Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Administrator nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

All usual and reasonable expenses of the Administrator that are not properly chargeable to or payable by the Plan (including payment out of forfeitures pursuant to Section 5.4) shall be paid by the Employer, and any expenses not paid by the Employer shall not be the responsibility of the Administrator personally. The Administrator or any other designated representative of the Employer who is an Employee of the Employer shall not receive any compensation with respect to services hereunder except as such person may be entitled to Benefits under this Plan.

It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

The Administrator will have full power to administer the Plan in all of its details subject to applicable requirements of law.

8.2 Records and Reports. The Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants and the balances, if any, which are maintained under this Plan. The Administrator shall be responsible for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 129 Plans.

8.3 Examination of Records. The Administrator will make available Participant such records as pertain to the Participant, for examination at reasonable times during normal business hours.

8.4 Reliance on Tables, etc. In administering the Plan, the Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by any accountant, counsel or other expert who is employed or engaged by the Administrator.

8.5 Rules and Decisions. The Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Administrator, whether discretionary or otherwise, shall be exercised in a uniform and consistent manner so that all persons similarly situated will receive substantially the same treatment. When making a determination or calculation, the Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or the legal counsel of the Employer.

8.6 Facility of Payment. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a Benefit or installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such person or to the person's legal representative or to a relative of such person for such person's benefit, or the Administrator may direct the Employer to apply the payment for the Benefit of such person in such manner as the Administrator considers advisable. Any payment of a Benefit or installment thereof in accordance with the provisions of this Section 8.6 shall be a complete discharge of any liability for making of such payment under the provisions of the Plan.

8.7 Claims and Review Procedures.

(a) A claim for Benefits under the Plan shall first be filed with the TPA. Notice of the decision shall be furnished to the claimant by the TPA within a reasonable period of time after receipt of the claim by the TPA. If a Participant does not receive notice of denial of a claim for Benefits under the Plan within 90 days of the filing of such claim, then the claim shall be deemed denied.

(b) A claimant may review all pertinent documents and may request a review by the TPA of any claim. Any such request must be filed in writing with the TPA within 90 days after the earlier of (i) receipt by the claimant of written notice of the decision on the claim or (ii) 90 days after the initial filing of such claim. Such written request for review shall contain all additional information, which the claimant wishes the TPA to consider. Notice of the decision on review shall be furnished in writing to the claimant within 90 days (unless special circumstances require an extension of up to 90 additional days) following the receipt of the request for review. The TPA's written decision shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan or of the Plan Documents on which the decision is based.

(c) If such claim is denied by the TPA, a claimant may appeal in writing to PEIA. Such appeal must be filed with PEIA within 30 days of receipt of the TPA's decision denying such claim. All information relating to the denial, including a copy of the denial letter from the TPA, must be supplied to PEIA by the claimant. PEIA will, after reviewing the facts, make a final determination and notify the claimant of its decision. Such decision shall be final and binding.

8.8 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

8.9 Indemnification of Administrator. PEIA agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fee and amounts paid in settlement of

any claims approved by PEIA) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

8.10 Appointment of Agency by Plan Administrator. The Plan Administrator may delegate its duties to a TPA, and such TPA may perform all of the duties of the Administrator as set forth in this Article VIII, subject to the terms of the Plan.

ARTICLE IX – AMENDMENT OR TERMINATION OF PLAN

9.1 Amendment of Plan. This Plan may be amended at any time by the PEIA to any extent and in any manner that it may deem advisable, by a written instrument signed by PEIA.

9.2 Termination of Plan. PEIA has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but PEIA will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time without liability. Upon termination or discontinuance of the Plan, all elections and reductions in Compensation related to the Plan shall terminate, and reimbursements shall be made in accordance with Article VI and Article VII.

ARTICLE X – MISCELLANEOUS PROVISIONS

10.1 Communication to Employees. Promptly after the Plan is adopted, PEIA will notify all Employees of the availability and terms of the Plan.

10.2 Information to be Furnished. Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration on the Plan.

10.3 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Administrator or the Employer, except as expressly provided herein, and in no event, will the terms of employment or service of any Participant be modified or in any way be affected hereby.

10.4 Benefits Solely from General Assets. The Benefits provided hereunder will be paid solely from the general assets of the Employer. The Benefits provided by the Plan are given in exchange for the Participant's salary reduction agreement. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or the person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

10.5 Non-assignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his creditors by any process whatsoever, and any attempt to cause such rights to be so subjected will not be recognized, except to such extent as may be required by law.

10.6 Non-alienation of Benefits. Benefits under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge

garnishment, execution or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to Benefits payable hereunder, shall be void. The Employer and PEIA shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to Benefits hereunder.

10.7 Divestment of Benefits. Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to the benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.

10.8 Guarantee of Tax Consequences. Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under Article VI will be excludable from the Participant's gross income for Federal or State Income Tax purposes, or that any other Federal or State tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under Article VI is excludable from the Participant's gross income for Federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe any such payments is not so excludable.

10.9 Indemnification of Employer by Participants. If any Participant receives one or more payments or reimbursement under Article VI that are not for Dependent Care Expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal or State income tax or Social Security tax from such payment or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and State income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.10 Governing Law. The Plan will be construed, administered and enforced according to the laws of the State of West Virginia.

10.11 Execution of Documents. Each Employee, family member or beneficiary, does, by his acceptance of potential Benefits under this Plan agree to execute any documents, which may be necessary or proper in the carrying out of the purpose and intent of the Plan.

10.12 Election Not to Participate. Each eligible Participant shall have the right to elect not to participate in this Plan.

10.13 Not a Contract of Employment. This Plan shall not be deemed to constitute a contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant. Nothing contained in this Program shall be deemed to give any Participant the right to be retained in the service of the Employer or to interfere

with the right of the Employer to discharge any Participant at any time regardless of the effect which such discharge shall have upon him or her as a Participant of the Plan.

10.14 Severability. If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

10.15 Construction of the Plan. PEIA and/or the Administrator may construe any ambiguous provisions of the Plan, correct any defect, supply any omission, or reconcile any inconsistency, in such manner and to such extent as PEIA in its discretion may determine, any such action of PEIA shall be binding and conclusive upon all Participants.

APPENDIX A: LISTING OF CURRENT TPAs

Third-Party Administrator for Medical Claims Processing and Customer Service UMR P.O. Box 30541 Salt Lake City, UT 84130-0541 1-888-440-7342	***Administrator for PEIA Basic and Optional Life Insurance and AD&D*** Life Claims: MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 Toll-free 1-888-466-8640 Statement of Health unit: MetLife Statement of Health unit P.O. Box 14069 Lexington, KY 40512 Toll-free 1-888-466-8640 Beneficiary designations: MetLife Recordkeeping and Enrollment Services P.O. Box 14401 Lexington, KY 40512-4401 Toll-free 1-888-466-8640
Third-Party Administrator for Medical Utilization Review UMR P.O. Box 30541 Salt Lake City, UT 84130-0541 1-888-440-7342	***Third-Party for Subrogation of Claims*** Beacon Recovery, LLC 300 Trade Center Suite 7640 Woburn, MA 01801 (617) 570-8000 ext. 123
Third-Party Administrator for Prescription Drug Plan Express Scripts Attn: Commercial Claims P.O. Box 14711 Lexington, KY 40512-4711	***Third-Party Administrator for Managed Care Plan*** The Health Plan of West Virginia, Inc. 1110 Main Street Wheeling, WV 26003 1-800-624-6961
Administrator for Mountaineer Flexible Benefits FBMC Benefits Management, Inc. P.O. Box 1878 Tallahassee, FL 32302-1878 1-800-559-8248	***Administrator for Medicare Advantage Plan/Prescription Drug (MAPD) Plan*** Humana P.O. Box 14168 Lexington, KY 40512-4168 1-800-783-4599

APPENDIX B: PREMIUMS (PPB, MANAGED CARE AND LIFE)

PLAN YEAR 2025 (July 1, 2024 – June 30, 2025)

A listing of premiums for Plan Year 2025 may be found here:

https://peia.wv.gov/Forms-Downloads/Pages/Premium-Rates.aspx

https://peia.wv.gov/Forms-Downloads/Pages/Shopper's-Guides.aspx

https://peia.wv.gov/Forms-Downloads/Pages/Medicare-Shopper's-Guides.aspx

APPENDIX C: DEDUCTIBLES, COINSURANCE AND COPAYMENTS FOR PEIA PPB MEDICAL BENEFITS PLANS A, B, AND D

ANNUAL MEDICAL DEDUCTIBLES

Annual Deductibles						
	Annual Salary	Employee Only	Employee & Child(ren)	Family	Family with Employee Spouse	Family with Spousal Surcharge
PEIA PPB Plan A & D (state agencies, colleges, universities and county boards of education)	$0 - $30,400	$325	$650	$650	$650	$650
	$30,401- $40,400	$375	$750	$750	$750	$750
	$40,401- $46,400	$425	$850	$850	$850	$850
	$46,401- $52,400	$450	$900	$900	$900	$900
	$52,401- $60,400	$475	$950	$950	$950	$950
	$60,401- $72,900	$600	$1,200	$1,200	$1,200	$1,200
	$72,901- $85,400	$625	$1,250	$1,250	$1,250	$1,250

	$85,401- $110,400	$650	$1,300	$1,300	$1,300	$1,300
	$110,401- $135,400	$725	$1,450	$1,450	$1,450	$1,450
	$135,401+	$825	$1,650	$1,650	$1,650	$1,650
PEIA PPB Plan B (state agencies, colleges, universities and county boards of education)	$0 - $30,400	$430	$860	$860	$860	$860
	$30,401- $40,400	$490	$1,000	$1,000	$1,000	$1,000
	$40,401- $46,400	$560	$1,130	$1,130	$1,130	$1,130
	$46,401- $52,400	$600	$1,190	$1,190	$1,190	$1,190
	$52,401- $60,400	$620	$1,260	$1,260	$1,260	$1,260
	$60,401- $72,900	$790	$1,580	$1,580	$1,580	$1,580
	$72,901- $85,400	$830	$1,660	$1,660	$1,660	$1,660
	$85,401- $110,400	$860	$1,720	$1,720	$1,720	$1,720
	$110,401- $135,400	$960	$1,920	$1,920	$1,920	$1,920
	$135,401+	$1,090	$2,140	$2,140	$2,140	$2,140
Non-State Plan A	Not Applicable	$450	$900	$900	N/A	N/A
Non-State Plan B	Not Applicable	$725	$1,450	$1,450	N/A	N/A
Non-Medicare Retirees Plan A	Not Applicable	$525	N/A	$1,050	N/A	N/A

Non-Medicare Retirees Plan B	Not Applicable	$925	N/A	$1,850	N/A	N/A
Deputy Sheriff's Early Retirement Plan A	Not Applicable	$450	N/A	$900	N/A	N/A
Deputy Sheriff's Early Retirement Plan B	Not Applicable	$725	N/A	$1,450	N/A	N/A
State-funded Elected Officials Plans A and D	Not Applicable	$450	$900	$900	$900	$900
State-funded Elected Officials Plan B	Not Applicable	$725	$1,450	$1,450	$1,450	$1,450

OOSINNA or Lower Level of Benefit: For in-network out-of-state care beyond the bordering counties, if not approved in advance at the highest out-of-state benefit level, the deductible and out-of-pocket maximum amounts are doubled, and the plan pays only a smaller percentage of the allowed amount.

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

Deductibles for Family with Employee Spouse coverage are based on the average of the two employee's salaries. Add the annual salaries together and divide by two to get the basis of the premium. This provision does not apply to local government agency or retired employees.

The OOSINNA (Lower level of Benefit) deductible applies to the in-network deductible, but the in-network deductible does not satisfy the OOSINNA deductible. Please note that the amounts listed in the chart are for in-network deductibles. OOSINNA deductibles are twice the amount of the in-network deductibles listed above.

Prescription drug benefits are subject to a separate deductible. See the "Prescription Drug Benefit" section for details.

PEIA PPB PLANS A, B** & D***

Coinsurance for In-Network and Out-of-Network Benefits for PEIA PPB Plans

For this table, in-state means inside WV; bordering county means a contiguous county of a surrounding state, and out-of-state means outside WV beyond the bordering counties.

Where you get care	Where you live		
	WV Resident	**Bordering county resident**	**Out-of-state resident**
In-state, in-network	Plan A: 20% Plan B: 30% Plan C: 20% Plan D: 20%	Plan A: 20% Plan B: 30% Plan C: 20% Plan D: N/A	Plan A: 20% Plan B: 30% Plan C: 20% Plan D: N/A
Bordering county, in-network	Plan A: 20% Plan B: 30% Plan C: 20% Plan D: Not Covered	Plan A: 20% Plan B: 30% Plan C: 20% Plan D: N/A	Plan A: 20% Plan B: 30% Plan C: 20% Plan D: N/A
Out-of-state, in-network with UMR approval (Higher Level of Benefit)	Plan A: 30% Plan B: 35% Plan C: 20% Plan D: Not Covered	Plan A: 30% Plan B: 35% Plan C: 20% Plan D: N/A	Plan A: 30% Plan B: 35% Plan C: 20% Plan D: N/A
Out-of-state, out-of-network with UMR approval*	Plan A: 30% + amounts that exceed Reasonable and Customary Plan B: 35% + amounts that exceed Reasonable and Customary. Plan C: 20%	Plan A: 30% + amounts that exceed Reasonable and Customary Plan B: 35% + amounts that exceed Reasonable and Customary. Plan C: 20%	Plan A: 30% + amounts that exceed Reasonable and Customary Plan B: 35% + amounts that exceed Reasonable and Customary. Plan C: 20%

Out-of-state, in network without UMR approval (Lower Level of Benefit)	Plan A: 40% + up to a $500 copayment Plan B: 50% + up to a $500 copayment Plan C: 20%	Plan A: 40% + up to a $500 copayment Plan B: 50% + up to a $500 copayment Plan C: 20%	Plan A: 30% Plan B: 35% Plan C: 20%
Out-of-state, out-of-network without UMR approval*	Not Covered except for a medical emergency.	Not Covered except for a medical emergency.	Not Covered except for a medical emergency.

*PEIA PPB Plan D has NO coverage for out-of-state services. Plan D members cannot receive services outside WV, except in a medical emergency or when UMR determines that a needed service is not available within WV. In these cases, out-of-state care is covered as in-network care.

*Prior approval is generally only provided if services are not available in West Virginia.

The PEIA PPB Plans A, B & D are designed to provide as much care as possible within the State of West Virginia. The PEIA Preferred Provider Organization (PPO) is made up of West Virginia health care providers who provide health care services or supplies to PEIA participants. For services provided outside of the State, PEIA uses UnitedHealthcare Choice Plus Preferred Provider Organization.

SERVICES COVERED IN FULL

The following services are covered in full if in-network for all PEIA PPB Plans.
These are subject to change as USPSTF,CDC, and HRSA recommendations are updated.

Type of Service	**Frequency**
Covered Preventive Services for Adults *AWV=Annual Wellness Visit	
Abdominal Aortic Aneurysm one-time screening for men aged 65-75 who have ever smoked	Once per lifetime
Alcohol Misuse screening and counseling	Included in AWV
Aspirin use for men and women of certain ages (requires a prescription; covered under prescription drug plan)	As Needed
Blood Pressure screening for all adults	Included in AWV
Cholesterol screening for men age 35 and older and women age 45 and older or others at higher risk	Included in AWV
Colorectal Cancer screening for adults over age 45	See Colorectal Cancer Screening in the Summary Plan Description ABD
Depression screening for adults	Included in AWV
Type 2 Diabetes screening for adults aged 40 – 70 who are overweight or obese	Included in AWV

Type of Service	Frequency
Diet counseling for adults at higher risk for chronic disease	Included in AWV
Falls prevention for adults aged 65 and older	Included in AWV
Hepatitis B screening for people at high risk	As Needed
Hepatitis C screening for adults aged 18 - 79	As Specified
HIV pre-exposure prophylaxis (PrEP)	As Needed
HIV screening for all adults at higher risk	Annually
Immunization vaccines for adults—doses, recommended ages, and recommended populations vary: Hepatitis A — Hepatitis B Herpes Zoster — Human Papillomavirus (HPV) Influenza (Flu Shot) — Measles, Mumps, Rubella Meningococcal — Pneumococcal Tetanus, Diphtheria, Pertussis — Varicella COVID — Shingles All other CDC recommended Adult Vaccines	As Recommended by the CDC
Lung cancer screening for adults 50-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years	As Specified
Obesity screening and counseling for all adults	Included in AWV
Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk	Included in AWV
Tobacco Use screening for all adults and cessation interventions for tobacco users (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	See Tobacco Cessation in the Summary Plan Description ABD
Syphilis screening for all adults at higher risk	Annually
Statin preventative medication for adults aged 40 – 75 at high risk	As Needed
Tuberculosis screening for high risk adults without symptoms	As Needed
Unhealthy drug use screening	Included in AWV
Covered Preventive Services for Women, Including Pregnant Women	
Anemia screening on a routine basis for pregnant women	As Needed
Bacteriuria urinary tract or other infection screening for pregnant women	As Needed
BRCA counseling about genetic testing for women at higher risk	As Needed
Breast Cancer Mammography screenings every 1-2 years for women over 40	Every 1-2 years
Breast Cancer Chemoprevention counseling for women at higher risk	Once per lifetime
Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women	As Needed
Cervical Cancer screening for women aged 21 - 65	Every 3 years
Chlamydia Infection screening for younger women and other women at higher risk	Annually
Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling (generic oral contraceptives require a prescription; covered under the prescription drug plan)	As Needed
Domestic and interpersonal violence screening and counseling for all women	Included in AWV
Folic Acid supplements for women who may become pregnant (requires a prescription; covered under prescription drug plan)	As Needed
Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes	Once per pregnancy
Gonorrhea screening for all women at higher risk	Annually

Type of Service	Frequency
Hepatitis B screening for pregnant women at their first prenatal visit	Once per pregnancy
Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women	Annually
Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every five years for women with normal cytology results who are 30 or older	Every 5 years
Osteoporosis screening for women over age 65 or women younger depending on risk factors	Annually
Preeclampsia prevention and screening	As Needed
Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk	As Needed
Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	See Tobacco Cessation in the Summary Plan Description ABD
Sexually Transmitted Infections (STI) counseling for sexually active women	Included in AWV
Syphilis screening for all pregnant women or other women at increased risk	Annually
Urinary incontinence screening	Included in AWV
Well-woman visits to obtain recommended preventive services	Annually
Covered Preventive Services for Children (*WCC=Well Child Care)	
Alcohol and Drug Use assessments for adolescents	Included in WCC
Autism screening for children at 18 and 24 months	Included in WCC
Behavioral assessments for children of all ages Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Blood Pressure screening for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Bilirubin concentration screening for newborns	As Needed
Cervical Dysplasia screening for sexually active females	Annually
Congenital Hypothyroidism screening for newborns	Once, for newborn
Congenital/inherited metabolic disorders and hemoglobinopathies	Once, for newborn
Depression screening for adolescents	Included in WCC
Developmental screening for children under 3, and surveillance throughout childhood	Included in WCC
Dyslipidemia screening for children at higher risk of lipid disorders Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	As specified
Fluoride Chemoprevention supplements for children without fluoride in their water source (requires a prescription; covered under the prescription drug plan)	As Needed
Fluoride varnish for all infants and children as soon as teeth are present through age 5	As specified
Gonorrhea preventive medication for the eyes of all newborns	Once, for newborn
Hearing screening for all newborns	Once, for newborn
Height, Weight and Body Mass Index measurements for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Hematocrit or Hemoglobin screening for children	Once per lifetime
Hepatitis B screening in adolescents at increased risk	Annually
HIV screening for adolescents at higher risk	Annually

Type of Service	Frequency
Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis — Haemophilus influenzae type B Hepatitis A — Hepatitis B Human Papillomavirus (HPV) — Inactivated Poliovirus Influenza (Flu Shot) — Measles, Mumps, Rubella Meningococcal — Pneumococcal Rotavirus — Varicella COVID Other vaccines recommended by the CDC	As Recommended by the CDC
Iron supplements for children ages 6 to 12 months at risk for anemia (requires a prescription; covered under the prescription drug plan)	As Needed
Lead screening for children at risk of exposure	As Needed
Maternal depression screening for mothers of infants at 1, 2, 4, and 6 month visits	Included in WCC
Medical History for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years	Included in WCC
Obesity screening and counseling	Included in WCC
Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years	Included in WCC
Phenylketonuria (PKU) screening for this genetic disorder in newborns	Once, for newborn
Preexposure prophylaxis for HIV in ages 12 or older	As Needed
Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk	Included in WCC
Skin Cancer Prevention	Included in WCC
Tuberculin testing for children at higher risk of tuberculosis Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	As specified
Vision screening for all children	Included in WCC

COPAYMENT ONLY

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

Type of Service	Your In-network Cost
Primary Care Physician Office Visits – treat illness or injury	$20 copayment per visit with no deductible
Specialist Office Visit	$40 copayment per visit with no deductible
Out-of-State Primary Care Office Visits (In-Network)	$20 copayment per visit with no deductible
Second Surgical Opinions*	$40 copayment per visit with no deductible
Pain management and Rehabilitative Outpatient Services Visits 1-20	$20 copayment per visit with no deductible

*No copayment if required by UMR.

COPAYMENT, COINSURANCE AND DEDUCTIBLE

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

Type of Service	Your In-network Cost
Inpatient Hospital Stay	$100 copay + deductible and coinsurance
Emergency Services (including supplies)	$100 copayment + deductible and coinsurance
Non-emergency services at emergency room*	$100 copayment + deductible and coinsurance
Ambulatory surgery/Outpatient surgery (facility-based)	$100 copayment + deductible and coinsurance
Bariatric surgery and dental procedures	$500 copayment + deductible and coinsurance
Out-of-network transplant services	Deductible + coinsurance + additional $10,000 deductible
Outpatient Therapy Services visits 1-20	$10 copayment + deductible and coinsurance
Outpatient Therapy Services visits 21 +	$25 copayment + deductible and coinsurance
Out-of-state, in-network care without prior approval from UMR	$500 copayment + deductible + applicable coinsurance

*Non-emergency services received at the emergency room are very expensive to the PEIA Plans. Members who visit the emergency room for non-emergency services an excessive number of times may be placed on Complex Condition CARE or otherwise have payment for their ER services restricted or terminated by the PEIA Plans.

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

COINSURANCE AND DEDUCTIBLE

Services not listed in the three preceding charts are covered after the deductible is met. The coinsurance amounts are shown in the chart below:

	In WV and within contiguous counties*	In-Network Outside WV WITH Approval from UMR* Higher Level of Benefit	Out-of-State, In-Network Not Approved by UMR (OOSINNA) Lower Level of Benefit	Out-of-network Outside WV WITHOUT Approval from UMR
Plan A	80/20	70/30	60/40	Not Covered
Plan B	70/30	65/35	50/50	Not Covered
Plan D	80/20*	70/30	Not Covered	Not Covered

You pay your deductible, coinsurance, and any charges for services not covered by the plan directly to your health care provider.

* Contiguous counties are not covered in Plan D

APPENDIX D:

OUT-OF-POCKET MAXIMUMS, PEIA PPB PLANS A, B & D

ANNUAL BENEFIT MAXIMUMS

Out-of-Pocket Maximum Amounts			
Employee Status	**Employee's Annual Salary**	**Annual In-network Out-of-Pocket Maximum**	**Annual In-Network Out-of-State w/o Approval* Out-of-Pocket Maximum**
PEIA PPB Plans A and D (Active, State Agency, Colleges and Universities, Board of Education)	$0 - $30,400	$1,800/single; $3,600/family	$3,600/single; $7,200/family
	$30,401- $40,400	$2,100/single; $4,200/family	$4,200/single; $8,400/family
	$40,401- $46,400	$2,250/single; $4,500/family	$4,500/single; $9,000/family
	$46,401- $52,400	$2,500/single; $5,000/family	$5,000/single; $10,000/family
	$52,401- $60,400	$2,750/single; $5,500/family	$5,500/single; $11,000/family
	$60,401- $72,900	$2,800/single; $5,600/family	$5,600/single; $11,200/family
	$72,901- $85,400	$2,850/single; $5,700/family	$5,700/single; $11,400/family
	$85,401- $110,400	$2,900/single; $5,800/family	$5,800/single; $11,600/family
	$110,401- $135,400	$3,000/single; $6,000/family	$6,000/single; $12,000/family
	$135,401+	$3,250/single; $6,500/family	$6,500/single; $13,000/family
PEIA PPB Plan B (state agencies, colleges, universities and county boards of education)	$0 - $30,400	$2,400/single; $4,800/family	$4,800/single; $9,600/family
	$30,401- $40,400	$2,800/single; $5,500/family	$5,600/single; $11,000/family
	$40,401- $46,400	$3,000/single; $6,000/family	$6,000/single; $12,000/family
	$46,401- $52,400	$3,400/single; $6,600/family	$6,800/single; $13,200/family
	$52,401- $60,400	$3,600/single; $7,300/family	$7,200/single; $14,600/family
	$60,401- $72,900	$3,700/single; $7,400/family	$7,400/single; $14,800/family
	$72,901- $85,400	$3,700/single; $7,600/family	$7,400/single; $15,200/family
	$85,401- $110,400	$3,800/single; $7,700/family	$7,600/single; $15,400/family
	$110,401- $135,400	$4,000/single; $7,900/family	$8,000/single; $15,800/family
	$135,401+	$4,300/single; $8,600/family	$8,600/single; $17,200/family
Non-State Plans A & D	Not Applicable	$2,500/single; $5,000/family	$5,000/single; $10,000/family
Non-State Plan B	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family
Non-Medicare Retirees Plan A	Not Applicable	$1,500/single; $3,000/family	$3,000/single; $6,000/family
Non-Medicare Retirees Plan B	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family
Deputy Sheriff's Early Retirement Plan A	Not Applicable	$2,500/single; $5,000/family	$5,000/single; $10,000/family

Deputy Sheriff's Early Retirement Plan B	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family
State-funded Elected Officials Plans A and D	Not Applicable	$2,500/single; $5,000/family	$5,000/single; $10,000/family
State-funded Elected Officials Plan B	Not Applicable	$3,000/single; $6,000/family	$6,000/single; $12,000/family

*PEIA PPB Plan D has no out-of-network or out-of-state benefit, so this column does not apply to Plan D members.

BENEFIT MAXIMUMS

For certain types of services, the plan will pay up to a set amount per plan year as shown below. Patients experiencing a severe medical episode and patients with very complicated medical conditions are assigned a nurse case manager. For catastrophic cases involving serious long-term illness or injury resulting in loss or impaired function requiring medically necessary therapeutic intervention, the case manager may, based on medical documentation, recommend additional treatment for services marked with an asterisk (*), if any. For details of these benefits, see Section V.5. Covered Services. All services listed below must be medically necessary; otherwise, they are not covered.

Pursuant to W.Va. Code §5-16-7, PEIA may not apply treatment limitations to benefits for behavioral health, mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits: *Provided,* That any service, even if it is related to the mental health diagnosis if medical in nature, shall be reviewed as a medical claim and undergo all utilization review as applicable.

Annual Benefit Maximums	
Type of Service	**Benefit Maximum (per member per plan year)**
Christian Science Treatment	$1,000
Inpatient Rehabilitation	150 Days
Skilled Nursing Facility	100 Days

APPENDIX E: MEDICAL EQUIPMENT NOT COVERED

Examples of Durable Medical Equipment that are not covered expenses:

- Augmentative communication devices
- Bath Paraffin (Unit)
- Bariatric beds and chairs
- Bathroom Equipment:
  - Toilet Seat
  - Commode
  - Scale
  - Bathtub seat, Bathtub fit Rail or Grab Bar
- Bed Baths
- Bed Board
- Breast Pump
- Chair Tables
- Chair, Recliner or Autotilt
- Child's Stroller
- Contour Chair
- Diapers (Adult or Infant)
- Diathermy Machines
- Disposable insulin delivery systems, except Omnipod.
- Ear plugs or Molds
- Educational equipment
- Electric Bed
- Enuresis Unit
- Environmental Control Equipment:
  - Air Cleaner or Filters
  - Air Conditioner
  - Air Filter
  - Air Freshener
  - Assistance Devices
  - Humidifiers
  - Dehumidifiers
  - Portable Heaters
  - Dust extractors
  - Sweeper
- Equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; star lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs (including Hoyer lifts); recliners; contour chairs; adjustable beds; or tilt stands

- Support devices which are widely available over the counter such as prophylactic wrist, ankle, and knee supports
- Escalator, Elevator or Stair Lift
- Exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines
- Geri Chairs
- Hearing Aids
- Heat Lamps
- Heating Pads
- Hydraulic Van or Car Lifts
- Hygienic equipment such as bed baths, commodes, and toilet seats
- Irrigating Kit
- Language Master and Other Vocabulary Aids
- Lift Chair and Lifts
- Low Vision Devices:
    - Magnifiers, Telescopic Lenses, Closed Circuit TVs
- Massage Devices, Vibrators
- Motorized Scooters
- Muscle Stimulators
- Nutritional supplements, over-the-counter (OTC) formula, food liquidizers or food processors
- Orthopedic Mattress
- Orthopedic shoes (unless attached to brace)
- Percussion Packs
- Professional Medical Equipment:
    - Blood Pressure Kit
    - Stethoscope, etc.
- Pulse Tachometer
- Replacement of lost or stolen items
- Rollabout Chairs
- Room Heater (portable)
- Sauna Baths
- Special Adaptive Equipment
- Standing tables
- Standing or tilt wheelchairs
- Supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags
- Telephone Arms
- Thermometer
- Traction Devices
- Transfer Bars or Benches
- Trapeze Bar
- Treadmill, Jogger
- Vibrators

- Walking Cane with Seat
- Waterbed
- Whirlpool or Hydro Massage Equipment
- Whirlpool pumps or equipment
- Wig and/or Wig Styling

APPENDIX F: PEIA OUT-OF-STATE PPO PROGRAM

(Not applicable to Plan D)

Preferred provider Organizations

For services provided outside the State of West Virginia, the PEIA/UMR network principally utilizes the UMR network. This network reviews their providers for quality standards such as licensing, background and treatment patterns. As part of their agreement with the network, the amount paid for services is a discounted amount. All services received out-of-state by a W.Va. resident member (including border counties), other than services by a PPO provider in a county that borders West Virginia, must have prior approval in order to receive the highest level of benefit. Prior approval for access to out-of-state network providers at the higher level of benefit (80%) will usually not be granted if the service is available from in-state providers. However, if an insured is traveling out-of-state and has an emergency or accident, the insured should go directly to the nearest provider for treatment without calling for approval first.

When receiving services, always follow these important steps:

1. Always carry the most current Identification Card.

2. When seeking services outside West Virginia and beyond the bordering counties, call UMR or their sub-contractor for prior approval to receive the highest level of benefits.

3. In an emergency or accident outside of West Virginia or a bordering county, prior approval is not necessary to receive the highest level of benefits. If the insured is admitted to the hospital, he/she or the provider must call UMR within 48 hours of the admission.

4. If the out-of-state service is approved, please make sure the provider is a preferred provider with the PEIA/UMR Network.

5. Call UMR or their sub-contractor for network provider information.

6. At the doctor's office or hospital, the insured must present the PEIA PPB Plan Identification Card, and the doctor or hospital will verify membership and coverage information.

7. After receiving medical attention, the claim is routed to UMR.

8. All PPO providers are paid directly, relieving insureds of any hassle and worry. Insureds will need to pay for out-of-pocket expenses (deductible, copayments, coinsurance and non-covered services). UMR will send insureds an Explanation of Benefits.

PEIA PPB Plan D has NO coverage for out-of-state services. Plan D members cannot receive services outside WV, except in a medical emergency or when UMR determines that a needed service is not available within WV. In these cases, out-of-state care is covered as in-network care.

The PEIA PPB Plans A, B & D are designed to provide as much care as possible within the State of West Virginia. The PEIA Preferred Provider Organization (PPO) is made up of West Virginia health care providers who provide health care services or supplies to PEIA participants. For services provided outside of the State, PEIA uses UMR network with a few exclusions.

APPENDIX G: COORDINATION OF PEIA'S BENEFITS WITH OTHER BENEFITS

I. APPLICABILITY

A. This Coordination of Benefits ("COB") provision applies to This Plan when an employee, retired employee or covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another plan. The benefits of this Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefit determination rules, another plan determines its benefits first. The above reduction is described in Section IV, "Effect on the Benefits of This Plan."

C. This Plan will never provide benefits as both a Primary plan and a Secondary Plan for the same item of Allowable Expense incurred by the same Person. No person may receive benefits for the same item of Allowable Expense from more than one PEIA-sponsored plan. "PEIA-sponsored plan" shall include both this Plan and any plan offered by an insurance company, health maintenance organization or other entity which has a contract with the PEIA to provide group medical benefits to PEIA-eligible employees and dependents.

D. This Plan will not coordinate benefits with any optional dental, vision, or disability insurance offered through the PEIA-sponsored flexible benefits plan.

E. For any PEIA-insured person who is eligible for Medicare Parts A and B, This Plan will coordinate benefits as if the person has enrolled for both Part A and B coverage, regardless of whether or not the person has actually enrolled for such coverage.

II. DEFINITIONS

A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance and group subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;

(4) Group-type contract. Group-type contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description are included in the definition of "Plan" whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designed (for example, "franchise" or "blanket");

(5) The amount by which group or group-type hospital PPB benefits exceed $100 per day. Hospital PPB benefits are benefits not related to expenses incurred;

(6) The medical benefits coverage is group, group-type and individual automobile medical pay provisions; and

(7) Coverage under a governmental plan, or coverage required or provided by law. This does not include a State plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security act, as amended from time to time);

(8) For purposes of Section III, Paragraph B (1)(b) only, "Plan" shall also include, for any person covered as a spouse or other dependent under This Plan (i.e., the PEIA Plan), individual hospital and surgical insurance coverage or individual major medical insurance coverage in which the spouse or dependent is the named insured or certificate holder and in which:

(a) The policy covers a specified disease, accident only, disability, or other limited benefits; and

(b) The policy is specifically designed, represented and sold as a supplement to other basic sickness and accident coverage; and

(c) The entire premium for the policy is paid by the insured or insured's family.

B. "This Plan" is the part of the PEIA group benefit plan that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

Allowable Expenses under This Plan are calculated according to PEIA fee schedules, rates and payments policies.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because a covered person does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES

A. General. When there is a basis for a claim under This Plan and another plan, This Plan and another plan, This Plan is Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, retired employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent under this Plan:

(a) Where two employees, both eligible to enroll for PEIA coverage in their own names, are married to each other and are covered under one PEIA family plan (one spouse is treated as the named policyholder and the other as a dependent for purposes of these rules;

(b) W.Va. Code §5-16-13(b) provides that when a person is covered as a spouse or other dependent under the PEIA Plan, then "such spouse and dependent coverage shall be limited to excess or secondary coverage for each spouse and dependent who has primary coverage from any other source. For purposes of this section, the term 'primary coverage' means individual or group hospital and surgical insurance coverage or individual or group major medical insurance coverage or group prescription drug coverage in which the spouse or dependent is the named insured or certificate holder." Accordingly, whenever a person is covered under This Plan (i.e., the PEIA Plan) as a spouse or other dependent, and such person also has other individual or group hospital and surgical coverage or individual or group major medical coverage or group prescription drug coverage in which the person is the named insured or certificate holder, then This Plan shall be the Secondary Plan and such other plan of coverage shall be the Primary Plan and determine its benefits first;

(c) Where a spouse would be subject to both Paragraphs B (1)(a) and (b) above, then only (a) shall apply;

(d) Exception to the rules stated in Paragraph B (1) above: for retirees covered by the PEIA PPB Plan and Medicare, regardless of age, Medicare is primary and PEIA is secondary (this may not be applicable to Medicare End Stage Renal Disease benefits) and for PEIA PPB Plan active employees who are age 65 or older and eligible for Medicare PEIA PPB is usually primary;

(e) Exception to the rules stated in Paragraph B(1) above: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social security Act and implementing regulations, Medicare is (i) Secondary to the Plan covering the person as a dependent, and (ii) Primary to the Plan covering the person as other than a dependent (e.g., a retired employee), then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in Paragraph B (3) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents;"

(a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year (considering only the month and day, and not the year, of birth); but

(b) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order;

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that person has actual

knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. The plan of the spouse of the parent with custody of the child shall be the Tertiary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge. For purposes of this paragraph, the PEIA will not be deemed to have actual knowledge of a court decree until actual receipt of a copy of that decree by the PEIA.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III B (2).

(5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as the employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.

(6) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (e.g., the Consolidated Omnibus Budget Reconciliation Act of 1987, as amended) or state law also as covered under another plan, the following shall be the order of benefit determination:

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

(b) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(7) Longer/Shorter Length of Coverage. If none of the above rules determines the order of the benefits, the benefits of the Plan which covered an employee, retired employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

IV. EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to

one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of the COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds either: (a) one hundred percent (100%) of the actual charges by providers to the insured in a Claim Determination Period, or (b) the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision, depending on the type of PEIA coverage (see C below) under which the person is covered. In these cases, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than either: (a) those actual charges, or (b) the benefits that would be payable under This Plan in the absence of this COB provision, depending on the type of PEIA coverage under which the person is covered.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any application benefit limit of This Plan.

C. Methods of Coordination. When This Plan is a Secondary Plan, there are two methods of calculating the amount which This Plan will pay. The method which will be applied depends upon the PEIA coverage the person has:

(1) **"Traditional" Method.** Under the traditional method of coordinating benefits, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than the actual charge.

The traditional method shall be used to coordinate benefits only for:

(a) Retired employees or their dependents that are covered under PEIA "Basic Plan;"

(b) Dependents of retired employees, for whom Medicare is the Primary Plan and who are covered under the PEIA "Basic Plan; and,

(c) Active employees or their dependents for whom Medicare is the Primary Plan (e.g., persons who are eligible for Medicare because of End Stage Renal Disease).

(2) **"Carve-out" Method.** Under the carve-out method of coordinating benefits, the benefits that would be payable under This Plan in the absence of this COB provision will be reduced by the benefits payable under the other plans. "Benefits payable under the other plans" shall include benefits that would have been payable had claim been duly made for those benefits.

The carve-out method shall be used to coordinate benefits for:

(a) Active employees and their dependents who are not included in Paragraph C (1) above ("Traditional" Method);

(b) Retired employees and their dependents who are enrolled in the PEIA "Basic Plan II," or PEIA "Catastrophic Plan," and

(c) Retired employees who are enrolled in the PEIA "Basic Plan," and their dependents who are not included in Paragraph C (1)(b) above.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. PEIA has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person to the extent reasonably necessary to apply these rules. To the extent permissible under existing law and to the extent reasonably required PEIA need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give PEIA any facts it reasonably needs to pay the claim.

VI. FACILITY OF PAYMENT

A payment made under another plan may include any amount which should have been paid under This Plan. If it does, PEIA may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. PEIA will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. RIGHT OF RECOVERY

If the amount of the payments made by PEIA is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or
C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

PEIA shall have the right, after making reasonable attempts to collect from the person or entity to whom or for whom an overpayment has been made, to deduct the amount of the overpayment from other benefits or payments which are or may become payable to or on behalf of the person or entity to or for whom the overpayment was made.

APPENDIX H: ANNUAL PRESCRIPTION DRUG COPAYMENTS/COINSURANCE

If a prescription is filled at a drug store that is not a part of the current TPA-P's network, the insured will be responsible for the entire cost at the time of purchase. The claim can be submitted to the TPA-P for reimbursement of PEIA's allowed amount for the drug, which is based on the TPA-P contracted rate less the PEIA discount, plus the dispensing fee, minus the insured's responsibility. The allowed amount is usually less than the submitted amount.

Prescription drug Copayments and Coinsurance		
PEIA PPB Plan A or D		
	Up to a 30-day supply	90-day supply*
Generic Drug	$10	$20
Brand-name drug listed on the WV Preferred Drug List	$25	$50
Brand-name drug not listed on the WV Preferred Drug List*	75% Coinsurance	75% Coinsurance
Common Specialty Medications on WV Preferred Drug List	$100	Not Available
Common Specialty Medications NOT on WV Preferred Drug List †	$150	Not Available
PEIA PPB Plan B		
Generic Drug	$10	$20
Brand-name drug listed on the WV Preferred Drug List	$30	$60
Brand-name drug not listed on the WV Preferred Drug List#	75% Coinsurance	75% Coinsurance
Common Specialty Medications on WV Preferred Drug List	$100	Not Available
Common Specialty Medications NOT on WV Preferred Drug List†	$150	Not Available

*For maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. You must purchase all medications on the Maintenance Drug List in 90-day supplies through a Retail Maintenance Network pharmacy or through Mail Service. (See Maintenance Medications in the SPD)

† Should your doctor prescribe, or you request the brand-name Specialty Medication when a generic drug is available, you must pay 75% coinsurance.

Should your doctor prescribe, or you request the brand-name drug when a generic drug is available, you must pay 75% coinsurance.

APPENDIX I: Privacy and Security Amendment, Information from Health Plans to Plan Sponsor

1. The group health plans will not disclose protected health information to PEIA, in its capacity as the plan sponsor, unless the required provisions set forth in PEIA's policies and procedures for use and disclosure of protected health information are met.

2. Uses and disclosures of protected health information will be made to plan sponsor employees and the workforce of PEIA in order to administer and achieve the purposes of the group health plans as set out in this Plan Document and West Virginia Code §§5-16-1 et seq. all to be done consistent with: PEIA's policies and procedures for use of protected health information; PEIA's Notice of Privacy Practices and Procedures (Appendix J), and applicable law.

3. In accordance with 45 CFR Part 160 and Subparts A and C of Part 164, the plan sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that it creates, receives, maintains or transmits on behalf of the group health plan.

4. The plan sponsor will not use, or further disclosure PHI received from the group health plans other than as permitted or required by the plan documents or as required by law.

5. The plan sponsor will ensure that any agents, including any subcontractor, to whom it provides protected health information received from the group health plans, agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information. This includes, but is not limited to, the implementation of reasonable and appropriate security measures. The plan sponsor conveys the right(s) and authority to the group health plans to conduct certain vendor assurances on any and/or all contractors and/or subcontractors who perform administrative and/or healthcare operational services for the plans to ensure compliance with any and/or all applicable rule(s), regulation(s), and/or rule referenced guidance as it relates to maintaining and ensuring the privacy, security, confidentiality, and integrity of any and/or all personally identifiable information (PII) and/or protected health information (PHI) managed by and/or for the plans.

6. The plan sponsor will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor unless compelled to do so by a subpoena or Order from a court of competent jurisdiction.

7. The plan sponsor will report to the group health plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the plan documents of which it becomes aware. The plan sponsor will further report to the group health plan any security incident of which it becomes aware.

8. The plan sponsor will permit individuals to have access to any PHI which it has received from the group health plan, in accordance with PEIA's RIGHT OF ACCESS TO PROTECTED HEALTH INFORMATION policy.

9. The plan sponsor will make available protected health information for amendment and incorporate any amendments to protected health information in accordance with PEIA's individual requests to amend health information policy.

10. The plan sponsor will make available the information required to provide an accounting of disclosures in accordance with PEIA's accounting of disclosures of health information policy.

11. The plan sponsor will make its internal practices, books, and records relating to the use and disclosure of protected health information received from the group health plans available to the Secretary, U. S. Department of Health and Human Services, for purposes of determining compliance by the group health plan with federal privacy regulations regarding PHI (specifically, 45 CFR Parts 160 and 164).

12. The plan sponsor will, if feasible, return or destroy all protected health information received from group health plans that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

13. In order to provide adequate separation between the plan sponsor and the group health plans, only the following employees or classes of employees or other persons under the control of the plan sponsor will be given access to the protected health information to be disclosed. This will include any employee or person who receives protected health information relating to payment, ***health care operations***, or other matters pertaining to the group health plans in the ordinary course of business. The following categories of employees and other members of the workforce will be given access to protected health information.

    a. Those who are assigned to the administration of the group health plans. This includes claim processing, maintenance of enrollment, payroll and premium, and eligibility records, analysis of payment and utilization data, and other matters pertaining to the ordinary course of business of the group health plan; and,

    b. Others who are authorized to have access to PHI on behalf of PEIA in its role as the plan sponsor, for purposes permitted by the Plan Document, including, but not limited to, benefit coordinators, payroll clerks, and personnel officers. The plan sponsor shall regularly update benefit coordinator information, ensure that only PEIA-trained persons may act as a benefit coordinator, and benefit coordinator duties shall not be

shared by any person who is not specifically designated, identified and trained by PEIA.

c. The plan sponsor will ensure that the adequate separation is supported by reasonable and appropriate security measures.

14. The plan sponsor will restrict the access to and use of PHI received from the group health plan by members of its workforce (as listed in item 12, above) to the plan administration functions that the plan sponsor performs for the group health plan.

15. Employees and others in the workforce will be subject to discipline, including suspension or termination, in the event any member of the workforce who is authorized to have access to the group health plan's PHI violates any of the provisions of the Plan Documents as set forth in this policy.

REFERENCE: 45 CFR 164.504(f) & 164.314(b)

APPENDIX J: NOTICE OF PRIVACY PRACTICES

If you have questions about this notice, please contact the person listed under "Who to Contact". THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary

In order to provide you with benefits, PEIA will receive personal information about your health, from you, your physicians, hospitals, pharmacies, and others who provide you with health care services. We are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

We use members' health information to provide benefits, including making claims payments and providing customer service. We disclose members' information to health care providers to assist them in providing you with treatment or to help them receive payment. We may disclose information to other insurance companies as necessary to receive payment or coordinate benefits. We may use the information within our organization to evaluate quality and improve health care operations, and we may make other uses and disclosures of members' information as required or allowed by law or as permitted by PEIA policies.

Kinds Of Information That This Notice Applies To

This notice applies to any information that is created, received, used, or maintained by PEIA or its Business Associates that relates to the past, present, or future physical or mental health, healthcare, or payment for the healthcare of an individual.

Who Must Abide by This Notice

- PEIA

- All employees, staff, students, volunteers, contractors, and other personnel who work for and/or under the direct control of PEIA.

The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms and have been trained in their roles and responsibilities. We may share your information with each other for the purpose(s) of treatment, and as necessary for payment and healthcare operations activities as described below.

Our Legal Duties

- We are required by law to ensure the confidentiality, integrity, and availability of all PHI we create, use, receive, maintain or transmit.

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

- We are required to respond to your requests or concerns within a timely manner.

• Implement administrative, physical and technical safeguards to ensure compliance with this notice.

• We are required to abide by the terms of this notice until we officially adopt a new notice.

How We May Use or Disclose Your Health Information.

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

1. Treatment. We may use your health information to provide you with medical care and services. This means that our employees, staff, students, volunteers and others whose work is under our direct control may read your health information to learn about your medical condition and use it to help you make decisions about your care. For instance, a health plan nurse may take your blood pressure at a health fair and use the results to discuss your health issues. We will also disclose your information to others to provide you with options for medical treatment or services. For instance, we may use health information to identify members with certain chronic illnesses and send information to them or to their doctors regarding treatment alternatives.

2. Payment. We will use your health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our customer service department or at our claims processing administrators may use your health information to help pay your claims. And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the subscriber and each dependent that are enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information confidentially: see the "Confidential Communication" section in this notice. We may also disclose some of your health information to companies with whom we contract for payment-related services. For instance, if you owe us money, we may give information about you to a collection company that we contract with to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.

3. Health Care Operations. We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may also provide health information to students who are authorized to receive training here. We may disclose your health information as necessary to others who we contract with to provide administrative services or health care coverage. This includes our third-party administrators, available managed care plans, wellness

programs, lawyers, auditors, accreditation services, and consultants, for instance. These third-parties are called "Business Associates" and are held to the same standards as PEIA with regard to ensuring the privacy, security, integrity, and confidentiality of your personal information. If, in the course of healthcare operations, your confidential information is transmitted electronically, PEIA requires that information to be sent in a secure and encrypted format that renders it unreadable and unusable to unauthorized users.

4. For Purposes of Providing Certain Health and Wellness Services. West Virginia Code §5-16-8 requires PEIA to provide certain health benefits and services which require PEIA to disclose and/or share PEIA member information with third parties for the administration and management of said services.

5. Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the state health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by state auditors. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process. We will only disclose the minimum amount of health information necessary to fulfill the legal requirement.

6. Public Health Activities. We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.

7. To Report Abuse. We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

8. Law Enforcement. We may disclose your health information for law enforcement purposes other than as outlined in Sections 14 and 15 of this Notice.. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations. We will only disclose the minimum amount of health information necessary to fulfill the investigation request.

9. Specialized Purposes. We may disclose the health information of members of the armed forces as required by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, and protection of the president. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate

with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution.

10. To Avert a Serious Threat. We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

11. Family and Friends. Under specific circumstances covered by policy, we may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.

12. Research. We may disclose your health information in an appropriately de-identified format in connection with approved medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.

13. Information to Members. We may use your health information to provide you with additional information. This may include sending newsletters or other information to your address. This may also include giving you information about treatment options, alternative settings for care, or other health-related options that we cover.

14. Prohibitions on PEIA. PEIA is prohibited from using or disclosing an individual's PHI for the purpose of conducting a criminal, civil, or administrative investigation into, or imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care that is lawful under the circumstances in which it is provided; meaning that it is either: (1) lawful under the circumstances in which such health care is provided and in the state in which it is provided; or (2) protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which such health care is provided

15. Attestations. PEIA is required by law to collect an attestation from requesters of PHI potentially related to reproductive health care. HHS makes clear that group health plans such as PEIA and business associates cannot rely on the attestation and must make an independent determination on the use or disclosure of PHI. HHS intends on providing a model attestation form. The attestation will include: the types of PHI being requested, the name of the individual whose PHI is being requested, and that the use or disclosure is not for the prohibited purpose of criminal prosecution. The attestation will be limited to the specific use or disclosure, so each use or disclosure request will require its own attestation.

16. Health Benefits Information. If your enrollment in PEIA's health plan is offered through your employer, your employer may receive limited information, as necessary, for the administration of their health benefit program. The employers will not receive any additional information unless it has been de-identified or you have authorized its release.

17. No Surprises Act. PEIA will provide or otherwise make available PHI/PII to members as requested so that they may pursue claims or resolution(s) under the "No Surprises Act" which is part of the Consolidated Appropriations Act of 2020 in accordance with the patient rights outlined at: https://www.cms.gov/medical-bill-rights.

18. Substance Abuse Records. PEIA will allow a single consent for all future uses and disclosures for treatment, payment, and health care operations related to the treatment of Substance Use Disorders (SUDs). HIPAA allows covered entities like PEIA and its business associates that receive records under this consent to redisclose the records in accordance with the HIPAA regulations.

19. De-identified data. PEIA may disclose records without patient consent to public health authorities, provided that the records disclosed are de-identified according to the standards established in the HIPAA Privacy Rule.

20. Restrictions. PEIA may restrict the use of records and testimony in civil, criminal, administrative, and legislative proceedings against patients, absent patient consent or a court order.

21. PEIA will not release, disclose, exchange, and/or sell your health information for use in marketing or for-profit ventures by third parties.

Your Rights

1. Authorization. We may not use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. We will only disclose the minimum amount of health information necessary to fulfill the authorization request. If you authorize us to use or disclose your health information in additional circumstances, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the person listed under "Who to Contact" at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

2. Request Restrictions. You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

3. Confidential Communication. If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of

benefits that contain your health information to a different address rather than to home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will agree to any reasonable request.

4. Inspect and Receive a Copy of Health Information. You have a right to inspect the health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you and certain specific exclusions do apply. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing. We will accept electronic request for releases of information in the form of e-mails or other electronic means. If you choose, you may receive your records in an electronic format but PEIA has the right to make sure that electronic information is delivered in s safe, secure, and confidential format. We may charge a fee for the cost of copying, mailing and/or e-mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under "Who to Contact" at the end of this notice. We will respond to your request within 30 days. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

5. Amend Health Information. You have the right to ask us to amend health information about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

6. Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. We cannot include disclosures made before April 14, 2003. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.

7. Paper Copy of this Privacy Notice. You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Who to Contact" at the end of this notice.

8. Complaints. You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under "Who to Contact" at the end of this notice. You may also file a complaint directly with the:

Region III, Office for Civil Rights, U.S. Department of Health and Human Services, 150 South Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111. All complaints must be in writing. We will not retaliate against you if you file a complaint.

Our Right to Change This Notice

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice including the change. The new notice will include an effective date. We will make the new notice available to all subscribers within 60 days of the effective date.

Who to Contact

Contact the person listed below:

- For more information about this notice, or
- For more information about our privacy policies, or
- If you have any questions about the privacy and security of your records, or
- If you want to exercise any of your rights, as listed on this notice, or
- If you want to request a copy of our current notice of privacy practices.

Privacy Officer, West Virginia Public Employees Insurance Agency, 601 57th St. SE, Charleston, WV 25304-2345, **304-558-7850** or **1-888-680-7342**

Copies of this notice are also available at the reception desk of the PEIA office at the address above. This notice is also available by e-mail.

Send an e-mail to: PEIA.Help@wv.gov

Revised: May 23, 2024

APPENDIX K:

WV PUBLIC EMPLOYEES INSURANCE AGENCY

PURCHASING POLICY

FOR GOODS AND SERVICES PROCURED THROUGH LEGISLATIVE EXEMPTION

601 57TH STREET SE, SUITE 2

CHARLESTON, WV 25304

TELEPHONE: (304) 558-7850

PEIA.WV.GOV

ISSUED: 8/27/2020

UPDATED: 6/15/2023

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SECTION 1: GENERAL INTRODUCTION

1.1 INTRODUCTION

The West Virginia Public Employees Insurance Agency contracts with vendors for goods and/or services to manage the provision of health insurance, life insurance, and flexible benefits for State Employees and Participating Agencies. PEIA is subject to the policies of the Purchasing Division of the Department of Administration in most cases. However, there are instances where purchasing exemptions are appropriate to ensure ongoing, effective operation of PEIA programs for the benefit of its members.

The purpose of this Purchasing Policy is to provide PEIA employees with a framework for standardized agency procurement of goods and/or services procured through Legislative Exemption. Although PEIA has limited exemption from direct Purchasing Division oversight on a specific range of procurements, the Agency maintains a responsibility to ensure that tax-payer money is spent responsibly. PEIA follows Purchasing Division policy where possible on exempt purchases, and any differences are for the express purpose of ensuring effective and uninterrupted coverage for PEIA members.

PEIA employees are required to work with PEIA procurement staff to procure exempt goods and services contracts.

1.2 AUTHORITY TO PROCURE GOODS AND/OR SERVICES

For many procurements, PEIA is required to follow the policies put in place by the West Virginia Purchasing Division, which operates under W. Va. Code §5A-3-1 *et seq* and Legislative Rule W. Va. 148 C.S.R. 1). These policies include, but are not limited to, the reimbursement of employee travel expenses, the use of State-Wide Contracts and Mandatory resources, the use of WV Oasis for Agency procurements, and adherence to Purchasing Division regulations where PEIA exemption does not apply.

PEIA has a partial exemption from Purchasing Authority relating to the process of acquiring commodities or services that directly relate to the operation of the Plan, as established by West Virginia Code §5-16-3(c). The rules contained in this handbook refer only to procurements that PEIA determines will fall under its Legislative

exemption and should not be used by PEIA employees to circumvent Purchasing Division authority where it exists.

1.3 REQUIRED USE OF HANDBOOK

PEIA staff are required to use this handbook to perform procurement and other activities relating to the Legislative exemption.

1.4 ROLE OF THE PROCUREMENT OFFICER

The procurement officer is responsible for the following:

- Keep apprised of the current statutory and regulatory requirements for state purchasing through training opportunities offered by the Purchasing Division, in accordance with the West Virginia Code of State Rules;
- Serve as the first point of contact to provide guidance to internal agency staff regarding purchasing issues;
- Review and approve specifications prior to solicitation issuance;
- Managing PEIA procurement processes in the wvOasis system;
- Review bids and concur with agency recommendation prior to award;
- Maintain proper documentation and files for public record;
- Update internal procurement templates and standardized forms as necessary;
- Maintain the PEIA Purchasing policy and update it as needed; and
- Perform other related procurement duties as needed.

1.5 DISCLAIMER

The PEIA Purchasing Policy may be amended or changed at any time to ensure compliance with the laws, rules, and procedures of PEIA, the Purchasing Division, and the State of West Virginia. Exceptions to the guidelines require written requests to and approval of the PEIA Director. Employees are responsible for ensuring that they are using the most recent version of the policy for purchasing activities. In the event of a conflict between the PEIA Purchasing Policy and current State laws or regulations, employees should defer to current State laws or regulations.

1.7 ETHICS

PEIA employees have the responsibility of purchasing commodities used in the

operation of public programs and services in the most effective and efficient method available. In performing this task, certain guidelines based on West Virginia Code must be followed. Our ethical standards must be of the highest degree since public funds are being used.

1.8 wvOASIS ENTERPRISE RESOURCE PLANNING (ERP) SYSTEM

The state's enterprise resource planning (ERP) system, which is referred to as *wv*OASIS, is a comprehensive suite of software modules that provide for statewide administrative functions, including financial management, procurement, asset management, personnel administration, payroll, time reporting and benefits administration. This system is used for advertising solicitations of $20,000 and more and awarding all procurements exceeding $5,000.

SECTION 2: DEFINITIONS, ABBREVIATIONS, & ACRONYMS

The following definitions apply and/or relate to the PEIA Purchasing Policy:

Agency – For the purpose of this policy, "agency" is synonymous with "spending unit.". This definition includes any department, bureau, division, office, board, commission, authority, agency, or institution of state government for which an appropriation is requested by the Governor, or to which an appropriation is made by the Legislature, unless a specific exemption from W. Va. Code §5A-1 is provided.

Agency Delegated Open-End Contract – A legal and binding instrument between the state agency and a vendor to exclusively provide a commodity which was competitively bid, evaluated, awarded, and maintained by the state agency. This contract is for agency-delegated purchases under Purchasing Authority based on the agency's current spend threshold as set by the Purchasing Division.

Agency Delegated Purchase Order – A transaction which may be used by an agency to procure items within its agency-delegated purchase authority.

Agency Open-End Contract – A legal and binding instrument between the state agency and a vendor to exclusively provide a service or commodity which was competitively bid, evaluated, and awarded by PEIA and maintained by the state agency.

Award Date – The award date is the date of encumbrance in wvOasis.

Best Value Procurement – Purchasing methods used in awarding a contract based on evaluating and comparing all established quality criteria where cost is not the sole determining factor in the award. This includes Request for Proposals (RFP) and Expressions of Interest (EOI).

Bid – Anything that a vendor submits in response to a solicitation that constitutes an offer to the State and includes, but is not limited to, documents submitted in response to a request for quotation (RFQ), proposals submitted in response to a request for proposal, or proposals submitted in response to an expression of interest.

Bid Bond – A bond in which a third party agrees to be liable to pay a certain amount of money in the event a selected bidder fails to accept the contract as bid. This bond is usually five percent (5%) of the total bid amount.

Bid Opening – A firmly established date and time for the public opening of responses to a solicitation.

Business Associate - a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity as defined in 45 CFR 164.502(e), 164.504(e), 164.532(d) and (e)

Buyer – An employee of PEIA; the designated primary or back-up purchaser of commodities or services on behalf of the Agency.

Change Order – A document which is used when it becomes necessary to amend, clarify, change, or cancel purchasing documents issued by PEIA.

Commodity – Supplies, materials, equipment, and any other articles or things used by or furnished to a department, agency, or institution of state government.

Competitive Bidding – The process by which individuals or firms compete for an opportunity to supply specified commodities and services by submitting an offer in response to a solicitation.

Contract – An agreement between a state spending unit and a vendor relating to the procurement of commodities or services, or both.

Delivery Order – A written order to the contractor authorizing quantities of commodities and/or services to be delivered all in accordance with the terms, conditions, and prices stipulated in the original contract.

Electronic Transmission – Any process of communication not directly involving the physical transfer of paper that is suitable for retention, retrieval, and reproduction of information by the recipient.

Emergency – A purchase made when unforeseen circumstances arise, including delays by contractors, delays in transportation and unanticipated volumes of work.

A report of any such purchase, together with a record of competitive bids upon which it was based, is to be submitted to the Purchasing Director. Emergency purchases are not used for hardship resulting from neglect, poor planning, or lack of organization by the spending unit. Failure to plan does not make it an emergency.

Encumbrance – A process which ensures that funding is available for payments relating to a specific purchase order or contract.

Evaluation of Bids – After bids are opened, the process of examining all offers to determine the bidder's responsibility, responsiveness to requirements, conformance to specifications and other characteristics important to the recommendation or selection for award.

Expendable Commodities – Commodities which, when used in the ordinary course of business, will become consumed or of no market value within the period of one year or less.

Fixed Assets – Reportable property with an acquisition cost of $1,000 or more and has a life of one (1) year or more.

HIPAA – The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191

HITECH Act - The Health Information Technology for Economic and Clinical Health Act, abbreviated HITECH Act, was enacted under Title XIII of the American Recovery and Reinvestment Act of 2009 (Pub.L. 111–5).

Lease – A written agreement between the owner of equipment (lessor) and a state agency (lessee) by which the owner agrees to give the agency permission to use the equipment for a predetermined fee (rental) for a period exceeding thirty (30) days. Title does not pass from the lessor to the lessee.

Lease Purchase – A written agreement in which the lease payments are applied, in whole or in part, as installment payments for equity or ownership upon completion of the agreement. Title transfers with the last installment payment to the lessee.

Mandatory Terms – All terms and conditions in the written specification which are absolute and the compliance with cannot be waived. Failure to comply with

mandatory terms shall require the vendor to be disqualified. Mandatory terms are indicated using the terms *shall, will* or *must.*

Non-Mandatory Terms – All terms and conditions in the written specification which are not absolute. Non-mandatory terms are indicated using the terms *may, should, preferred* or *could*, and are understood to be permissive and shall not be used to disqualify any vendor.

Notice to Proceed – A formal written communication used to establish the date for work to commence and determines the date for completion.

Open-End Contract – A generic term used for a contract that covers a period in which all terms, conditions and prices are specified except for quantity.

Piggybacking – Utilizing any existing open-end contract of the federal government, agencies of other states, other public bodies, or other state agencies to which the requesting agency was not an original party. Piggybacking requires prior approval by the Purchasing Director.

Pre-bid Conference – A meeting between vendors and agency personnel which offers an opportunity to emphasize and clarify critical aspects of a solicitation, eliminates misunderstanding, and permits vendor input. Vendor attendance may be mandatory or voluntary as specified in the bid document.

Procurement – The buying, purchasing, renting, leasing or otherwise obtaining of commodities or services.

Protest – A formal, written complaint filed by a vendor regarding specifications or an award.

Public funds – Funds of any character, including federal monies, belonging to or in the custody of any state spending unit.

Purchase Order – A document issued by the Agency used to execute a purchase transaction with a vendor. It serves as notice to a vendor that an award has been made.

Removable Property – Any personal property not permanently affixed to or forming a part of real estate.

Renewal – When an existing contract is renewed for an additional period in accordance with the terms and conditions of the original contract.

Rental – Temporary compensation or fee paid for the use of any equipment usually for a period of less than 30 days.

Request for Information (RFI) – A document used to solicit information to assist in preparing specifications for a Request for Quotation (RFQ) or Request for Proposal (RFP). No award can be made from an RFI.

Request for Quotation (RFQ) – A document, containing the specifications or scope of work and all contractual terms and conditions, which is used to solicit written bids. Conformity to specifications and price are the only factors used in the evaluation process.

Request for Proposals (RFP) – A best value procurement tool used to acquire professional and other services where the scope of work may not be well defined, and cost is not the sole factor in determining the award. All criteria by which the bidders will be evaluated must be contained within the bid document.

Requisition – An electronic request in wvOasis by an agency for the purchase of commodities and services.

Services – The furnishing of labor, time, expertise, or effort, not involving the delivery of a specific end commodity or product other than one that may be incidental to the required performance.

Solicitation – A written or oral attempt made by the state to obtain bids or proposals for the purpose of entering into a contract. Requests for Quotation (RFQ), Requests for Proposal (RFP), telephone calls or other documents may be used.

Spending Unit – A department, bureau, division, office, board, commission, authority, agency or institution of state government for which an appropriation is requested by the Governor, or to which an appropriation is made by the Legislature, unless a specific exemption from W. Va. Code 5A-1 is provided.

Standardization – A process established by W. Va. Code §5A-3-61 that allows the agency to specify a brand of product for competitive bidding or other appropriate procurement method without the need to consider other brands.

Statewide Contract – An open-end contract issued by the Purchasing Division and made available to all state agencies to purchase frequently used commodities and services.

Stringing – Issuing a series of requisitions or dividing or planning procurements to circumvent the agency-deleated spending threshold or otherwise avoid the use of sealed bids.

Terms and Conditions – Standard clauses and requirements developed and incorporated into solicitations and resulting contracts. PEIA uses Purchasing's standard General Terms and Conditions for solicitations procured under Purchasing Division oversight and PEIA General Terms and Conditions for solicitations procured through legislative exemption.

Tie Bid – When two or more bids of equal terms and amount or score are received in response to a solicitation.

Unit Price – The cost per unit of the commodity or service.

Vendor – Any person or entity that may, through contract or other means, supply the state or its subdivisions with commodities and services, and lessors of real property.

Vendor Assurances – the process whereby a covered entity such as PEIA confirms that a Business Associate is compliant with applicable provisions of the HIPAA Privacy and Security Rule(s).

Vendor Self-Service (VSS) Portal – This feature incorporates the vendor registration function as well as the *West Virginia Purchasing Bulletin*, which includes commodities and services currently out for bid. The VSS portal also allows vendors to receive solicitation notifications by email based on commodities and services noted at the time of registration; review awarded contracts; perform

inquiries pertaining to awards; view payment status; and update company contact information, including mail and email addresses.

wvOasis – An enterprise resource planning (ERP) system used by the state of West Virginia to process all financial transactions, including procurement.

SECTION 3: PROCUREMENT METHODS

Prior to the procurement process, PEIA staff must ensure that they are pursuing the most appropriate procurement method. Below are the methods that PEIA uses to procure products/services. PEIA staff must make sure, prior to using one of the below methods, that the service/commodity is not available through a Purchasing Division Mandatory Resource.

3.1 Request for Quotation

The RFQ should be used to acquire all tangible property (i.e. equipment, supplies, etc.). An RFQ consists of:

(a) A detailed description of, or specification for, the item(s) being purchased;

(b) Delivery date, if required;

(c) Commodity units vendors will bid on (per job, per hundred, etc.)

(d) Any applicable maintenance; and

(e) Quantities of all items

Each item should be identified by a model number or some other specific identification. Award will be made to the vendor with the lowest bid meeting specifications.

3.2 Request for Proposal

RFP's should be used when the method of achieving an objective are not well known, making the development of mandatory requirements difficult. Using this method, lowest price is not the sole determining factor. The time required to process an RFP is longer than other procurement methods, and may require additional personnel, time, and resources to complete.

RFP Awards are made to the highest scoring responsive and responsible bidder. The award is based upon a subjective technical evaluation, where the agency first determines that all mandatory requirements have been met. It then assigns a subjective point value to the vendor's responses to the specifications, followed by an objective point value based on the vendor's cost proposal and the cost score valuation formula.

3.2.1 Mandatory Requirements: RFP requirements should be evaluated carefully, as they cannot be waived. A vendor's failure to meet a mandatory requirement results in disqualification. Before including any mandatory requirement in an RFP, the agency must decide whether it is willing to disqualify any one vendor, or all vendors, if the requirement is not met. If the agency is not willing to disqualify a vendor, then the requirement should not be mandated.

3.2.2 Evaluation Criteria: All evaluation criteria must be clearly defined in the specifications section of the RFP and based on a 100-point total score. This score is usually comprised of a technical score of 70 points possible and a cost score of 30 points possible, but the point allocation may be adjusted as appropriate for an individual solicitation.

3.2.3 Proposal Format and Content: Proposals from vendors must be requested and received in two distinct parts: technical and cost. All cost information must be contained in the cost proposal, which must be sealed and submitted separately from the technical proposal. Vendors must not include cost information in the technical proposal, which ensures that the technical proposal can be evaluated purely on its own merit.

3.3 Memorandum of Understanding

PEIA may engage in agreements with other state agencies through a Memorandum of Understanding (MoU). Although MoU's are not a purchase agreement, they are an important tool used by Agency to clarify working relationships with other state agencies. A Memorandum of Understanding (MoU) is a written agreement that clarifies relationships and responsibilities between two or more organizations, usually government agencies that share services, clients, and/or resources. PEIA contracts may prove advantageous for other State Agencies that manage healthcare related items, and a MoU can facilitate a relationship between the Agency and other agencies. The MoU serves to define the on-going consultation and communication between the two agencies and documents the recognition of the working relationship. The Agency enters into MoU's at the discretion of the PEIA Director or designee.

3.4 Direct Award

A direct award is a procurement method that provides a contract to a vendor without competitive bidding when circumstances allow. Competition should

be solicited where possible, but a direct award may be made when the PEIA Director and/or designee determines it to be the best option for the Plan. Direct awards are at the sole discretion of the PEIA Director and/or designee.

Although direct awards are not bid, all other procurement rules apply. PEIA has developed a standard Master Agreement template that must be used.

3.5 Emergency Purchase

Purchases may be necessary when unforeseen causes arise; however, emergency purchases are not used for hardship resulting from neglect, poor planning, or lack of organization. Emergency Purchase also cannot be used to circumvent Purchasing Division rules where Purchasing Division rules apply.

An emergency purchase can only be made if the PEIA Director, exercising sound judgment and discretion, concludes in good faith and upon reasonable and sufficient grounds that some unforeseen or unexpected circumstance has suddenly created a situation requiring that commodities or services be immediately purchased. A request for an emergency purchase must be made in writing to the Director, providing the scope of the purchase to alleviate the emergency situation. If approved, the Director will request that the PEIA Procurement Officer or backup facilitate the purchase and gather/maintain all appropriate records.

SECTION 4: PROCUREMENT PROCESS

4.1 Procurement Planning

PEIA staff should consider the following when planning a procurement:

4.2.1 Internal State Resources – Review Internal State resources to determine if an internal source exists that may fulfill procurement needs (i.e. WV Correctional Industries).

4.2.2 Statewide Contracts – Review Statewide Contracts to see if an agreement is already in place between a vendor and the State for the service or commodity sought.

4.2.3 Authority to Procure – PEIA staff must evaluate the procurement to determine whether it should be purchased entirely under the authority of the Purchasing Division or through the PEIA Legislative Exemption.

PEIA's Legislative Exemption does *not* exempt PEIA from Purchasing regulations regarding file documentation or vendor registration and may not be used to circumvent any State Law under any circumstance.

4.2.4 Third Party Approval - Solicitations may require approval outside of PEIA. This includes approval from the Secretary of Administration, the Governor's Office, the Office of Technology, and any other required entities that may need to approve a solicitation at some point during the process. Any employee writing specifications for the purpose of issuing a solicitation is responsible for working with the PEIA Procurement Officer to ensure that any necessary approvals are obtained at the times they are required (before issuance, before award, etc.).

4.2.5 Privacy Impact Assessments – Per State of West Virginia Executive Branch policy, certain procurements may require the PEIA Privacy & Security Officer to conduct a Privacy Impact Assessment to determine the real and potential impact a procurement may have on the privacy, security, confidentiality, and integrity of data held, stored, used, maintained, or transmitted by PEIA.

4.2.6 Data Requirements – Solicitations will be reviewed to determine what, if any, data must be shared with potential vendors in order for them to make a proper bid submission. The Procurement Officer will

coordinate with the bid project manager and the Privacy & Security Officer to arrange for the exchange of data necessary to complete the solicitation. In all cases, only the minimum necessary data will be exchanged for the meaningful use of responding to the solicitation. If data is exchanged to a potential vendor, that data may only be used by the potential vendor for the sole use of making a PEIA solicitation response. No ownership rights to the data exchanged, either expressed or implied, are conveyed from PEIA to the vendor and the vendor shall be responsible for the proper disposal of the data exchanged upon completion of the solicitation process.

4.2 PEIA Specification Templates

Specification templates related to in-house procurement transactions are available and recommended for use by employees to standardize and streamline the procurement processes. These templates have been designed to ensure that PEIA solicitations and the resulting contracts meet all rules and regulations of State of West Virginia. Other than adding information directly related to a current solicitation, changes to the templates should be reviewed by the PEIA Procurement Officer.

4.3 Design Services/Consultant

Any individual, corporation or firm (except as provided by a statewide contract) paid to custom design or write specifications for any PEIA solicitation shall not be permitted to competitively bid to provide the product or service that was designed. This removes the possibility of the designer developing specifications that only the designer can meet or restrict another vendor from meeting. This also prevents the appearance of any impropriety, thereby protecting the integrity of the competitive bid process.

4.4 Spending Thresholds

4.4.1 Purchases $5,000 and Less: Competitive bids are not required but are encouraged when possible.

4.4.2 Purchases $5,000.01 to $20,000: A minimum of three verbal bids are required, when possible, and the lowest bidder meeting specifications must be awarded the purchase order/contract. All bids must be present in the file.

PEIA may solicit bids within this threshold using the *West Virginia Purchasing Bulletin*; however, it is not required.

Bids shall be documented and recorded for public record using the *Verbal Bid Quotation Summary* form provided by the WV Purchasing Division. A wvOASIS procurement award document is required for purchases exceeding $2,500. Awards are to be made only to vendors who are properly registered with the Purchasing Division. Signed faxed bids or electronic bids are acceptable. Screen prints from Internet sites in which the commodity or service is for sale and may be procured can substitute for a verbal bid. A "no bid" is not considered a bid.

4.4.3 Purchases $20,000.01 and higher: A minimum of three written bids are required, when possible, and the lowest bidder meeting specifications must be awarded the purchase order/contract. All bids must be present in the file.

A Request for Quotation or a Request for Purchase should be used for documenting and making these requests. In all cases, the agency must attempt to obtain at least three written bids for a product or service. A "no bid" is not considered a bid. The date and time of the bid opening shall be published on the RFQ or RFP and the solicitation must be advertised in wvOasis. A wvOasis procurement award document is required.

4.4 Bid Submissions / Openings

4.5.1 Submissions - Bids shall be accepted as follows

(a) Request for Quotations: PEIA will accept RFQ bids via:

1. wvOasis
2. Physical mail
3. Fax
4. Secure e-mail

(b) Request for Proposal: PEIA will accept RFP bids as specified within the Solicitation. RFP responses cannot be submitted via wvOasis or Fax, but PEIA may accept both physical mail and secure e-mail responses as is appropriate for the Solicitation. Bid requirements must be clearly stated within the Solicitation.

(c) Sealed bids: Bids sent directly to PEIA are considered sealed if they are unopened and untampered with as initially sent, whether physically or digitally. If PEIA is working with a third party bid consultant for the solicitation, a bid is considered sealed so long as it stays within the purview of the bid consultant; no part of the bid may be shared with the solicitation committee prior to the appropriate bid opening date and time.

(d) PEIA assumes no liability or responsibility for late, incomplete, and/or otherwise non-compliant submissions

4.3.2 Openings - All solicitations shall have an established date and time for the bid opening, after which bids will no longer be accepted. Bids arriving late will be marked "Bid Received Late" and maintained with the rest of the Solicitation file but will not be considered for award.

(a) Request for Quotations: Bids shall be sealed until the date and time set for the bid opening. After the bid opening, bids will be examined by the agency to ensure compliance with all specifications and to determine the lowest responsible bidder. All bidders will be notified of the results.

(b) Request for Proposal: RFP bids shall be opened in two parts. Bids shall be sealed until the date and time set for the technical bid opening. At the technical bid opening, the agency will verify that cost proposals were sent separately. Technical proposals will be reviewed by committee members after the bid opening. Once technical scoring is complete, agency will schedule a time to open cost proposals.

SECTION 5: EVALUATION AND AWARD

5.1 Evaluation

5.1.1 Request for Quotation: Bids will be evaluated solely to ensure all mandatory specifications are met. Award will be given to the lowest bidder meeting specifications.

5.1.2 Request for Proposal: RFP bids will be evaluated in two parts: Technical Proposal and Cost Proposal. Bids must meet a Minimum Acceptable Score on their Technical Proposal in order for their Cost Proposal to be reviewed. Bids will be reviewed by an Evaluation Committee, who will then make a recommendation to the PEIA Director for BAFO and/or final award.

5.1.2.1 Evaluation Committee – The evaluation committee is responsible for evaluating the vendor bids and making a recommendation to the PEIA Director and/or designee for contract award. Prospective Evaluation Committee members shall be required to take Purchasing training prior to serving on an Evaluation Committee. The Committee shall be comprised of the following:

(a) Committee Chair – The Committee Chair must be a PEIA employee knowledgeable about the subject matter. The Committee Chair will be a full voting member and is responsible for mediating all discussions related to the evaluation and assisting with time management. The Committee Chair must also prepare the consensus of the committee and submit the recommendation for award to the PEIA Director or his/her designee.

(b) PEIA Procurement Officer - The Procurement Officer is a voting member and will be a PEIA employee knowledgeable about purchasing techniques and procedures. The Procurement Officer will be responsible for advising the committee regarding procurement regulations pertaining to the solicitation process. The Procurement Officer must also create and maintain the solicitation file and manage all documentation related to

the solicitation. The Procurement Officer may serve as the Committee Chair when appropriate.

(c) Members-at-Large – Members-at-Large are voting members and must be PEIA employees or PEIA Finance Board Members and should be somewhat knowledgeable about the subject matter. Members-at-Large will be required to attend bid openings and meetings related to bid evaluation.

(d) Subject Matter Experts (Optional) – PEIA may invite individuals to serve as non-voting members who are subject matter experts to assist in the evaluation process and advise the voting members as needed.

5.1.2.2 Proposal Evaluations – The evaluation committee shall review the technical proposals, assign appropriate points, and make a final written consensus recommendation to the PEIA Director or designee.

The evaluation committee initially determines if the technical proposals meet the mandatory requirements. Proposals that fail to meet the mandatory requirements may be rejected without further review.

The committee will then evaluate all technical proposals that met mandatory requirements to assign appropriate scores to the bids. During this evaluation, all proposals begin with the maximum score. The evaluation committee then deducts points for any identified deficiencies in each proposal. Technical proposals may be compared against one another to determine the best in class solution. Those proposals that exceed the mandatory requirements or the non-mandatory desirables should be assigned the maximum points in that category, with lesser solutions assigned an appropriately lower score. All deductions issued for each proposal must include justification, with fairness and consistency.

Proposals must obtain a Minimum Acceptable Score (MAS) of the total technical points possible to be considered for the award. The appropriate MAS will be determined at the time

the specifications are created. Standard MAS is typically 60% or 70% but should be set to reflect the relative importance of cost vs technical scoring based on the commodity and/or service sought. Vendors not attaining the MAS will be disqualified and removed from further consideration. Once the evaluation committee reaches a consensus on the technical scores, the cost proposals will be opened. The evaluation committee will review the cost proposals and using the cost formula, assign appropriate cost scores to each proposal not disqualified.

Once both a technical and cost score have been assigned to all qualifying bids, the Committee Chair will prepare a final recommendation for contract award, to be signed by all committee members, to be given to the PEIA Director. Assuming the PEIA Director concurs with the recommendation, the contract will be processed for award.

5.1.2.2.1 Oral Presentations – The evaluation committee may, at their discretion, request oral presentations from the top scoring vendors after the technical and cost proposals have been opened and preliminary scores have been assigned. The Oral Presentation will allow the vendors to further explain and/or clarify their bid in part or in whole. The Oral Presentation may not be scored. After the Oral Presentations, the evaluation committee may alter vendor technical scores based on the presentations prior to giving their recommendation to the PEIA Director.

5.1.2.2.2 Best and Final Offer (BAFO) – The PEIA Director or designee may, at his/her discretion, request BAFO's from finalists in the solicitation process, or enter into BAFO negotiations with the winning vendor(s) to further negotiate pricing and/or contract terms.

5.2 Vendor Documentation Review

Once the Evaluation Team and the PEIA Director have determined which vendor has submitted the apparent winning bid, the Procurement Officer and the Legal team will review vendor requirements (see 7.1.1) to ensure that all documents or registrations have been completed and submitted to PEIA. If documentation or registrations are still needed, vendor[s] will be contacted and given a deadline for completing and submitting any remaining documentation or proof of registrations in full.

If vendor does not submit remaining documentation by the deadline provided, vendor bid may be disqualified.

5.3 Bid Rejection

Vendor bids may be rejected for the following reasons

(a) Late submission: Bids must be received by the time and date of the bid opening detailed in the solicitation.

(b) Failure to meet mandatory requirements: Bids must meet all mandatory requirements detailed in the solicitation. Non-mandatory requirements are not required to be met, and do not merit disqualification.

(c) Failure of vendor to meet vendor requirements: Vendor must meet both State vendor requirements and PEIA specific requirements, which will be detailed in the solicitation. Any vendor who fails to meet a requirement by the date requested will be disqualified. A vendor may be disqualified even after being chosen for failing to meet vendor requirements. If that happens, the next lowest bidder or highest scorer will be given the award.

(d) Erroneous bids: If an error in a bid is found, request for relief must be made in writing by the vendor and should be received by PEIA within five days from the bid opening date. The PEIA Director may allow rejection of an erroneous bid if:

1. An error was made;

2. The error materially affected the bid;

3. Rejection of the bid would not cause a hardship to PEIA other than losing an opportunity to receive commodities and/or service at a reduced cost; and

4. Enforcement of the bid in error would be unconscionable

The vendor must specifically identify the error(s) and provide documentation to substantiate that the above criteria are met. The solicitation file must contain all documented evidence and rejection justification.

5.4 Tie Bid

When purchasing commodities and services, occasionally two or more bids of equal terms and amount are received in response to a solicitation, thus, resulting in a tie bid. If multiple awards are not made, the tie bid(s) must be resolved. When tie bids are received, the PEIA Director or designee shall break the tie by allowing the tied vendors to make a best and final offer, flip of a coin, draw of the cards, or any other impartial method considered prudent. A witness must be present when resolving the tie and documentation of the method and results, with signatures of all witnesses, must also be included in the file.

5.5 Award

Bids shall be awarded to the lowest bidding vendor meeting specifications (RFQ) or the most responsive and responsible bidder (RFP). Bid evaluation documentation shall be saved in the solicitation file. In the event that an award is made to other than the lowest biding or highest scoring vendor, documentation justifying the award shall be kept in the contract file. Initial notification of a successful bid to a vendor must include clarification that they are the "apparent successful vendor" in case vendor is deemed disqualified for any reason after the evaluation is complete but before the contract is final. Any mention of specific contract start dates is considered to be an "estimated" date, and is subject to change if deemed necessary.

SECTION 6: CONTRACT CANCELLATION & VENDOR REMEDIES

6.1 Contract Cancellation

The agency may cancel a contract or purchase order obtained through the agency delegated process upon written notice to the vendor under any one of the following conditions including, but not limited to:

(a) The vendor agrees to the cancellation;

(b) The vendor has obtained the contract by fraud, collusion, conspiracy or in conflict with any statutory or constitutional provision of the state of West Virginia;

(c) Failure to conform to contract requirements or standard commercial practices;

(d) The existence of an organizational conflict of interest is identified;

(e) Funds are not appropriated, or an appropriation is discontinued by the legislature for the acquisition;

(f) Violation of any federal, state, or local law, regulation, or ordinance; or

(g) Failure to maintain vendor requirements (see section X)

(h) The contract was awarded in error.

The agency may also cancel a purchase order or contract for any reason, upon 30 days' written notice to the vendor.

6.2 Vendor Remedies

In the event that a vendor fails to honor any contractual term or condition, or violate any provision of federal, state, or local law, regulation or ordinance, the agency may request the vendor remedy the contract breach or legal violation within a time frame the agency determines to be appropriate. If the vendor fails to remedy the contract breach or legal violation, then the agency may cancel immediately without providing the vendor an opportunity to perform a remedy.

SECTION 7: VENDOR REQUIREMENTS AND PROTEST

Vendors have the right to submit a formal protest to PEIA based on bid specifications or contract award.

7.1 Vendor Requirements

PEIA's Legislative Authority does not negate any Purchasing Division vendor requirements except the vendor registration fee. In addition, due to PEIA's status as a Healthcare Agency, vendors for some contracts may have additional requirements that must be met.

7.1.1 At the time of contract award

Vendor requirements must be detailed in the Solicitation. No contract can be fully awarded until all Vendor requirements have been met. This may include, but is not limited to:

(a) Secretary of State Registration
(b) wvOasis Vendor Registration
(c) WV Tax Department Registration
(d) Signed Limited Data Use Agreement (for certain Solicitations)
(e) Signed Business Associate Addendum and corresponding Appendix A – if applicable
(f) Signed Data Exchange – Data Management Addendum – if State data is to be exchanged and/or released as part of the contract or bid award
(g) West Virginia Office of Technology Vendor Confidentiality form – if any member of the vendor's workforce will require access to State systems and/or platforms as part of the scope of work on an Agreement
(h) West Virginia Public Employees Insurance Agency HIPAA Vendor Assurance Forms – if applicable
(i) Insurance requirements relevant to the commodity/service being requested

7.1.2 Annual Verifications

Vendors are required to maintain vendor requirements throughout the life of the contract. Vendors found to be out of compliance with vendor requirements may be considered in breach of contract requirements. In

the event that a contract is in place for longer than one (1) year, PEIA will conduct an annual Vendor Requirements check including, but not limited to:

(a) Verifying Secretary of State Registration
(b) Verifying wvOasis Vendor Registration
(c) State and Federal Debarment
(d) Verifying Insurance Requirements

7.2 Submission of Protest

Protests based on bid specifications must be submitted to the PEIA Director no later than five business days prior to bid opening. Protest of purchase orders or contract awards must be submitted no later than five business days after the award. Protest of proposed Direct Awards must be submitted no later than five business days after the award. The vendor is responsible for knowing the bid opening and award dates. Protests received after these dates may be rejected at the option of the PEIA Director.

All protests shall be submitted in writing to PEIA and contain the following information:

(a) The name and address of the protestor;
(b) The requisition, purchase order or contract numbers;
(c) A statement of the grounds of protest;
(d) Supporting documentation (if necessary); and
(e) The resolution or relief sought

Failure to submit this information shall be grounds for rejection of the protest by the PEIA Director.

7.3 Protest Review

The PEIA Director and/or his/her designee shall review the matter of protest and issue a written decision. A hearing may be conducted at the option of the PEIA Director or assigned designee.

Continuation or delay of the purchase order or contract award while the protest is considered is at the discretion of the PEIA Director.

PEIA may refuse to review any protests when the matter involved is the subject of litigation before a court of competent jurisdiction; if the merits have

previously been decided by a court of competent jurisdiction; or if it has been decided in a previous protest by the PEIA Director or assigned designee.

Responsibility for delivery of the protest to the PEIA Director shall remain with the protesting vendor. A failure by a third party to forward the protest to the Director shall not be grounds for extending the time for receipt of protests.

SECTION 8: RECORDS

8.1 Solicitation Files

The Procurement Officer will maintain a digital folder for all ongoing solicitations in the PEIA Procurement Shared Drive folder. All information relating to a solicitation must be placed in this folder including, but not limited to: solicitation documents, vendor bids, committee scoring, third-party approvals, and other documents relating to the solicitation and subsequent award.

The physical copy of the winning vendor bid will be incorporated into the resulting contract. If there is no physical copy of the winning vendor bid (i.e. a large and complex RFP for a Third-Party Administrator for which electronic bids and bid documents were accepted), the file will be noted as such. The bid will still be considered part of the contract file and must be maintained in the digital contract file.

Physical copies of all other vendor bids should be maintained for up to 2 years in case of post-award vendor disqualification requiring a re-award to the next lowest bidding or highest scoring vendor. After 2 years, physical copies of bids may be disposed of securely. Digital copies should be maintained for as long as the contract is active.

The PEIA Procurement Officer shall be responsible for the organization of the Procurement folder, including the archiving of solicitation files after a solicitation is complete.

8.2 Contract Files

The Procurement Officer, with the PEIA's Administrative Secretary, will maintain physical and digital contract files for all active contracts. The Procurement Officer is responsible for assembling and organizing the digital and physical folders and sending them for review by his/her supervisor and the General Counsel.

Contract files will be reviewed annually, regardless of renewal status, to ensure continued compliance with the appropriate Purchasing regulations including, but not limited to: Purchasing Affidavits (renewed annually), wvOasis vendor registration requirements, compliance with WV SOS

(checked annually), wvOasis document information, and renewal documentation if necessary.

8.3 Access to PEIA Records

8.3.1 Redacted Bid Documents

WV PEIA regularly receives Freedom of Information Act (FOIA) requests for solicitations, vendor proposals, and final contracts. A vendor's submission of any information to PEIA puts the risk of disclosure on the vendor. A vendor may request (as described in the General Terms and Conditions) that certain information be exempted from disclosure under W. Va. Code §29B-1-4, but PEIA makes no guarantee that such a request will be honored. The vendor is solely responsible for the defense against the release of any information in a bid submission.

If Vendor proposal contains confidential, trade secret. or proprietary information that should not be subject to public disclosure or view, Vendor should include a redacted copy of any relevant bid documents to WV PEIA during the bid process. Any redacted documents sent should be clearly identified. Should WV PEIA receive a FOIA request pertaining to a solicitation, WV PEIA will not reach out to vendors after the fact to request redacted proposals. WV PEIA cannot and will not assume the liability and/or responsibility for defending against the release of a Vendor's proposal under a Freedom of Information Act request. Failure of a vendor to redact confidential, trade secret, or proprietary information, or their failure to defend such release in a court of competent jurisdiction, may result in that information being released under a FOIA request. PEIA assumes no direct or indirect liability for the release of such information based on a lawful request.

8.3.2 Records Access

All records maintained by PEIA related to purchase orders and contracts are considered public records and may be made available through a FOIA request. If a Vendor has provided PEIA with redacted bid documents, the redacted documents will be released rather than the original documents containing proprietary or confidential information.

Information relating to the evaluation and eventual award of a Solicitation will not be made public until after an award has been made. Contract award information released prior to a contract award may be incorrect, premature, or erroneous; negotiations of pricing and contract terms may still be on-going. An award is considered complete only if the contract has been signed by the PEIA Director or Designee, approved as to form by any third parties where required, encumbered, and either placed in the U.S. mail or sent digitally to the vendor to a previously confirmed e-mail address.

Copies of records are available upon written request. An electronic copy of imaged documentation may be obtained.

PEIA contracts and supporting documentation are maintained as per its Records Retention Schedule on file with the West Virginia Department of Administration or until the agency obtains permission to destroy the documents from the Legislative Auditor's office pursuant to W. Va. Code § 5A-3-11(h). PEIA reviews bids for the inadvertent inclusion of social security numbers or other protected health information. Questions regarding the redaction of information, if any, should be directed to the agency's privacy officer.