An Independent Licensee of the Blue Cross and Blue Shield Association

WV GROUP GOLD SHARED COST PPO 1000

HEALTH CARE CERTIFICATE

YOUR HEALTH CARE BENEFITS
AND
HOW TO USE THEM

WV Group Gold Shared Cost PPO 1000
Health Care Certificate

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I. WV Group Gold Shared Cost PPO 1000 Health Care Certificate

A. GROUP CONTRACT AND CERTIFICATE

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

The actual Group Contract is between Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield West Virginia ("Highmark WV") and the employer or organization that pays or forwards the premiums and any administrative costs for your coverage with Highmark WV. Highmark WV may be referred to throughout this Certificate as **we**, **us**, **or our**. The employer or organization will be called the **Group, Plan, Plan Sponsor, or Plan Administrator**. The benefits provided under the Contract are referred to as **Plan** or **Group Health Plan**. All persons who meet eligibility criteria in this Certificate are eligible for coverage under the Group Contract. They are referred to as **Covered Persons, you or your**. They must:

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

Certain words used in this Certificate have special meaning. They will be capitalized throughout the text so that you will pay special attention to them. They are either defined in Section IX, or where used in the text.

Premiums are computed in accordance with Highmark WV's rating formula; which reflects, among other things, costs and charges associated with the selected benefit policy.

The Group shall have the right to return the Contract within 10 days of its delivery and to have the premium refunded if, after examination of the Contract, the Group is not satisfied for any reason. In the event the Group exercises this right, Highmark WV shall not be obligated to pay any benefits under the Group Health plan for Claims submitted to Highmark WV during such 10-day period.

B. FINANCING ARRANGEMENT

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

C. IMPORTANT INFORMATION ABOUT THIS COVERAGE

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

2. **Precertification Review.** This Certificate contains a Precertification Review limitation. It is described in Sections III and Section VIII Precertification Review is limited solely to determining Medical Necessity. It is not a guarantee of coverage or payment. **Remember, in an emergency, always go to the nearest appropriate medical facility.**

3. Mastectomy Benefits. This Group Health Plan provides certain reconstructive services for mastectomy benefits. See Section V for more information.

4. Ministerial Duties of Highmark WV

Highmark WV shall, in accordance with the Group Health Plan and Contract, perform the following ministerial duties: (a) determine questions of eligibility; (b) determine the amount and type of benefits payable under the Group Health Plan; and (c) implement claim and appeal procedures established by the Department of Labor under Claim Rules set forth in 29 CFR Part 25607. In carrying out these functions, Highmark WV shall have the exclusive right to apply the terms and provisions of the Group Health Plan and this Contract and to determine any and all questions arising under the Group Health Plan or this Contract, or in connection with these functions, including, without limitation, the right to remedy or resolve possible ambiguities, disputes, inconsistencies, or omissions by general rule or particular decision. Highmark WV shall have the exclusive right and authority to make any findings necessary or appropriate for the purpose of these functions, including, but not limited to, the determination of the eligibility for, and the amount, manner, and time of payment of, any benefit payable under the Group Health Plan or this Contract. Benefits will be paid only if Highmark WV decides, in accordance with the Group Health Plan and this Contract, that the claimant is entitled to them

5. Blue Cross and Blue Shield Association

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

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

6. Address

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

7. Member Services

If you have questions about your coverage or are directed to contact Highmark WV, you should contact Member Services, unless directed otherwise. Member Services can be reached using the number and address located on the back of your ID Card.

8. Information for Non-English Speaking Members

Members who do not speak English can call the toll-free number on the back of their ID Card to be connected to the language services interpreter line. Member Services representatives are trained to make this connection.

9. Member Rights and Responsibilities

You have the right to:

a. Receive information about Highmark WV, its products and its services, its practitioners and providers, and your rights and responsibilities.
b. Be treated with respect and recognition of your dignity and right to privacy.
c. Participate with practitioners in decision-making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.
d. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage.
e. Voice a complaint or file an appeal about Highmark WV or the care provided and receive a reply within a reasonable period of time.
f. Make recommendations regarding the Highmark WV Members' Rights and
g. Responsibilities policies.

You have a responsibility to:

a. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.
b. Follow the plans and instructions for care that you have agreed on with your practitioners. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

10. How We Protect Your Right to Confidentiality

We have established policies and procedures to protect the privacy of our members' protected health information ("PHI") in all forms, including oral PHI, from unauthorized or improper use. Some of the ways we protect your privacy include not discussing PHI outside of our offices, e.g., in hallways, elevators, as well as verifying your identity before we discuss PHI with you over the phone. As permitted by law, we may use or disclose protected health information for treatment, payment and health care operations, such as: claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review and underwriting. With the use of measurement data, we are able to manage members' health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness and disease management programs.

If we ever use your protected health information for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas.

You have the right to access the information your doctor has been keeping in your medical records, and any such request should be directed first to your network physician.

You benefit from the many safeguards we have in place to protect the use of data we maintain. This includes requiring our employees to sign statements in which they agree to protect your confidentiality, using computer passwords to limit access to your protected health information, and including confidentiality language in our contracts with physicians, hospitals, vendors and other health care providers.

Our Privacy Department reviews and approves policies regarding the handling of confidential information.

II. How To Use Your Certificate

This Certificate gives you the details you need in order to understand your health care benefits. We have tried to write it in simple terms that are easy to understand. Please read this Certificate carefully and completely to understand the benefit coverage. It is important that you keep a copy of this Certificate and refer to it if you have any questions about the benefits. Please refer to www.mybenefitshome.com to assure you have the most current version. You may also call Member Services to have a new Certificate sent to you.

III. Summary of Benefits

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

IV. Eligibility

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

V. Benefits

This Section explains types of health care benefits in your coverage.

VI. Exclusions

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

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

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

VIII. General Provisions

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

IX. Definitions

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

X. Prescription Drug Benefits

This Section describes your coverage for Prescription Drugs.

XI. Statement of ERISA Rights

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

XII. Group Health Plan Information

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

III. WV Group Gold Shared Cost PPO 1000 Summary of Benefits

IMPORTANT - Read this Section carefully. See Section V for a detailed description of benefits. Section X describes Prescription Drug benefits if such are provided under this Policy.

This Section indicates the amounts for Coinsurances, Deductible, Fees, reimbursement percentages, and Benefit Maximums. You will receive notification if your benefits change. Please refer to www.mybenefitshome.com to assure you have the most current version. You may contact Member Services to request an updated Policy.

A. PROVIDER NETWORKS AND DIRECTORY

The choice of a Provider is solely yours. All Providers are designated as either Network or Non-Network. **The amount of benefits that you will receive for Covered Services will vary depending upon whether the Provider is in the Network.** Your financial responsibility will also vary between these Provider designations.

Examples of Providers include, but are not limited to the following: primary care physicians; specialists; mental health and substance abuse providers; community and specialty hospitals; and laboratories. You have access to care 24 hours a day/7 days a week. If you have Covered Services outside of your primary care physician's hours, you should follow up with them after receiving care.

You will receive greater benefits by seeking Covered Services from Network Providers. This section tells you how much we will pay for Covered Services at Network and Non-Network Providers.

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

Network Provider online directory information is available by accessing www.highmarkbcbswv.com or you may also obtain such information by logging on to www.mybenefitshome.com or www.bcbs.com/healthtravel/finder/html. **The Network status of Providers listed in a directory may change from time to time. You should be sure of the status of the Provider before receiving Services**. To request a copy of the Provider Directory or check the status of a Provider, you may call the number on your ID Card. If you are outside of our Service Area, you may also call 1-800-810-BLUE. See Section VIII for more information on the meaning of Provider status.

B. MEDICAL COST-SHARING PROVISIONS (MEMBER LIABILITY)

The expenses you may incur include, but are not limited to, those briefly defined and described below. Further detail is provided later in this Section III, Section V, and throughout this Certificate. The Network Provider may request that you pay any applicable unmet Deductible, Coinsurance or Fee for the Covered Services at the time Covered Services are rendered.

Note: You may be responsible for a facility fee, clinic charge, or similar fee or charge in addition to the Physician's charge if the Service is provided at a Physician's office, a Hospital or Facility Other Provider, Ancillary Provider, Retail Clinic or Urgent Care Center.

1. **Benefit Accumulation.** Some employers may offer more than one health insurance policy through Highmark WV. Should you decide to change policies within the same company and within the same Benefit Period, for example, from a $500 Deductible to a $1,000 Deductible option, any Deductibles and Coinsurances earned on the $500 Deductible option shall apply to the $1,000 Deductible option. This provision does not apply if you change employment and both employers offer group health insurance through Highmark WV. If you have any questions about this provision, contact Member Services.

2. **Benefit Maximums.** Once the Benefit Maximum is met for a Covered Service(s) within the Benefit Period, any additional Charges Incurred will be your responsibility. Charges for Services above a Benefit Maximum will not apply to Fees, Deductibles, Network and Non-Network Coinsurances, or other Covered Person responsibilities. In some circumstance, the Benefit Maximums are combined for Network and Non-Network Services.

3. **Coinsurance and Coinsurance Limits.** This is a percentage of the Plan Allowance after your Deductible has been satisfied. **Network Coinsurance** percentages generally are less than **Non-Network Coinsurance**. Normally you receive greater benefits from Network Providers. There are separate limits for Network Coinsurance (**Network Coinsurance Limits**) and Non-Network Coinsurance (**Non-Network Coinsurance Limits**).

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

   Non-Network Coinsurance and Liability Limits. The Non-Network Coinsurance is in addition to your Network Coinsurance Limit. Also, Non-Network Liability amounts will not be applied toward satisfying either your Network or Non-Network Coinsurance Limits.

   After your Network Coinsurance Limit is satisfied, benefits for Covered Services provided by a Network Provider are payable by Highmark WV at 100% of the Plan Allowance, unless otherwise stated.

   After your Non-Network Coinsurance Limit is satisfied, benefits for Covered Services provided by a Non-Network Provider are payable by Highmark WV at 100% of the Plan Allowance, unless otherwise indicated. You are responsible for payment of some or all of the Provider Charges in excess of the Plan Allowance for Covered Services received from a Non-Network Provider (Non-Network Liability).

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

5. **Deductible.** A specified dollar amount you must pay for Covered Services each Benefit Period before we begin to provide payment for benefits. You may be required to pay any applicable Deductible at the time you receive care from a Provider. The copayment is typically payable at the time Covered Services are rendered.

6. **Maximum Out-of-Pocket**. The maximum amount of expenses Incurred for Deductibles, Copayments and Coinsurances for Covered Services for a Benefit Period per individual or family. The Maximum Out-of-Pocket does not include Non-Network Liability.

7. **Non-Covered Services.** Certain Services that may be Incurred or recommended by a Provider may not be a Covered Service under your Policy. As a result, you will be responsible for the cost of such Services. These Services will **not** apply towards any Fees, Deductibles, and Coinsurances.

8. **Non-Network Liability.** In addition to any Deductible and Non-Network Coinsurance, you may be responsible for some, or all, of the amount of Actual Charges in excess of our agreed Plan Allowance, when you obtain Services from Non-Network Providers.

9. **Office Visit Fees.** An upfront charge, usually stated in dollars, for Office Visits with Physicians and Professional Other Providers. The Office Visit Fee applies to Charges for the Office Visit only. This Fee does not apply to other Services received during a Visit, except as specified. Office Visit Fees are in addition to, and do not apply toward any other Deductibles, Fees or Coinsurances. The Office Visit Fee applies per Visit and is payable at the time Covered Services are received.

10. **Precertification Review Penalty.** A financial penalty that you are required to pay for most Inpatient Admissions if you do not contact us as required in Section VIII.

11. **Waivers**. In some instances, a Network Provider may ask you to sign a "waiver" or other document prior to receiving care. This waiver may state that you accept responsibility for the Charges above the applicable Plan Allowance with Highmark WV or for Services deemed not Medically Necessary by Highmark WV. Generally, Network Providers are prohibited from this practice. See Section V. for circumstances where you may be responsible for non-Medically Necessary Services.

C. SUMMARY OF BENEFITS DESCRIPTIONS The following pages provide details regarding specific benefit amounts and limits.

WV Group Gold Shared Cost PPO 1000

SUMMARY OF BENEFITS[1]

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

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $1,000 $2,000	 $2,000 $4,000
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Maximums (Includes deductible, coinsurance and copayments. Once met, plan pays 100% for the rest of the benefit period.) Individual Family	 $3,000 $6,000	 $6,000 $12,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	80% after deductible	60% after deductible
Primary Care Provider Office Visits	100% after $25 copayment	60% after deductible
Specialist Office & Virtual Visits	100% after $35 copayment	60% after deductible
Virtual Visit Originating Site Fee	80% after deductible	60% after deductible
Urgent Care Center Visits	100% after $35 copayment	60% after deductible
Telemedicine Service(2)	100% after $10 copayment	
Preventive Care(3)		
Routine Adult		
Adult immunizations	100% (deductible does not apply)	Not Covered
Colorectal cancer screening	100% (deductible does not apply)	Not Covered
Diagnostic services and procedures	100% (deductible does not apply)	Not Covered
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	Not Covered
Physical exams	100% (deductible does not apply)	Not Covered
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	Not Covered
Routine adult vision exam	100% (deductible does not apply)	Not Covered
Routine Pediatric		
Diagnostic services and procedures	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	Not Covered
Physical exams	100% (deductible does not apply)	Not Covered
Pediatric Vision(4)		
Exam (including dilation, as professionally indicated)	100% (deductible does not apply)	Not Covered
Pediatric frame selection	100% (deductible does not apply)	Not Covered
Standard eyeglass lenses (per pair)	100% (deductible does not apply)	Not Covered
Pediatric Dental(4)		
Exam and Cleanings	100% (deductible does not apply)	Not Covered
Basic Services (Fluoride treatments, sealants, consultations)	50% (deductible does not apply)	Not Covered
Major Services (Radiographs (all x-rays), space maintainers, amalgam restorations (metal fillings), resin based composite fillings (white fillings), crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.))	50% (deductible does not apply)	Not Covered
Orthodontics(5) (Medically necessary with prior approval. Waiting limits apply.)	50% (deductible does not apply)	Not Covered

Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	
Maternity (non-preventive facility & professional services) including dependent daughter	80% after deductible	
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	80% after deductible	
Emergency Services		
Emergency Room Services	80% after deductible	
Emergency Room Services – Non-Emergency	80% after deductible	60% after deductible
Ambulance	80% after deductible	
Ambulance – Non-Emergency	80% after deductible	60% after deductible
Therapy, Rehabilitative and Habilitative Services		
Occupational Therapy (Rehabilitative and Habilitative)	80% after deductible	60% after deductible
	Limit: 30 combined rehabilitative/habilitative visits/benefit period	
Physical Therapy (Rehabilitative and Habilitative)	80% after deductible	60% after deductible
	Limit: 30 combined rehabilitative/habilitative visits/benefit period	
Respiratory Therapy	80% after deductible	60% after deductible
Speech Therapy (Rehabilitative and Habilitative)	80% after deductible	60% after deductible
Spinal Manipulations (Rehabilitative and Habilitative)	80% after deductible	60% after deductible
	Limit: 30 combined rehabilitative/habilitative visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
Mental Health/Substance Abuse		
Inpatient	80% after deductible	60% after deductible
Inpatient Detoxification/Rehabilitation	80% after deductible	
Outpatient	100% after $35 copayment	
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
	100 visits per benefit period, aggregated with Visiting Nurse	
Hospice	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment(6)	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible	60% after deductible
	35 visits per benefit period	
Skilled Nursing Facility Care	80% after deductible	60% after deductible
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements(7)	Yes	

Prescription Drugs	
Prescription Drug Deductible Individual Family	 None None
Prescription Drug Program(8) Soft Mandatory Generic *Defined by the Premier 2012 Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with an Incentive Formulary Benefit Design.*	**Retail Drugs (34 -day Supply)** $4 generic copayment $40 formulary brand copayment $70 non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $10 generic copayment $100 formulary brand copayment $175 non-formulary brand copayment

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) Services must be performed by a Highmark approved telemedicine provider.
(3) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
(4) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
(5) A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality. Prior approval is required. 12 month waiting period required. See your benefit booklet for more details.
(6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(7) Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
(8) Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

EHB West Virginia– Pediatric Vision (High Option)

Vision Care Plan Benefit Summary

IN-NETWORK BENEFIT	**FREQUENCY**
Eligible Participants	Members under 19 years of age[1]
Eye Examination (including dilation, as professionally indicated)	Once every 12 months
Eyeglass lenses	Once every 12 months
Frames	Once every 12 months
Contact lenses (in lieu of eyeglass lenses)	Once every 12 months
	MEMBER RESPONSIBILITY
EYE EXAMINATION (including dilation as professionally indicated)	Covered In Full
FRAMES	
Pediatric Frame Selection	Covered In Full
STANDARD EYEGLASS LENSES[2] (per pair)	
Single vision	Covered In Full
Bifocal	Covered In Full
Trifocal	Covered In Full
Lenticular	Covered In Full
OPTIONAL EYEGLASS LENSES/COATINGS/TREATMENTS (per pair)	**MEMBER RESPONSIBILITY**
Standard progressive lenses[3]	Covered In Full
Select progressive lenses[3]	Member pays $70
Premium progressive lenses[3]	Member pays $90
Ultra progressive lenses[3]	Member pays $195
Polycarbonate lenses	Covered In Full
Blended segment lenses	Member pays $20
Intermediate vision lenses	Member pays $30
Glass photochromic lenses	Member pays $20
Plastic photosensitive lenses	Covered In Full
High-index (thinner and lighter) lenses	Member pays $55
Polarized lenses	Member pays $75
Fashion, sun or gradient tinted plastic lenses	Covered In Full
Ultraviolet Coating	Covered In Full
Scratch-resistant coating	Covered In Full
Scratch Protection Plan Single Vision	Member pays $20
Scratch Protection Plan Multifocal	Member pays $40
Standard ARC (anti-reflective coating)	Member pays $35
Premium ARC (anti-reflective coating)	Member pays $48
Ultra ARC (anti-reflective coating)	Member pays $60
CONTACT LENSES (in lieu of eyeglass lenses—per pair or initial supply of disposable contact lenses from the Pediatric Contact Lens Selection)	
Contact lens evaluation and fitting	
Daily wear	Covered in full when the performing provider dispenses from the pediatric contact lens selection
Extended wear	Covered in full when the performing provider dispenses from the pediatric contact lens selection
	Pediatric Contact Lens Selection[4]
Standard daily wear contact lenses	Covered In Full
Specialty contact lenses	Covered In Full
Disposable contact lenses	Covered In Full
Medically necessary contact lenses (prior approval required)	Covered In Full

(1) Dependents will be terminated from the contract at the end of the month in which they turn 19 for individual contracts.
Note: Termination rules for employer groups are determined by client.
(2) Includes glass, plastic or oversized lenses.
(3) Progressive multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive lenses. However, the member's payment towards the progressive upgrade will not be refunded.
(4)Disposable contact lens wearers will receive four multi-packs of lenses. Planned replacement lens wearers will receive two multi-packs of lenses.

EHB West Virginia– Adult Vision (High Option)

Vision Care Plan Benefit Summary

NETWORK BENEFIT (Independents & Vision Works)	**FREQUENCY**
ELIGIBLE PARTICIPANTS	Members 19 years of age or older
Eye Examination *(including dilation, as professionally indicated)*	Once every 12 months
POST REFRACTIVE SERVICES	
Frames	Discount on post refractive services received through a participating provider
Eyeglass Lenses	
Contact Lenses	

Schedule of Benefits

THIS PLAN MEETS THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.
THESE BENEFITS ARE ONLY AVAILABLE FOR CHILDREN THROUGH THE END OF THE CONTRACT YEAR THAT THEY TURN 19.

This Policy will pay benefits for Covered Services shown below subject to the Schedule of Exclusions and Limitations and other Policy terms. Payment is based on the Maximum Allowable Charge (MAC) for the specific Covered Service. Participating Dentists accept contracted MACs as payment in full for services. Non-participating Dentists do not limit their charges and may bill You for the difference between their charge and the benefit paid by the Policy.

Contract Year Deductible per Member:	$0
Annual Maximum per Member:	Unlimited
Out of Pocket (OOP) Maximum per Member:	Combined with Medical

Service Category	Waiting Period	Policy Pays at		After Deductible
		Participating Dentists	Non-Participating Dentists	
Oral Evaluations (Exams)	None	100%	100%	N/A
Radiographs (All X-Rays)	None	50%	50%	N/A
Prophylaxis (Cleanings)	None	100%	100%	N/A
Fluoride Treatments	None	50%	50%	N/A
Palliative Treatment (Emergency)	None	50%	50%	N/A
Sealants	None	50%	50%	N/A
Other Diagnostic & Preventive Services	None	Not Covered	Not Covered	N/A
Space Maintainers	None	50%	50%	N/A
Amalgam Restorations (Metal fillings)	None	50%	50%	N/A
Resin-based Composite Restorations (White fillings)	None	50%	50%	N/A
Crowns	None	50%	50%	N/A
Inlays and Onlays	None	Not Covered	Not Covered	N/A
Crown Repair	None	50%	50%	N/A
Endodontic Therapy (Root canals, etc.)	None	50%	50%	N/A
Other Endodontic Services	None	50%	50%	N/A
Surgical Periodontics	None	50%	50%	N/A
Non-Surgical Periodontics	None	50%	50%	N/A
Periodontal Maintenance	None	50%	50%	N/A
Prosthetics (Complete or Fixed Partial Dentures)	None	50%	50%	N/A

Service Category	Waiting Period	Policy Pays at		After Deductible
		Participating Dentists	Non-Participating Dentists	
Adjustments and Repairs of Prosthetics	None	50%	50%	N/A
Other Prosthetic Services	None	50%	50%	N/A
Maxillofacial Prosthetics	None	Not Covered	Not Covered	N/A
Implant Services	None	50%	50%	N/A
Simple Extractions	None	50%	50%	N/A
Surgical Extractions	None	50%	50%	N/A
Oral Surgery	None	50%	50%	N/A
General Anesthesia, Nitrous Oxide and/or IV Sedation	None	50%	50%	N/A
Consultations	None	50%	50%	N/A
Adjunctive General Services	None	Not Covered	Not Covered	N/A
Medically Necessary Orthodontics, with Our prior approval and a written plan of care Orthodontics	12 Months	50%	50%	N/A

Medically Necessary Orthodontics Coverage:

In this section, "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician or Dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. in accordance with the generally accepted standards of medical/dental practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. not primarily for the convenience of the patient or physician/Dentist, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

As used subpart 1, above, "generally accepted standards of medical/dental practice" means:

- standards that are based on credible scientific evidence published in peer-reviewed, medical/dental literature generally recognized by the relevant professional community;
- recognized Medical/Dental and Specialty Society recommendations;
- the views of physicians/Dentists practicing in the relevant clinical area; and
- any other relevant factors.

A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality.

Coverage of Medically Necessary Orthodontics:

1. Orthodontic treatment must be Medically Necessary and be the only method capable of:
   a) Preventing irreversible damage to the Member's teeth or their supporting structures and,
   b) Restoring the Member's oral structure to health and function.

2. Members must have a fully erupted set of permanent teeth to be eligible for comprehensive, Medically Necessary orthodontic services.

3. **All Medically Necessary orthodontic services require prior approval** and a written plan of care.

IV. Eligibility

A. APPLYING FOR COVERAGE

When you apply for coverage, you will be asked to select one of the following types of coverage:

- Employee only.
- Employee and child.
- Employee and spouse.
- Employee and children.
- Family.

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

B. ELIGIBLE EMPLOYEES AND PREMIUM COST SHARING

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

C. ELIGIBLE DEPENDENTS

An eligible Dependent is an individual identified by the Certificate Holder through the appropriate enrollment process or on an application form accepted by the Plan who is:

a. Spouse of the opposite sex:
The Certificate Holder's spouse under a legally valid existing marriage between persons of the opposite sex.

Please check with your Group Administrator to see if the following (b and c) are applicable:

b. **Spouse of the same sex:**
The Certificate Holder's spouse under a legally valid existing marriage between persons of the same sex when entered into within a state that sanctions such marriages by law and that is valid pursuant to such law at the time of the marriage.

c. Domestic Partner:
A Domestic Partner shall be considered for eligibility as long as a domestic partnership (a voluntary relationship between two (2) Domestic Partners) exists with you. In addition, the children of the Domestic Partner shall be considered for eligibility as if they were your children as long as the domestic partnership exists.

d. Dependent Children:

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

1. Dependent Age Limits and Disabled Children

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

2. Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is legally placed with you for adoption, will be eligible for Dependent insurance upon the date of placement with you. A child will be considered placed for adoption when the natural parents (or legal guardian) legally consent to the adoption process under applicable state law and you come legally obligated to support that child, totally or partially, prior to that child's adoption. You may be required to provide documentation evidencing the consent. See the Special Enrolment Procedures.
If a child placed for adoption is not adopted, all health coverage ceases when the placement ends.

3. Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and the child will not be considered a Late Entrant for Dependent insurance. A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state agency that satisfies all of the following:

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

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

4. Custodial Parent Rights

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

The payment to the custodial parent, the Provider or the state Medicaid agency fully satisfies our obligation to the noncustodial parent under this Group Health Plan with respect to the covered child's Claims.

D. ENROLLMENT UPON INITIAL ELIGIBILITY

1. Time for Applying. An Eligible Employee has until the first of the month beginning after the date of becoming an Eligible Employee to enroll by submitting an Application for participation on such form(s) as may be prescribed from time to time by the Group Health Plan and by providing the Group Health Plan with such other information as may be requested.

2. **Required Information**. Participation by the Eligible Employee and, if applicable, his Eligible Dependent(s) shall be contingent upon receipt by the Group Health Plan of a completed Application form and any other information requested by the Group Health Plan or us and, if applicable, payment of any required employee contribution.

3. **Effective Date**. If an Eligible Employee enrolls in the Group Health Plan pursuant to this section, the Eligible Employee and, if applicable, his or her Eligible Dependent(s) shall become Covered Person(s) effective the first day of the month after he or she first becomes an Eligible Employee (the Covered Person's "Enrollment Date"). If the Eligible Employee and, if applicable, his or her Eligible Dependent(s), fail to enroll in the Group Health Plan by the first day of the month after becoming eligible, the Eligible Employee and, if applicable, his or her Eligible Dependents must wait for the Group Health Plan's next open enrollment period to enroll in the Group Health Plan unless they are eligible to enroll under a Special Enrollment procedure or a Qualified Medical Child Support Order described elsewhere within this Section IV.

4. **Initial and Annual Enrollment and Effective Dates for Coverage Offered Through an Exchange.** If your coverage under the Group Health Plan is a QHP offered through an Exchange, the Exchange is responsible for establishing an enrollment process that includes:

- Determining employer eligibility to purchase coverage for Qualified Employees;
- Providing the timeframe for a qualified employers to select the level of coverage or QHP that will be available to Qualified Employees;
- Providing the timeframe for a Qualified Employee to complete an application for coverage;
- Determining and verifying employee eligibility to enroll in a QHP;
- Processing the enrollment of Qualified Employees into QHPs; and
- Establishing effective dates for employee coverage.

A qualified employer may purchase coverage during the initial open enrollment period beginning on October 1, 2013 for coverage effective as of January 1, 2014.

After the initial open enrollment period, Qualified Employees generally may enroll in or change QHP coverage only during subsequent open enrollment periods that occur after the employer's annual election period unless otherwise specified in this Section IV.

E. ELIGIBILITY CHANGES AND SPECIAL ENROLLMENT PROCEDURES

For Highmark WV to administer consistent coverage for you and your Dependents, you must inform the Group immediately of any changes in eligibility (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

1. **Dependent Additions and Special Enrollment Available for New Dependents**

Special Enrollment is available if you marry or acquire a child through birth, adoption or placement for adoption. You must notify your Plan Administrator and submit an Application to us within 30 days of the event to add a newly acquired Eligible Dependent. If we receive the Application within 30 days of the event, the Effective Date of the Eligible Dependent's coverage will be:

- The date of birth or placement for adoption.
- The first of the next month after marriage.

If we do not receive the Application within 30 days of the event, acceptance of the Application may be denied.

2. **Special Enrollment Rights for Loss of Other Coverage**

a. **Loss of other group coverage**. Special Enrollment is available for individuals, provided:

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

b. Loss of Medicaid or CHIP Coverage. Special Enrollment is also available to an individual if the individual:

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

(ii) becomes eligible for assistance for Group Health Plan coverage under title XIX of the Social Security Act (Medicaid) or state children's health plan under title XXI of the Social Security Act, provided the individual requests coverage under the Group Health Plan within 60 days of the date the individual is determined to be eligible for assistance.

Coverage for both of the above situations shall be effective on the first day of the month following the date of enrollment.

3. Additional Special Enrollment Rights if you have coverage through an Exchange

You may be permitted a Special Enrollment period of 30 days through an Exchange from the date of occurrence of any of the following triggering events:

- A Qualified Employee or dependent (including a spouse) of an enrollee loses other minimum essential coverage;
- A Qualified Employee gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
- A Qualified Employee's enrollment or non-enrollment in a QHP is unintentional, inadvertent, erroneous or is the result of an error, misrepresentation, or inaction of the Exchange or its agents;
- An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled violated a material provision of its contract with the enrollee;
- A Qualified Employee or enrollee gains access to new QHPs as a result of a permanent move;
- An Indian may enroll in a QHP or change from one QHP to another one time per month; or
- A Qualified Employee demonstrates to the Exchange that the individual meets "other exceptional circumstances" as the Exchange or HHS may provide, including those that would impede his or her ability to enroll on a timely basis, through no fault of his or her own (*e.g.*, a natural disaster).

4. Changes in Eligibility

You must immediately notify your Group of any changes in eligibility (e.g., divorce) or when a Covered Person under your Certificate becomes eligible for Medicare or becomes covered under another health insurance policy. When you or a Dependent becomes ineligible, you and your Dependents may be eligible for continuation coverage described in this Section IV. COBRA continuation coverage allows individuals 60 days to notify their Group of such ineligibility from the date they become ineligible. It is important to notify the Group as soon as possible to avoid loss of guaranteed availability rights for other coverage.

5. Nondiscrimination

Subject to all limitations within this Contract, individuals may not be excluded from coverage under the terms of the Contract, or charged more for benefits, based on specified factors related to

health status, medical condition (both physical and mental), Claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

Highmark WV does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

F. OPEN ENROLLMENT

During the Group Health Plan's open enrollment period, an Eligible Employee may elect to participate in the Group Health Plan, singly or with his Eligible Dependents, or to add, modify, or eliminate coverage under the Group Health Plan. Any changes elected during the Group Health Plan's open enrollment period shall be effective as of the first day of the Benefit Period immediately following the close of the open enrollment period.

G. EFFECTIVE DATE

Coverage starts on the Effective Date:

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

No benefits will be provided for Charges Incurred prior to your Effective Date. Coverage will not be delayed or denied due to confinement in a Hospital or other health care institution on your Effective Date.

H. IDENTIFICATION CARDS (ID CARDS)

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

I. MEDICARE ELIGIBILITY

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

1. Active Employees

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

2. Retirees

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

If your former Group does not provide retiree benefits, coverage may be available with Highmark WV. To be considered for coverage, you **must** apply for and enroll in Medicare Part A and Part B.

Highmark WV is not permitted to offer a Direct Pay (non-group) policy to a Medicare-eligible person. You may obtain a Medicare Supplemental or Medicare Advantage policy, however if you are a Medicare eligible resident of West Virginia, you are not eligible for Traditional Medicare Supplemental coverage if you are presently enrolled in a Group Medicare Advantage product.

J. NON-MEDICARE RETIREES

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

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

K. HOW AND WHEN YOUR BENEFITS MAY CHANGE

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

L. HOW AND WHEN YOUR COVERAGE STOPS

- When a Covered Person stops being an Eligible Dependent, coverage stops as specified in this Certificate or Group Contract.
- When a Covered Person stops being an eligible Certificate Holder, all coverage stops according to the terms of the Group Contract.
- Termination of the Group Contract by the Plan Administrator automatically ends all of your coverage. It is the responsibility of the Plan Administrator to tell you of such termination.
- If Highmark WV terminates the Contract, you and the Plan Administrator will be notified 60 days in advance of the coverage termination date. You may be eligible for conversion coverage as indicated in this Section IV.
- We have the right to void coverage of any Covered Person who engages in fraud or an intentional misrepresentation of a material fact.
- When a Group or Covered Person fails to make a required premium payment, coverage stops at the end of the month of the last fully paid premium payment.

For enrollees in a QHP through an Exchange, coverage may terminate when:

- The enrollee is no longer eligible for coverage in a QHP through the Exchange;
- The enrollee changes from one QHP to another during the annual enrollment period;
- The QHP terminates or is no longer certified;
- Non-payment on premiums; or
- The employer chooses to withdraw from participation in the Exchange.

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

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

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

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

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

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

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

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

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

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

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

The Eligible Employee or family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing Dependent status within 60 days of the date of the qualifying event which would cause a loss of coverage. The notice must be in writing, and should be sent to the Plan Administrator. When the employer is notified that one of these events has happened, you will in turn be notified that you and your Eligible Dependents have the right to choose continuation coverage. Under the law, you and your Eligible Dependents have 60 days from the later of the date you would lose coverage or from the date of the notice to elect continuation coverage. If and when you and your Eligible Dependents make this election, coverage will become effective on the day after coverage would otherwise be terminated.

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

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

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

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

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

You do not have to show that you are insurable to choose continuation coverage. However, **you will have to pay all of the cost, the Group rate premium plus a 2% administrative fee, for your continuation coverage.** At the end of the 18-month, 29-month, or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under the current group health plan, if the plan provides a conversion privilege. In addition, under the Health Insurance Portability & Accountability Act (HIPAA, 1996), in certain circumstances, such as when you exhaust COBRA coverage, you may have the right to buy individual health coverage.

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

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

N. CONTINUATION COVERAGE – MINI-COBRA

West Virginia law requires that insurers offer Group coverage, at the same benefit levels and Group rates for a period of up to 18 months, in the event a Covered Person loses Group coverage due to termination for reasons other than misconduct that would disqualify you for unemployment benefits. This law applies to former Covered Persons of certain small employers with 2-19 employees who are not entitled to coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

A Covered Person must give written notice to Highmark WV within 20 days after the termination of employment of his or her intent to apply for continuation coverage. The notice must, at a minimum, identify the Covered Person, the Employer and, to the extent that information is known, the names and addresses of all other eligible dependents, and the benefit plan number. You may obtain a copy of this notice for your completion by contacting Member Services.

Highmark will then send each eligible adult Covered Person an election and premium notice within 15 days after receipt of the completed notice of intent. The election and premium notice, along with the initial premium payment, must be submitted to Highmark WV within 30 days.

This continuation coverage may be terminated for any of the following reasons:

1. After 18 months of continuation coverage;
2. If you do not pay the premium for your continuation coverage in a timely manner;
3. If you become covered under any other group health plan;
4. If you become entitled to Medicare; or
5. Your former employer terminates coverage for all employees and does not replace it with similar coverage under another group health plan.

O. MILITARY SERVICE

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

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

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

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

No other benefits will be provided once your coverage stops.

Q. CONVERSION PRIVILEGE

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

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

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

R. GUARANTEED RENEWABILITY OF COVERAGE

Your coverage will renew or continue in force except in situations involving nonpayment of premiums, fraud, violation of participation or contribution rules, termination of the plan, enrollee's movement outside the service area or discontinuance of a product or all coverage.

V. Health Care Benefits

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

For assistance in obtaining more specific benefit information on what procedures or tests are covered, call Member Services. **Certain Services may also require Prior Authorization. For additional information, see Section VIII, visit Highmark WV's website at www.highmarkbcbswv.com or contact Member Services.**

A. MEDICAL NECESSITY REQUIREMENT AND MEMBER LIABILITY

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

B. PRIOR AUTHORIZATION

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

C. ALLERGY TESTS AND TREATMENT

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

D. AMBULANCE SERVICES

See also, Emergency Care Services Section.

1. General

Ambulance Services are covered when clinical condition is such that the use of any other method of transportation would endanger the patient's medical condition. Payment will not be made for ambulance Service when an ambulance was used simply for convenience or because other means of transportation was not available.

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

Reimbursement may be made for Services that meet the following conditions:

- Emergency situations, e.g., as a result of an accident, injury or acute illness, or
- The need to be restrained, or
- Unconsciousness or shock, or
- Oxygen or other emergency Treatment is required on the way to the destination, or
- Fracture that had not been set or the possibility of a fracture, or

- Sustained an acute stroke or myocardial infarction, or
- Severe hemorrhage, or
- Confinement to a bed before and after the ambulance trip, or
- Could be moved only by stretcher.

Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies, and, in non-emergency situations, be capable of transporting Members with acute medical conditions. The vehicle must comply with state or local laws governing the licensing and certification of an emergency medical transportation vehicle.

2. Air Ambulance Services.
Air ambulance transportation is covered if the aircraft meets air ambulance criteria and when the Service is medically appropriate. The Covered Person's medical condition must require immediate and rapid ambulance transportation that cannot be provided by land ambulance and either:

- The point of great distances or other obstacles are involved in getting the patient to the nearest Hospital with appropriate facilities capable of providing the required level and type of care to treat the Member's condition; or
- Pick-up is inaccessible by land vehicle.

Air ambulance Services are not covered for transport to a facility that is not an acute care Hospital, such as a nursing facility, physician's office or a Member's home.

E. AUTISM SPECTRUM DISORDER

Treatments include those that are ordered or prescribed by a licensed physician or licensed psychologist in accordance with a Treatment Plan developed from a comprehensive evaluation by a Certified Behavior Analyst for an individual diagnosed with Autism Spectrum Disorder. See Section VIII for information regarding Treatment Plans. Treatment may include, but not be limited to, Applied Behavioral Analysis provided or supervised by a Certified Behavioral Analyst.

Progress reports are required semi-annually from the Certified Behavior Analyst. In order for Treatment to continue, we may require documented Objective Evidence or a clinically supportable statement of expectation that:
(1) The individual's condition is improving in response to Treatment, and
(2) A maximum improvement is yet to be attained, and
(3) There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

F. BONE MARROW PROCEDURES

Benefits are provided for the following types of bone marrow transplants.
- Allogeneic.
- Autologous.
- Syngeneic.
- Peripheral stem cell transplants.

Covered Services will include the following.
- Bone marrow donation and storage.
- Pre-transplant chemotherapy and/or radiation Treatment.
- Bone marrow or peripheral stem cell transplant.
- Post-transplant Outpatient care directly related to the transplant.

- Expenses for transportation to and from the site of the transplant operation. Benefits will also be provided for meals and lodging for the covered recipient and one additional adult. If the patient is a minor, expenses for transportation, meals, and lodging will be provided for the patient and two accompanying adults (Contact Medical Management to receive further details regarding travel and lodging), and
- Retransplantation.

G. CLINICAL TRIALS COVERAGE

Coverage is provided for approved clinical trials if the individual's referring provider has concluded that the member's participation in the trial would be appropriate or the individual provides medical and scientific information establishing that participation in the trial would be appropriate. Coverage includes routine patient costs for items and services furnished in connection with participation in the trial. Highmark WV will not discriminate against any individual participating in such trials.

An approved clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

1. A federally funded or approved trial;
2. A clinical trial conducted under an FDA investigational new drug application; or
3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

H. COST EFFECTIVE NON-COVERED SERVICES

We may approve benefits that are not expressly Covered in this Policy in limited circumstances if we determine that any such Services present a more appropriate means of Treatment is appropriate. Coverage for these Services must be approved in advance and in writing by Highmark WV.

I. DENTAL SERVICES FOR AN ACCIDENTAL INJURY

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

J. DIAGNOSTIC SERVICES

Diagnostic Services include:

- Radiology, ultrasound and nuclear medicine,
- Laboratory and pathology Services,
- EKG, EEG, and other electronic diagnostic medical procedures,
- Other forms of medical imaging.

K. EMERGENCY SERVICES

Coverage shall be provided for Emergency Medical Services to the extent necessary to screen and Stabilize an Emergency Medical Condition. Emergency Services are those provided to evaluate and treat an Emergency Medical Condition, a condition manifesting itself by the sudden, and unexpected onset of acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairments to bodily functions or serious dysfunction of any bodily part or organ based on a Prudent Layperson standard. Emergency Medical Conditions include, but are not limited to, heart attacks, strokes, loss of consciousness or respiration, convulsions and other acute conditions, which we determine to be a Medical Emergency only if:

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

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

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

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

Transportation and related emergency Services provided by an Ambulance Service shall constitute Emergency Ambulance Services if the injury or the condition satisfies the criteria above.

Use of an ambulance as transportation to an emergency room of a Facility Provider for an injury or condition that does not satisfy the criteria above will not be covered as Emergency Ambulance Services.

Treatment for any occupational injury for which benefits are provided under any Worker's Compensation Law or any similar Occupational Disease Law is not covered.

L. HABILITATIVE SERVICES

Medically Necessary Services that help a person gain, keep or improve skills for daily living.

- **Occupational Therapy**. The Treatment by means of constructive activities designed and adapted to promote the ability to satisfactorily accomplish the ordinary tasks of daily living and those required by a particular occupational role.
- **Physical Therapy**. The Treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities.
- **Spinal Manipulation**. The Treatment by means of manual manipulation of the spine.
- **Speech Therapy**. The treatment for the correction of a speech impairment.
- **Cardiac Rehabilitation**. The physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

M. HOME HEALTH CARE SERVICES

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

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

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

- Dietician Services.
- Homemaker Services.
- Food or home delivered meals.
- Custodial Care.
- Maintenance therapy.
- Routine prenatal care.
- Mental Illness, Drug Abuse, or Alcoholism services.
- Private duty nursing.
- Personal comfort items.

N. HOME, OFFICE AND OTHER OUTPATIENT VISIT

Medical Care rendered to a Member who is an Outpatient for a condition not related to Surgery, pregnancy or Mental Illness, except as specifically provided, including Medical care Visits, Telemedicine Services and consultations for the examination, diagnosis and treatment of an injury or illness.

O. HOSPICE SERVICES

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

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

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

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

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

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

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

P. HOSPITAL-BASED CLINICS

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

Q. INJECTABLE DRUGS

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

R. INPATIENT SERVICES

1. Bed, Board and General Nursing Services

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

2. Ancillary Services, including:

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

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

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

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

6. Diagnostic Surgical Procedures. Surgical procedures to diagnose your condition while you are in the Hospital.

7. Inpatient Consultation. A personal bedside examination by another Physician or Professional Other Provider, performing within the scope of their license, when requested by your Physician. The Physician or Professional Other Provider rendering the consulting Service must be board-eligible, if applicable, and possess the knowledge, training, and skill needed to provide this Service. Consultation Services are not covered if the consultant subsequently takes charge of the patient. At that point, we will consider him the treating Physician. We will not provide coverage for both the treating Physician and initial treating Physician for Services rendered during the same time period. Staff consultations required by Hospital rules are not covered.

8. Newborns

- **Inpatient Newborn Care**. Routine care of a newborn, including circumcision while the mother remains an Inpatient for the maternity admission **(if covered by your Policy),** or if the newborn is added to your Policy within the time limit specified in Section IV. Coverage must be in effect for the newborn care to be a Covered Service. **Each new Dependent must be added to your Policy within 31 days of acquiring the new Dependent, regardless of the type of coverage in effect at the time you acquire the**

new Dependent. Refer to the Section III for information on how to apply for the necessary coverage.

- **Newborn Hearing Impairment Testing.** In West Virginia, health care Providers present at or immediately after childbirth are required to perform a test for hearing loss on the infant unless the infant's parents refuse. If delivery takes place in a non-covered facility including home birth, a West Virginia health care Provider shall inform the parents of the need to obtain this Service within the first month of life. The newborn testing shall be a covered benefit.

- **Detection and Control of Diseases in Newborns.** West Virginia law requires the Hospital or Birthing Center in which the infant is born, the parents or legal guardians, the Physician attending the newborn child, or any person attending the newborn child not under the care of a Physician, to ensure that the newborn be tested for diseases specified by the State Public Health Commissioner and set forth in West Virginia code §16-22-3.

S. MATERNITY SERVICES

Hospital, medical and surgical Services for a normal pregnancy and complications of pregnancy, miscarriage, and non-elective abortions are Covered Services. Coverage for non-elective abortion is limited to those necessary to avert the death of the member or to terminate pregnancies caused by rape or incest. These are Covered Services for the Policyholder and all Eligible Dependents. These are not Covered Services if the Policyholder or Eligible Dependent has become pregnant to serve in the capacity of a Surrogate Mother or of Surrogate Parent.

We will not restrict maternity benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a Provider obtain Authorization from us for prescribing lengths of stay in excess of the above periods. Precertification is required **only** when the Inpatient stay exceeds 48 hours and 96 hours respectively.

T. MEDICAL SUPPLIES AND EQUIPMENT

1. **Medical and Surgical Supplies**. These Supplies include syringes, needles, oxygen, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use such as elastic bandages or thermometers.

2. **Durable Medical Equipment**. Durable medical equipment must be prescribed by a Physician or Professional Other Provider acting within the scope of their license. It must serve only a medical purpose and must be able to withstand repeated use. You may rent or purchase the equipment; however, we will not pay more in total rental costs than the customary purchase price, as determined by us.

3. **Orthotic Devices**. Rigid or semi-rigid supportive devices that limit or stop the motion of a weak or diseased body part.

4. **Prosthetic Appliances**. The purchase, fitting, adjustments, repairs and replacements of prosthetic devices that are artificial substitutes and necessary supplies that:
   - replace all or part of a missing body organ and its adjoining tissues.
   - replace all or part of the function of a permanently useless or malfunctioning body organ.

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

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

For purposes of Mental Health Parity, "Serious Mental Illness" means an illness included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, under the diagnostic categories or subclassifications of: (A) Schizophrenia and other psychotic disorders; (B) bipolar disorders; (C) depressive disorders; (D) substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; (E) anxiety disorders; and (F) anorexia and bulimia.

1. Mental Health Care

Covered Services for the Treatment of Mental Health Care include:

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

2. Drug Abuse and Alcoholism (Substance Abuse) Services

Covered Services for Drug Abuse and Alcoholism rehabilitation include:

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

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

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

V. ORGAN TRANSPLANT SERVICES

The following human organ transplants are Covered Services:

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

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

Benefits will be provided for:

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

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

W. PEDIATRIC DENTAL

Benefits are provided for Covered Persons under age nineteen (19) for the following when rendered by a Participating Dentist:

- Oral Evaluations:
  - Comprehensive, periodic and limited problem focused - one (1) of these services per six (6) months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
  - Consultations - one (1) of these services per Dentist per patient per twelve (12) months for a consultant other than a Pedodontist or Orthodontist.
  - Detailed problem focused - one (1) per Dentist per patient per twelve (12) months per eligible diagnosis.
- Radiographs - Full mouth x-rays - one (1) every five (5) year(s). Bitewing x-rays - one (1) set(s) per twelve (12) months.
- Prophylaxis - one (1) per six (6) months. One (1) additional for Covered Persons under the care of a medical professional during pregnancy.
- Fluoride treatments:
  - Topical fluoride treatment - one (1) per twelve (12) months under age fourteen (14).
  - Fluoride varnish - one per twelve (12) months under age fourteen (14).
- Palliative treatment (Emergency)
- Sealants - one (1) per tooth per lifetime under age sixteen (16) on permanent first and second molars.
- Space maintainers - one (1) per five (5) year period for Covered Persons under age fourteen (14) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.
- Preventive resin restorations - one (1) per tooth per lifetime under age sixteen (16) on permanent first and second molars.
- Amalgam Restorations (metal fillings).
- Crowns - one (1) per tooth per lifetime for Covered Persons under age fifteen (15).

- Periodontal Services:
  - Periodontal maintenance following active periodontal therapy - two (2) per twelve (12) months in addition to routine prophylaxis.
  - Surgical periodontal procedures - one (1) per thirty-six (36) months per area of the mouth.
- Replacement of restorative services only when they are not, and cannot be made, serviceable:
  - Basic restorations - not within twenty-four (24) months of previous placement.
  - Single crowns - not within five (5) years of previous placement.
  - Buildups and post and cores - not within five (5) years of previous placement.
  - Denture relining, rebasing or adjustments are considered part of the denture charges if provided within six (6) months of insertion by the same Dentist. Subsequent denture relining or rebasing limited to one (1) every three (3) years thereafter.
  - Pulpal therapy - one (1) per eligible tooth per lifetime. Eligible teeth limited to those with no secondary permanent tooth to replace the primary tooth.
  - Root canal retreatment - one (1) per tooth per lifetime.
  - Recementation - one (1) per five (5) years. Recementation during the first twelve (12) months following insertion by the same Dentist is included in the prosthetic service benefit.
  - General anesthesia and IV sedation - limited to thirty (30) minutes per session when Dentally Necessary and Appropriate and related to a Covered Service.
  - Orthodontics. Covered Services which are intended to treat a severe dentofacial abnormality and are the only method capable of preventing irreversible damage to the Member's teeth or their supporting structures, and restoring the Covered Person's oral structure to health and function.

Limitations

- Orthodontic treatment limitations:
  - All pediatric orthodontic treatment is subject to Precertification and must be part of an approved written plan of care.
  - To be eligible for pediatric orthodontic treatment, a Covered Person must:
    - have been enrolled under this Agreement for twelve (12) consecutive months ("waiting period"), and must continue to be enrolled during the duration of treatment; and
    - have a fully erupted set of permanent teeth.
- An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the Dentist. The ABP does not commit the Covered Person to the less costly treatment. However, if the Covered Person and the Provider choose the more expensive treatment, the Covered Person is responsible for the additional charges beyond those allowed under this ABP.

X. PEDIATRIC VISION

Benefits are provided for Covered Persons under age nineteen (19) every twelve (12) consecutive months for the following when rendered by a Participating Vision Provider:

- one (1) comprehensive eye examination (including dilation as professionally indicated);
- one (1) pair of single vision, bifocal, trifocal or lenticular lenses (including glass, plastic or oversized lenses); and
- one (1) pair of frames from a selection designated by Highmark WV.

Y. PRESCRIPTION DRUG CLAIMS

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

Z. PREVENTIVE CARE SERVICES

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

1. **Routine Gynecological Services**
   - Pap smears (including related Office Visits) - annually or more often if recommended by a Physician.
   - Human Papilloma Virus (HPV) Testing - one every 3 years age 30 and older.
   - Mammograms according to the following schedule:
     Age 35 through 39 years of age - one baseline mammogram
     Age 40 and over - one per Benefit Period

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

2. **Well-Woman Care Services**
   Benefits are provided for female Members for items and services in accordance with a predefined schedule based on age and sex, including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling and breastfeeding support and counseling.

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

4. **Colorectal Cancer Screening for individuals age 50 and older or a person under age 50 with high risk factors (e.g. family history).**
   - Exam - one per Benefit Period.
   - Fecal Occult Test - one per Benefit Period.
   - Flexible Sigmoidoscopy - one every 5 years.
   - Colonoscopy - one every 10 years.
   - Double Contrast Barium Enema - one every 5 years.

   Note: Benefits for Colorectal Cancer Screening are also provided for symptomatic persons under age 50. Coverage for this benefit is provided under Physician and/or Outpatient Hospital/Facility Services level as set forth in Section III rather than at the Preventive Care level.

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

6. **Other preventive Services as indicated in Section III.**

AA. PRIVATE DUTY NURSING SERVICES

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

BB. REHABILITATION SERVICES

Diagnostic tests, assessment, monitoring or Treatments which are designed to remediate a patient's condition or to restore the patient to his or her optimal physical, medical, psychological, social, emotional, vocational and economic status.

- **Occupational Therapy**. The Treatment by means of constructive activities designed and adapted to promote the ability to satisfactorily accomplish the ordinary tasks of daily living and those required by a particular occupational role. In order to be considered a Covered Service, this therapy must be expected to improve the level of functioning within a reasonable period of time.
- **Physical Therapy**. The Treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities.
- **Spinal Manipulation**. The Treatment by means of manual manipulation of the spine.
- **Speech Therapy**. The treatment for the correction of a speech impairment. In order to be considered a Covered Service, this therapy must be expected to improve the level of functioning within a reasonable period of time.
- **Cardiac Rehabilitation**. The physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

Rehabilitative services includes care rendered by the following:

- A Hospital duly licensed by the state of West Virginia that meets the requirements for rehabilitation;
- Hospitals as described in the Medicare Provider Reimbursement Manual, Part 1;
- A distinct part rehabilitation unit in a Hospital duly licensed by the state of West Virginia; or
- A Hospital duly licensed by the state of West Virginia that meets the requirements for cardiac rehabilitation; or
- Similar facilities located outside of the state.

Rehabilitation Services do not include Services for mental health, chemical dependency, Vocational Rehabilitation, long-term maintenance or custodial Services.

Your Physician must certify that there is reasonable likelihood that Rehabilitation Services will correct or restore you to your optimal physical, medical, psychological, social, emotional, vocational and economic status.

CC. SKILLED NURSING FACILITY SERVICES

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

No benefits are payable:

- Once a patient can no longer significantly improve from Treatment for the current condition as determined by us.
- For Custodial Care.
- Solely for the treatment of Mental Illness, Drug Abuse, Alcoholism, or pulmonary tuberculosis.

DD. SPECIAL SERVICES

1. **Pre-Admission Testing**. Outpatient tests and studies required for your scheduled Hospital admission as an Inpatient, which would have been covered as an Inpatient.

2. **Mastectomy Benefits.**
   - Reconstruction of breast on which the mastectomy was performed;
   - Reconstructive surgery of the other breast to present symmetrical appearance;
   - Prostheses and coverage for physical complications at all stages of the mastectomy procedure, including lymphedemas in a manner determined in consultation with the attending physician and the patient.
   - Minimum stay of 24 hours of Inpatient care following a total mastectomy or partial with lymph node dissection for treatment of breast cancer.
   - Minimum stay of 48 hours of Inpatient care for a radical or modified mastectomy.

3. **Diabetic Services. Services provided or performed for the Treatment of both insulin dependent and non-insulin dependent diabetes includes:**
   - Blood glucose monitors and monitor supplies; (paid under your durable medical equipment (DME) benefits)
   - Insulin infusion devices; (paid under your DME benefits)
   - Insulin, syringes (paid under your Prescription Drug benefits), and insulin injection aids or devices;
   - Pharmacological agents for controlling blood sugar (paid under your Prescription Drug benefits);
   - Urine ketone testing strips;
   - Urine micro albumin test;
   - Blood pressure monitoring device;
   - Podiatric appliances and therapeutic footwear;
   - Foot Orthotics; and
   - Orthopedic appliances including canes, crutches and walkers, and other items as may be medically necessary.

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

   Diabetes self-management education to ensure the proper self-management and Treatment, including diet education, is a Covered Service. However, this education is limited to:

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

Education services may be provided by:

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

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

4. Dental Anesthesia Services

General anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care is covered if the Member is:

- Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the enrollee or insured and for whom a superior result can be expected from dental care provided under general anesthesia; or
- A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

Prior authorization is required for general anesthesia and associated outpatient hospital or ambulatory facility charges for dental care and must be provided by:

- A fully accredited specialist in pediatric dentistry;
- A fully accredited specialist in oral and maxillofacial surgery; and
- A dentist to whom hospital privileges have been granted.

This section applies only to general anesthesia, not the dental care for which the general anesthesia is provided nor does it apply to dental care rendered for temporal mandibular joint disorders.

EE. SPECIALIST VIRTUAL VISITS

Benefits are provided for a Specialist Virtual Visit subsequent to the Member's initial Visit with his or her treating specialist for the same condition. The Specialist Virtual Visit is to provide specialist follow-up services to Members who do not have readily available access to such specialty services. Covered Services do not include services related to mental illness.

There may be an additional charge, dependent where this Covered Services is performed (Originating Site)

FF. SURGICAL SERVICES

1. Surgery. This must be done by a Physician or Professional Other Provider performing within the scope of their license. Benefits include Medical Care Visits before and after Surgery.

2. **Special Surgery**
   - Sterilization.
   - Removal of impacted teeth. Partial and Full-bony impacted teeth are covered under your medical benefits; all soft tissue impactions would be covered under your Dental benefits, if applicable.
   - Mandibular staple implant, due to trauma and/or accidental injury.
   - Maxillary or mandibular frenectomy.
   - Kidney transplants

3. **Multiple Surgical Procedures.** When more than one surgical procedure is performed through the same body opening during one operation, you are covered for the most complex procedure. When more than one surgical procedure is performed through more than one body opening during one operation, you are covered for the most complex procedure and for one-half of the benefit for additional procedures.

4. **Assistant at Surgery.** A Physician's help to your surgeon in performing covered Surgery when no qualified house staff member, intern, or resident exists.

5. **Anesthesia.** Administration of anesthesia, done in connection with a Covered Service, by a Physician or certified registered nurse anesthetist who is not the surgeon or the assistant at Surgery. This benefit includes care before and after the administration. The Services of a standby anesthesiologist are covered during coronary angioplasty Surgery.

6. **Second Surgical Opinion.** A second Physician's opinion and related Diagnostic Services to help determine the need for elective covered Surgery Services recommended by your first Physician is a Covered Service. The second opinion must be provided by someone other than the first Physician who recommended the Surgery. This benefit is not payable while you are an Inpatient of a Hospital. We cover a third opinion if the first two opinions conflict. The Surgery is a Covered Service even if the Physicians' opinions conflict.

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

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

HH. THERAPY SERVICES

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

1. **Radiation Therapy.** The Treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

2. **Chemotherapy.** The Treatment of malignant disease by chemical or biological antineoplastic agents.

3.

4. **Dialysis Treatments.** The Treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis Treatment includes home dialysis.

5. **Respiratory Therapy.** Introduction of dry or moist gasses into the lungs for Treatment purposes.

6. **Hyperbaric and Pulmonary Therapy.** The administration of oxygen in a pressurized chamber. Under pressurization, oxygen levels are increased.

II. WELL CHILD CARE AND IMMUNIZATION SERVICES

1. **Well Baby Care Services.**
   Routine Office Visits, lab tests and immunizations for ages one month to six years are Covered Services. Allowable Office Visits, lab tests and immunizations will follow the schedule recommended by the American Academy of Pediatrics (AAP). You may access this information at www.aap.org or contact Member Services.

2. **Well Child Care Service.**
   Routine immunizations and related Office Visits for children ages six years through seventeen years are Covered Services. Allowable Office Visits and immunizations will follow the schedule recommended by the AAP. You may access this information at www.aap.org or contact Member Services.

VI. Exclusions / What Is Not Covered

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

1. Not prescribed by or performed by or under the direction of a Physician or Professional Other Provider.
2. Not performed within the scope of the Provider's license.
3. Received from other than a Provider.
4. Experimental or Investigational.
5. Not Medically Necessary. (See Sections V for information on your liability for not Medically Necessary Services.)
6. Services outside generally accepted medical standards and practices.
7. To the extent governmental units or their agencies provide benefits, unless the injury, ailment, condition, disease, disorder, or illness is related to military service, except that benefits are provided for Covered Services received from a Veterans Administration Hospital.
8. Injuries, conditions, diseases, disorder, or illnesses that occur as a result of any act of war.
9. Where you have no legal obligation to pay in the absence of this or like coverage.
10. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
11. Received from a member of your Immediate Family.
12. Incurred before your Effective Date.
13. Incurred after you stop being a Covered Person, except as specified in Section VIII.
14. The following physical examinations or Services:
    - Solely required by an insurance company to obtain insurance.
    - Solely required by a governmental agency such as the FAA, DOT, etc.
    - Solely required by an employer in order to begin or to continue working.
    - Premarital examinations.
    - Screening examinations, except as specified.
    - Medical imaging examinations made without documented image.
    - Routine or annual physical examinations, except as specified.
15. For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
16. Received in a military facility for a military service related injury, ailment, condition, disease, disorder, or illness for which Governmental benefits are available.
17. Surgery and other Services or devices primarily to improve appearance and any complications incident to such services. Exceptions include: (a) only those that restore a body function or which were caused by disease, trauma, birth defects, growth defects, prior therapeutic processes; or (b) reconstructive Surgery following Covered Services for a mastectomy, including reconstruction of the other breast for the purpose of restoring symmetry; or (c) reconstructive or cosmetic Surgery necessary as a result of an act of family violence. There are no benefits for wigs and hair prostheses.

18. Inpatient admissions primarily for Diagnostic Services, physical therapy or occupational therapy, when these Services could have been performed on an Outpatient basis and it was not Medically Necessary that you be an Inpatient to receive them.

19. Custodial Care

20. Primarily for educational, vocational or training purposes, including speech therapy for language and/or developmental delay, stuttering and articulation errors, except as specified.

21. Conditions related to autistic disease of childhood, learning disabilities or mental retardation which extends beyond traditional medical management or for inpatient confinement for environmental change, except as specified.

22. Topical anesthetics or stand-by anesthesia, except as specified.

23. Arch supports, molded removable foot orthotics, and other foot care or foot support devices only to improve comfort or appearance such as care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses, ingrown toenails and similar foot conditions, including Visits Incurred specifically to prepare or fit for such devices.

24. The Treatment of obesity, including dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss. The only exception to this exclusion would be if Surgery is determined to be Medically Necessary.

25. Marital counseling or any Service for marital maladjustments. Specific non-covered therapies are: marital therapy or sexual therapy, or any therapy which is not specifically listed as a Covered Service.

26. Massage therapy, pet therapy, dance therapy, art therapy, nature therapy or any therapy which is not specifically listed as a Covered Service.

27. The Treatment of sexual problems not caused by organic disease or physical trauma.

28. Transsexual Surgery or any Treatment leading to or in connection with transsexual Surgery.

29. Reversal of sterilization.

30. In-vitro fertilization, gamete intra-fallopian transfer and other ova transfer procedures.

31. The Treatment of cysts or abscesses associated with the teeth, dental X-rays, dentistry or any other dental processes, except as specified.

32. Appliances designed for orthodontic purposes such as braces, bionators, functional regulators, Frankel, and similar devices.

33. Personal hygiene and convenience items. Examples include diapers, cervical pillows, lift chairs, Jacuzzi's, exercise equipment and special linens, pillows, and air filters for allergy conditions.

34. Unless otherwise stated, eyeglasses, contact lenses, or examinations for prescribing or the fitting of them, excluding those for aphakic patients and soft lenses or sclera sheets for use as corneal bandages.

35. Hearing aids

36. Hypnosis, acupuncture and massage therapy

37. Telephone consultations, missed appointments, or completion of a claim form.

38. Human organ transplant services, other than as listed in this Policy.

39. Rehabilitation Services for Vocational Rehabilitation, long-term maintenance, or Custodial Care.

40. Routine immunizations, except as specified.

41. Illness or injury arising in the course of employment or care received without cost under the laws of the federal or any state government or any political subdivision thereof, including any Workers' Compensation program or any employer self-funded Workers' Compensation plan .

42. Prescription Drugs, except as specified. Prescription Drugs purchased from a Pharmacy on an Outpatient basis are payable under Prescription Drug Benefits.

43. Unless otherwise stated, the Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or by any other method to alter vertical dimension; for the Treatment of temporomandibular joint dysfunction not caused by documented organic disease or physical trauma.

44. Routine immunizations, except as specified.

45. Any Service or Supply that can be purchased without a Prescription Order, Examples include nutritional supplements, Ensure, Pediasure or baby formula, batteries, earplugs and any over the counter item.

46. Any Service for or related to surrogate motherhood unless the Services are otherwise eligible and provided to the Covered Person under the terms of the Group Health Plan.

47. Residential Treatment Facilities.

48. Partial birth abortion.

49. Cloning or any Services related to cloning.

50. Cleft Palate Orthodontic Treatment.

51. Defective Services or Supplies.

52. Services or Supplies in excess of any maximum limits or benefits.

53. Services excluded elsewhere in this Certificate.

VII. Coordination of Benefits, Right of Recovery, Right of Reimbursement/Subrogation and Work Related Injuries or Illnesses

A. DOUBLE COVERAGE

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "Coordination of Benefits (COB)" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

COB is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, contact your member services or your state insurance department.

B. PRIMARY OR SECONDARY?

You will be asked to complete questionnaires from time to time to identify all the plans that cover members of your family. We need this information to determine whether Highmark WV is the "primary" or "secondary" benefit payer. To avoid possible claim denials you need to complete and return the questionnaires promptly. Also, please notify us timely with any changes to the other health care coverage.

C. ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

   Except: 1) a plan that does not contain a coordination of benefits that is consistent with this rule is always primary unless the provisions of both plans state that the complying plan is primary; or 2) coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverage that are written in connection with a closed panel plan to provide out-of-network benefits.

2. A plan may consider the benefits paid or provided by another plan in calculation payment of its benefits only when it is secondary to that other plan.

3. Each plan determines its order of benefits using the first of the following rules that apply:

   a. Non-Dependent/Dependent. The plan which covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

(i) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
- plan of the parent whose birthday falls earlier in a calendar year is the primary plan; or
- If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(ii) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
- If there is no court decree allocating responsibility for the dependent child's health care coverage, the order of benefits for the child are as follows:
  - The plan of the parent with custody of the child;
  - The plan of the spouse of the parent with the custody of the child;
  - The plan of the parent not having custody of the child; and
  - The plan of the spouse of the parent not having custody of the child;

(iii) If the specific terms of a court decree state that one of the parents is responsible for the health care coverage of the dependent child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

(iv) If a court decree states that both parents are responsible for the dependent child's health care coverage, the provisions of (i) above shall determine the order of benefits.

(v). If the court decree states that the parents have joint equal custody, without stating that one of the parents is responsible for the health care coverages of the dependent child, the provisions of (i) above shall determine the order of benefits.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.

4. Active Employees or Retired or Laid-Off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree this rule is ignored. This rule does not apply if the rule labeled 3(a) of this section can determine the order of benefits.

5. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plans do not have this rule, and as a result, the plans do not agree on the order of benefits this rule is ignored. This rule does not apply if the rule labeled 3(a) of this section can determine the order of benefits.

6. Longer or Shorter Length of Coverage. The plan that covered a person as an employee, member, subscriber or retiree longer is the primary plan and the plan that covered that person for the shorter period of time is the secondary plan.

7. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

D. HOW WE PAY CLAIMS WHEN WE ARE PRIMARY

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.

E. HOW WE PAY CLAIMS WHEN WE ARE SECONDARY

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense covered by one of the plans, including copayments, coinsurance and deductibles.

- If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) usually have contacts with their providers.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.
- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

F. FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan.

G. RIGHT OF RECOVERY

If the amount of the payments made by Highmark WV is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

H. RIGHT OF REIMBURSEMENT AND SUBROGATION

To the extent we pay any medical or other expenses, we shall have the right to be reimbursed in full for those expenses from any recovery that you may have obtained from the responsible party. This is known as our Right of Reimbursement.

If you or your eligible dependents fail or refuse to make or pursue a claim against any responsible party, then we shall have the right to make and/or pursue such claim against the responsible party. This right exists to the extent that we have paid any medical or other expenses for you or any eligible dependents under this Policy. This is known as our Right of Subrogation.

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

Assert a claim on behalf of the you or your eligible dependents against any responsible party (including bringing suit in the you or your eligible dependents name); or

Intervene in any lawsuit or claim that you or your eligible dependents has filed or made against any responsible party.

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

Our Right of Reimbursement shall constitute a lien against the proceeds of any:
Settlement or compromise between you or your eligible dependents and any responsible party; or
Judgment or award obtained by you or your eligible dependents against a responsible party; or
Third party reimbursement or proceeds

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

A Covered Person agrees not to do anything to prejudice our rights and agrees to cooperate fully with us. The Covered Person must notify our Third Party Recoveries Department, in writing, of the existence of any Responsible Party. If a Covered Person retains legal counsel to recover from any Responsible Party, the Covered Person must immediately notify legal counsel of our Right of Reimbursement. In addition, the Covered Person must immediately notify our Third Party Recoveries Department, in writing, that legal counsel has been retained. The Covered Person must also provide us with prompt notice of any Subrogated Recovery.

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

Filing of a lawsuit;

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

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

- Cancellation of benefits; and / or
- Denial of the Claim upon which our Right of Reimbursement is based.

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

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

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

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

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

You may contact Highmark WV's Third Party Recoveries Department.

E. WORK RELATED INJURY AND ILLNESS

This Group Health Plan does not provide benefits for a work-related injury or illness when covered under a Workers' Compensation Program. **It is your <u>responsibility</u> to inform the Provider of the work-related nature of the injury or illness and where appropriate, to seek benefits under any applicable Workers' Compensation Program.** If the Provider was not properly informed, or if Highmark WV paid Claims more appropriately paid by Workers' Compensation, you must notify Highmark WV's Third Party Recoveries Department by contacting Member Services.

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

If you enter into a settlement giving up your right to recover future medical benefits under a workers' compensation benefit, medical benefits that would have been compensable except for the settlement will not be Covered Services.

VIII. General Provisions

A. WHAT IS A CLAIM AND HOW TO APPLY FOR BENEFITS

1. Claim. A Claim is a request made by or on behalf of a Member for Precertification or prior approval of a Service, as required under this Policy, or for the payment or reimbursement associated with a Service that has been received by a Member. Claims for benefits provided under this Policy include the following types:

- **Pre-Service Claim.** A Pre-Service Claim is a Claim for Services that has not yet been rendered and for which you are required to contact us in advance.
- **Urgent Care Claim**. An Urgent Care Claim is any Claim for Medical Care or Treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or Treatment that is the subject of the Claim.
- **Concurrent Care Claim.** A Concurrent Care Claim is a Claim required for an ongoing course of Treatment that requires approval from us after a specified period of time or number of Treatments.
- **Post-Service Claim.** A Post-Service Claim is a Claim for Services that already have been rendered

Designation of a Claim or an appeal of a denied Claim as a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim will be determined at the time the Claim or appeal is filed with Highmark WV in accordance with its procedures for filing Claims and appeals.

There may be some instances when Covered Services may only be performed by a Non-Network Provider. You have the right to appeal these services to be paid with the higher level of benefits available for Network Providers. If approved, additional payment will be based upon the Plan Allowance. You will still be responsible for any Non-Network Liability. Please include the following information with your appeal:

1. An explanation of why the Covered Services could not have been provided by a Network Provider;
2. Copies of your medical records, including diagnostic reports.

Refer to the internal appeal process as indicated below for additional information.

This Policy will not cover Claims when premiums are not timely paid. Claims filed in the event of fraud or non-payment of premiums are not considered Claims since there are no benefits payable under this Policy in such circumstances.

2. Filing Claims. A Claim must be filed for you to receive benefits. Many Providers will submit a Claim for you. A Claim must contain certain minimum information in order to qualify. If certain minimum information is not included, it will be returned to the person who submitted it.

3. Notice of Claim and Proof of Loss (Applies to Post-service Claims Only)

a. Network Providers. Network Providers have entered into an agreement with Highmark WV for the provision of Covered Services rendered to a Member. When a Member receives Services from a Network Provider, it is the responsibility of the Network Provider to submit its Claim to Highmark WV in accordance with the terms of its agreement with Highmark WV. Should the Network Provider fail to submit its Claim in a timely manner or otherwise satisfy Highmark WV's requirements as they relate to the filing of Claims, the Member will not be liable and the Network Provider shall hold the Member harmless relative to payment of Covered Services received by the Member.

b. Non-Network Providers. Non-Network Providers are not obligated to bill Highmark WV directly. As a result, it will be your responsibility to submit to us the completed claim form. If the Provider does not have the forms, we will send you one. In such instances, the Member must submit the Claim in accordance with the following procedures:

i. Notice of Claim

Highmark WV will not be liable for any Claims unless proper notice is furnished to Highmark WV that Covered Services have been rendered to a Member. Notice given by or on behalf of the Member to Highmark WV that includes information sufficient to identify the Member that received the Covered Services shall constitute sufficient notice of a Claim to Highmark WV. A Charge shall be considered Incurred on the date a Member receives the Service or Supply for which the Charge is made.

ii. Claim Forms

Proof of loss for benefits under the Policy must be submitted to Highmark WV on the appropriate claim form. Highmark WV, upon receipt of a request for a claim form will, within fifteen (15) days following the date a notice of a Claim is received, furnish to the Member claim forms for filing proofs of loss.

iii. Proof of Loss and Timely Filing

Claims cannot be paid until a written proof of loss is submitted to Highmark WV. Proof of loss must contain all required information for Highmark WV to determine benefits and be given to us within one year of your receiving Covered Services or the date another payor, primary to Highmark WV, processes the Claim (pays or denies). We may require medical records or other supporting documents before a proof of loss is considered sufficient to determine benefits.

iv. Submission of Claim Forms

The completed claim form must be forwarded to Highmark WV at the address appearing on the Member's Identification Card in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under the Policy. To avoid delay in handling Member-submitted Claims, answers to all questions on the claim form must be complete and correct.

Highmark WV reserves the right to require additional information and documents as needed to support a Claim that a Covered Service has been rendered.

4. Explanation of Benefits (EOB's) You will receive an paper EOB for Claims for which you owe additional money, other than a copayment, and for Claims you file yourself. In most cases, the EOB or other notice will be issued directly to the Policy Holder . Policy Holders may view EOB's at: www.mybenefitshome.com. You may also request a copy of a particular EOB or you may request to continue to receive paper EOBs through Member Services.

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

B. PRE-SERVICE CLAIM CONDITIONS

1. Authorizations

An "Authorization" is a determination by Highmark WV that Services a Provider proposed for or provided to a Member is Medically Necessary. Authorization may also be called "Precertification," "Pre-authorization," "Prior Authorization," "Prospective Review," "Pre-Service Review," "Prior Approval" or other similar terms. If a Service requires Authorization, then the Provider or Member must contact Highmark WV to request the Medical Necessity review.

An Authorization is a determination of Medical Necessity only and doesn't guarantee coverage or payment.

2. Responsibility For Requesting Authorizations

Most Providers will call our medical management staff on your behalf to obtain an Authorization. Non-Network Providers however, are not required to contact us. In order to maximize your benefits, please follow up with your Provider to ensure the Precertification process (Prior Authorization) has been completed.

Generally, A Network Provider will bear the financial cost if Services are delivered and subsequently deemed not Medically Necessary. In these situations, the Network Provider cannot bill the Member.

3. Exception for Emergencies and Child Birth Admissions:

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

If you fail to contact us as required, you may be required to pay a Precertification Review Penalty.

4. Services Requiring Authorization

Highmark WV requires Prior Authorization for all Inpatient admissions and selected Outpatient Services, drugs and equipment.

The following Services are representative of those that require Prior Authorization **(this is not an all-inclusive list).** A current listing is published at www.highmarkbcbswv.com. (Click on the Provider tab then select "Working with Highmark West Virginia.").

- Behavioral health Intensive Outpatient and Partial Hospitalization.
- Certain non-emergency Outpatient imaging Services.
- Clinical trials.
- Durable medical equipment listed on the Highmark WV website and any non-standard issue (i.e. deluxe) DME.
- Home Health Care.
- Hospice.
- Hospital admissions for childbirth if the Inpatient stay extends beyond 48 hours after a vaginal delivery or 96 hours after a cesarean section delivery.
- Injectable drugs listed on the Highmark WV website.
- Inpatient admissions (e.g. Skilled Nursing Facility, rehabilitation, behavioral health, long term acute).
- Outpatient procedures listed on the Highmark WV website.
- Outpatient therapies (physical, occupational, speech, chiropractic) after a specified number of Visits or Treatments.
- Potentially Experimental, Investigational or cosmetic Services.

- Pulmonary rehabilitation.
- Transplant Services.

5. Precertification Penalty

The Covered Person is subject to a financial penalty (typically $500) if he or she fails to obtain Precertification (Authorization) for an Inpatient Hospital admission. This penalty is the Covered Person's responsibility. The Network Provider may bill the Covered Person (unless the entire admission is deemed not Medically Necessary).

C. CLAIMS PROCESS FOR INITIAL CLAIMS FOR BENEFITS

1. Pre-Service Claims

If your Pre-Service Claim is improperly filed, you and / or your Provider will be notified within five days of receipt of your Claim. If your Pre-Service Claim is properly filed, we will notify you and / or your Provider of our decision within a reasonable time appropriate to the medical circumstances, but no later than 15 days from the receipt of the Claim. We may extend this period for another 15 days if we determine it to be necessary because of matters beyond our control. In the event that this extension is necessary, you and / or your Provider will be notified prior to the expiration of the initial 15-day period as to the reasons for the extension. If additional information is needed to perfect or process the Claim, we will provide you and / or your Provider with at least 45 days from receipt of the notice to provide the specified information. If we are not provided the additional requested information within the designated time, we will complete our review based on the information we have been provided. Once we have made a decision on Services requiring prior contact, you and / or your Provider will receive notification of the decision.

2. Urgent Care Claims

For Urgent Care Claims, we will notify you and / or your Provider of our decision as soon as possible but not later than 72 hours after the receipt of the Claim by us. If we have not been provided with sufficient information to determine if the benefits are covered or payable, we will notify you and / or your Provider as soon as possible, but not later than 24 hours after receipt of the Claim of the specific information necessary to complete the Claim. You and / or your Provider shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours to provide the specified information.

3. Concurrent Care Claims

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

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

4. Post-Service Claims

Post-Service Claims filed as described in this Section VIII will be processed within a reasonable time, but no later than 30 days of receipt of the Claim. We may extend the initial period for 15 days if we determine it to be necessary because of matters beyond our control. In the event that we utilize this extension, you and / or your Provider will be notified prior to the expiration of the initial 30-day period as to the reasons for the extension. If additional information is needed to perfect or process the Claim, we will provide you and / or your Provider with at least 45 days from

receipt of the notice to provide the specified information. If we are not provided the additional requested information within the designated time, we will complete our review based on the information we have been provided.

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

D. NOTICE OF ADVERSE CLAIM/APPEAL DECISIONS

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

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

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

E. APPEAL PROCEDURES FOR ADVERSE BENEFIT DETERMINATIONS

1. Internal Appeal Process

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

a. At any time during the appeal process, a Member may choose to designate an authorized representative to participate in the appeal process on his/her behalf. The Member or the Member's authorized representative shall notify Highmark WV, in writing, of the designation. For purposes of the appeal process, Member includes designees, legal representatives and, in the case of a minor, parents of a Member entitled or authorized to act on the Member's behalf. Highmark WV reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member. Such procedures as adopted by Highmark WV shall, in the case of an Urgent Care Claim, permit a Professional Provider or Professional Other Provider with knowledge of the Member's medical condition to act as the Member's authorized representative.

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

c. If a Member has received notification that a Claim has been denied by Highmark WV, in whole or in part, the Member may appeal the decision. For purposes of this Subsection, determinations made by Highmark WV to rescind a Member's coverage or to deny the enrollment request of an individual that Highmark WV has determined is ineligible for coverage under this Policy, can also be appealed in accordance with the procedures set forth

in this Subsection. The Member's appeal must be submitted within one hundred eighty (180) days from the date of the Member's receipt of notification of the adverse decision.

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

e. The appeal will be reviewed by a representative from Highmark WV. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the Claim or matter which is the subject of the Member's appeal. In rendering a decision on the appeal, Highmark WV will take into account all evidence, comments, testimony, documents, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by Highmark WV. Highmark WV will perform a new review and we will not assume the correctness of the original determination. For appeals of Adverse Benefit Determinations which were based on medical judgment, including Medical Necessity or Experimental Treatment, we will consult with a Physician or other health professional that holds an unrestricted license and has appropriate training and experience in the field of medicine involved in the medical judgment, medical condition, procedures, or Treatment under review.

f. If additional information is needed to perfect or process the Claim, we will request the specific information from you and / or your Provider. If we are not provided the additional requested information we will complete our review based on the information we have on our files. Each appeal will be promptly investigated and Highmark WV will provide written notification of its decision within the following time frames:

   i. When the appeal involves a non-urgent care Pre-Service Claim, within a reasonable period of time appropriate to the medical circumstances involved not to exceed thirty (30) days following receipt of the appeal;

   ii. When the appeal involves an Urgent Care Claim, as soon as possible taking into account the medical exigencies involved but not later than seventy-two (72) hours following receipt of the appeal; or

   iii. When the appeal involves a Post-Service Claim or a decision by Highmark WV to rescind coverage or deny an enrollment request because the individual is not eligible for coverage, within a reasonable period of time not to exceed sixty (60) days following receipt of the appeal.

g. If Highmark WV fails to provide notice of its decision within the above-stated time frames or otherwise fails to strictly adhere to these appeal procedures, the Member shall be permitted to request an external review.

h. In the event that Highmark WV renders an adverse decision on the appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding the right of the Member to request an external review.

i. There is a process for an expedited review, which is reserved for Urgent Care Claims. In such cases, you or your authorized representative (your family, your Provider or other designee) can request an expedited review by calling Highmark WV. We will arrange to have the Adverse Benefit Determination reviewed by a clinical peer reviewer as soon as possible, but no later than 72 hours after we receive your request for review.

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

2. External Review Process

a. Where the Claim that has been denied or the matter involved in the internal appeal process relates to determinations made by Highmark WV to rescind a Member's coverage, the external review process will be as follows.

A Member will have four (4) months from the receipt of the notice of Highmark WV's decision to request an external review of the decision. The request shall be in writing unless the Member is required to file the request in an alternative format.

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

All records from the initial review shall be forwarded to an external Independent Review Organization (IRO). The external review will be conducted by an IRO selected by Highmark WV or as otherwise required by law. We will notify the Member or the Provider of the name, address and telephone number of the IRO assigned within two (2) business days following receipt of the request for assignment. Additional material related to the issue which is the subject of the external review may be submitted by the Member, the Provider or Highmark WV. Each shall provide to the other, copies of additional documents provided.

b. Where the Claim that has been denied in the internal appeal process is based on Highmark WV's requirements as to Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the Service, a Member or a Provider, with the written consent of the Member, may within four (4) months from the receipt of the notification of the decision, appeal the denial resulting from the Internal Appeal Process. This can be done by filing a request for an external review with Highmark WV. The Member should include any material justification and all reasonably necessary supporting information as part of the external review filing.

For medical judgment including Medical Necessity or Experimental Treatment:
Member Grievance & Appeals (RU65)
Attn: Review Committee
P.O. Box 1988
Parkersburg, WV 26102-1988

For other types of appeals:
Member Grievance & Appeals (RU65)
Attn: Review Committee
P.O. Box 1988
Parkersburg, WV 26102-1988

Within five (5) business days of the filing of the request for an external review, Highmark WV will notify, the Member or the Provider, as appropriate, that an external review request has been filed. Highmark WV shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision to the IRO conducting the external review within fifteen (15) days of the receipt of notice that the external review request was filed. Within this same period, the Highmark WV shall provide the Member or the Provider with a list of documents forwarded to the IRO for the external review. The Member or the Provider may supply additional written information, with copies to Highmark WV, to the IRO for consideration on the external review within fifteen (15) days of receipt of notice that the external review request was filed.

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

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

Within sixty (60) days of the filing of the external review, the IRO conducting the external review shall issue a written notification of the decision to Highmark WV, the Member or the health care Provider, including the basis and clinical rationale for the decision.

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

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

3. Member Assistance Services

Members may obtain assistance with Highmark WV's internal appeal and external review procedures set forth in this Subsection by contacting the Employee Benefit Security Administration (EBSA) at 1-866-444-EBSA (3272) or such other applicable office of health insurance consumer assistance or ombudsman.

4. Prescription Drug Claim Appeals

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

F. INFORMAL DISSATISFACTION RESOLUTION

In the event that you are dissatisfied with other aspects of your program, please contact Member Services at the toll-free number located on the back of your ID Card. The appropriate representative will review, research, and respond to your inquiry as quickly as possible.

G. DESIGNATING AN AUTHORIZED REPRESENTATIVE

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

H. TREATMENT PLANS

Certain Covered Services provide benefits only when you receive care as part of a Treatment Plan approved by us. In order to maximize your benefits, your Provider must submit a Treatment Plan to us as specified in Section V. When we approve this, we will give your Provider authorization for additional Treatments or Services. The Services or number of additional Treatments authorized will depend upon the Treatment Plan. We may need to request updated Treatment Plans as your Treatment progresses. If a

Treatment Plan is not submitted or approved, Services will be denied as not Medically Necessary. If you change Providers, a new Treatment Plan must be submitted. We will be flexible in allowing additional Visits while your Treatment Plan is being prepared or under review. A Treatment Plan typically involves a written course of Services and information to evaluate Medical Necessity of proposed Treatment(s). A Treatment Plan is required for Hospice Care Services.

I. OUR RIGHT TO REVIEW CLAIMS

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

J. PROVIDER SERVICES

1. Non-Assignability

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

2. Choice of Provider

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

3. Provider Status (Network or Non-Network)

Providers are designated as Network or Non-Network. The amount of benefits that you will receive for Covered Services may vary depending on whether the Provider is in the Network. You will receive greater benefits by seeking Covered Services from a Network Provider.

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

We have agreed to make payment directly to Network Providers for Covered Services. Therefore, you should not be required to pay for Covered Services at the time they are rendered by Network Providers other than any Deductibles, Coinsurances or Fees. Network Providers have the right to request proof that any required Deductible or other Covered Person cost sharing has been met before filing your Claim with Highmark WV. See Section III for how to verify a Provider's status.

4. Nondiscrimination - Providers

Highmark WV will not discriminate with respect to participation in coverage against any health care provider acting within the scope of his or her license or certification under state law.

K. HOW CLAIMS ARE PAID

You are responsible for payment of any Deductibles, Fees, Coinsurances and Non-Network Liabilities required under the Policy for Covered Services received from a Provider. See Section III for specific additional details.

1. Provider Payment and Covered Person Cost-Sharing

This coverage shares the cost of your medical expenses with you. Each Benefit Period before we start to pay, you must pay a certain dollar amount of Covered Services at a Network or Non-Network Provider, as specified in Section III. This front-end payment is your Deductible. Our

records must show that you have met this Deductible. Submit copies of all your bills, even those that you must pay to meet the Deductible.

After the amount of Covered Services exceeds your Deductible, we pay a portion of the remaining balance of Covered Services during that Benefit Period. The portion that you pay is called the Coinsurance. When you receive Covered Services from a Non-Network Provider, the amount that you pay is called the Non-Network Coinsurance. There are limits to the amount of Network and Non-Network Coinsurances for which you are responsible. The Deductible, Network and Non-Network Coinsurance amounts will renew each Benefit Period. Some of the benefits of this Policy have a maximum amount payable each Benefit Period. In addition to any Deductibles and Coinsurances, you may also be responsible for a Non-Network Liability. The Non-Network Liability is not applied towards any Network or Non-Network Coinsurance limits.

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

2. Non-Network Liability

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

3. Plan Allowance. The amount used to determine reimbursement by Highmark WV for Covered Services provided on behalf of a Covered Person based on the type of Provider who renders such Services or as required by law. The Plan Allowance is used to calculate Highmark WV's payment and to determine Member Liability. You will receive greater benefits when Services are received from a Network Provider. The Plan Allowance for Non-Network Providers will be different than the Plan Allowance for Network Providers as follows:

In the case of a Network Provider, Participating Dentist or Participating Vision Provider, the Plan Allowance is the contractual allowance for Covered Services rendered by a Network Provider in a specific geographic region. A Network Provider, Participating Dentist or Participating Vision Provider will accept the Plan Allowance, plus any Member liability, as payment-in-full for Covered Services.

The Plan Allowance for Non-Network Providers is different than the Plan Allowance for Network Providers as follows:

<u>Non-Network Providers Located in the Service Area</u>

In the case of a Non-Network Provider in the Service Area, the Plan Allowance shall be based on an adjusted contractual allowance for like Services rendered by a Network Provider in the same geographic region. The Covered Person will be responsible for any difference between the Provider's Actual Charges in excess of Highmark WV's Plan Allowance for the Non-Network Provider's Services, as well as any applicable Deductible, Coinsurance or Fees.

<u>Out-of-Area Providers</u>

In the case of an Out-Of-Area Provider, whether or not such Out-of-Area Provider has an agreement with the local licensee of the Blue Cross Blue Shield Association, the Plan Allowance shall be determined, for other than pediatric dental and vision care Covered

Services, based on prices received from local licensee pursuant to Highmark WV's participation in the BlueCard® Program, as set forth in this section.

The Plan Allowance is determined by Highmark WV in its sole discretion and in most circumstances unrelated to Actual Charges. Any waiver of a Covered Person's cost sharing obligations or Non-Network Liability by a Provider will be deemed an equivalent reduction of the Plan Allowance. The Plan Allowance may exceed Actual Charges in some circumstances.

4. Out-of-Area Services

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

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

a. BlueCard® Program

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

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

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

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

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

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

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

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

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

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

L. HOW TO REPORT FRAUD

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

- Don't give your Policy identification number over the telephone or to people you do not know, except for your health care Provider or us.
- Let only the appropriate medical professionals review your medical record or recommend Services.
- Avoid using Providers who say that an item or Service is not usually covered, but they know how to bill us to get it paid.
- Carefully review EOBs that you receive from us.
- Do not ask your Provider to make false entries on certificates, bills, or records in order to get us to pay for an item or Service.
- If you suspect that a Provider has charged you for Services that you did not receive, billed you twice for the same Service, or misrepresented any information, do the following:
  - ❖ Call the Provider and ask for an explanation. There may be an error.
  - ❖ If the Provider does not resolve the matter, call us at 800-788-5661 and explain the situation. All reports to this number are confidential and you can remain anonymous.

- Do not maintain as a family member on your policy:
  - ❖ Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - ❖ Your child over the age specified in Section III (unless he / she is disabled and incapable of self support).

If you have questions about the eligibility of a dependent, call Member Services.

You can be prosecuted for fraud if you falsify a Claim to obtain benefits or try to obtain Services for someone who is not eligible or is not longer enrolled in the Policy.

M. LIMITATION OF ACTIONS AND VENUE

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

N. NON-WAIVER PROVISION

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

O. SEVERABILITY

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

P. GOVERNING LAW

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

IX. Definitions

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

Adverse Benefit Determination. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's, or Eligible Dependent's, eligibility to participate in a group health plan a determination that a benefit is not a covered benefit; source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or a determination that a benefit is experimental, investigational, or not medically necessary or appropriate. An Adverse Benefit Determination also includes any rescission of coverage, whether or not there is an adverse effect on any particular benefit at the time.

Affordable Care Act (ACA). The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) and its implementing regulations.

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

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

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

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

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

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

Annual Open Enrollment Period. The period from October 15th through December 7th of each year during which an eligible individual may enroll or change coverage for the following Benefit Period under this Agreement.

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

Applied Behavior Analysis. The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder. Any pervasive developmental disorder, including autistic disorder, Asperger's Syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

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

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

Certificate. This document, including all Riders.

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

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

Charges. See Actual Charge.

Claim. A Claim is a request made by or on behalf of a Member for Precertification or prior approval of a Service as required under this Policy, or for the payment or reimbursement associated with a Service that has been received by a Member. A Claim is only a request for approval or payment. It must contain the information requirements and be in the format required by us. Approval or payment is specifically conditioned by the terms of this Policy.

Coinsurance. A percentage of the Plan Allowance for Covered Services for which you are responsible, after the Deductible has been met and benefits for Covered Services have been paid by us. See Sections III and VIII.

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

Contract . The agreement (including the Group Application, individual Applications of the Policyholder, this Policy, Summary of Benefits and any Riders) between your Group and us.

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

Covered Person. The Policyholder and, if other than individual coverage is selected, the Eligible Dependents of the Policyholder.

Covered Service. A Provider's Service or Supply, that is eligible as described in this Policy, and is Medically Necessary and within generally accepted medical standards.

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

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

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

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

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

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

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

Dependent. See Eligible Dependent

Dentally Necessary. Dental services determined by a Dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the Dentist and the prevailing standards of care in the professional community. This determination will be made by the Dentist in accordance with guidelines established by Highmark WV.

Dentist. A person who is a doctor of dental surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.), licensed where required and performing services within the scope of such licensure.

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

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

Domestic Partner. (Please check with your Group Administrator to see if the following is applicable.) A member of a domestic partnership consisting of two (2) partners, each of whom has registered with a Domestic Partner registry in effect in the municipality/governmental entity within which the Domestic Partner currently resides, or who meets the definition of a Domestic Partner as defined by the state or local government where the individual currently resides or meets all of the following:

- Is unmarried, at least eighteen (18) years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
- Is not related to the other party by adoption or blood;
- Is the sole Domestic Partner of the other partner and has been a member of this domestic partnership for the last six (6) months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and
- Meets (or agrees to meet) the requirements of any applicable federal, state or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future.

To be eligible for dependent coverage, proof that dependents meet the above criteria may be required.

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

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

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

Eligible Dependent. A Covered Person other than the Policyholder, as shown in the Eligibility Section of this Policy.

Eligible Employee. See Policy Holder.

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

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

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

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

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

Exchange (Health Insurance Marketplace). Governmental agencies or non-profit entities that will serve as marketplaces to facilitate the purchase of health insurance in the individual and small group markets, assist individuals who are eligible to receive premium tax credits and cost-sharing reductions and support enrollment in federal or state insurance programs.

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

Experimental and Investigational. A Treatment, procedure, facility, equipment, drug, Service or Supply ("intervention") that has been determined not to be medically effective for the condition being treated and therefore is considered Experimental/Investigative in nature. An intervention is considered to be Experimental/Investigative if:

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

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

Highmark WV believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with our nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered "experimental/investigative" and is not generally covered. However, it may be re-evaluated in the future.

A similar process is followed for evaluating new pharmaceuticals. The Pharmacy and Therapeutics (P & T) Committee assesses new pharmaceuticals based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark-employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two Doctors of Pharmacy currently providing clinical pharmacy services within the Highmark WV service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

Highmark WV recognizes that situations may occur when you elect to pursue experimental/investigative treatment. If you have a concern that a service you will receive may be experimental/investigational, you or the hospital and/or professional provider may contact Highmark's Member Service to determine coverage.

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

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

Fees. See Office Visit Fees and Co-Pay.

Group Contract. See Contract

Homebound. A condition due to an illness or injury which restricts ability to leave the residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, of the

assistance of another person or if the individual has a condition that leaving home is medically contraindicated (e.g. quarantined due to immunocompromised host, communicable disease).

Home Health Care Agency. A Facility Other Provider which:

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

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

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

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

Incurred (Incur). A Charge is considered Incurred on the date the Covered Person receives the Service or Supply for which the Charge is made.

Indian. An individual that meets the requirements of section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638).

Indian Health Service (IHS) Provider. The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization as defined in 25 U.S.C. §1603.

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

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

Investigational. See Experimental or Investigational.

Late Entrant. Enrollment in the Group Health Plan that is other than on the earliest date on which coverage can become effective under the terms of the Policy or a special enrollment date for the person.

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

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

Medically Necessary (or Medical Necessity). Health care Services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
(a) In accordance with generally accepted standards of medical practice;
(b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and
(c) Not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of that patient's illness, injury or disease.

Medical Screening Examination. An appropriate examination within the capability of the Hospital's emergency department, including ancillary Services routinely available to the emergency department, to determine whether an Emergency Medical Condition exists.

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

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

Member. See Covered Person.

Member Liability. The amount a Member is personally responsible for under the terms of this Policy. Such amounts include Deductibles, Fees, Coinsurance, Non-Network Liability and non-Covered Services.

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

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

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

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

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

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

Non-Network Liability. The amount of Actual Charges in excess of the Plan Allowance that you are responsible for when Covered Services are received from a Non-Network Provider. The Non-Network Liability is in addition to the Non-Network Coinsurance and any other Deductible or Fees for which you are responsible for under this Policy. It will not be applied to any limits applicable to your Deductible, Network or Non-Network Coinsurance.

Office Visit. Visit Services provided in the office of Physicians or Professional Other Providers.

Office Visit Fee. An upfront fee, for Office Visits with Physicians and Professional Other Providers.

Originating Site. A physical setting from which the Member's physician and the treating specialist communicate via interactive audio and streaming video telecommunications. This includes a Physician office, the outpatient department of a hospital or freestanding surgery facility or a Retail Clinic.

Out-of-Area Provider. A Provider located outside the Service Area

Outpatient. A Covered Person who receives Services or Supplies while not an Inpatient.

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

Participating Dentist. A Dentist who has an agreement with Highmark WV, either directly or indirectly, pertaining to payment as a participant in the United Concordia Advantage Provider Network for Covered Services rendered to a Member.

Participating Telemedicine Provider. A Physician licensed where required and performing within the scope of such licensure, who limits his or her practice to family, general or internal medicine and who has an agreement directly or indirectly with the Plan pertaining to payment for covered Telemedicine Services.

Participating Vision Provider. A Vision Provider who has an agreement with Highmark WV, either directly or indirectly, pertaining to payment as a participant in the Davis Vision Network for the payment of Covered Services rendered to a Member.

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

Plan Allowance. The amount used to determine reimbursement by Highmark WV for Covered Services provided on behalf of a Covered Person based on the type of Provider who renders such Services or as required by law. The Plan Allowance is used to calculate Highmark WV's payment, as set forth in Section III, and to determine Member Liability. You will receive greater benefits when Services are received from a Network Provider. The Plan Allowance for Non-Network Providers will be different than the Plan Allowance for Network Providers as follows:

> Non-Network Providers Located in the Service Area
> In the case of a Non-Network Provider in the Service Area, the Plan Allowance shall be based on an adjusted contractual allowance for like Services rendered by a Network Provider in the same geographic region. The Covered Person will be responsible for any difference between the Provider's Actual Charges in excess of Highmark WV's Plan Allowance for the Non-Network Provider's Services, as well as any applicable Deductible, Coinsurance or Fees.
>
> Out-of-Area Providers
> In the case of an Out-Of-Area Provider, the Plan Allowance shall be determined based on prices received from local licensees of the Blue Cross Blue Shield Association pursuant to Highmark WV's participation in the BlueCard® Program, as set forth in Section VIII.

The Plan Allowance is determined by Highmark WV in its sole discretion and in most circumstances unrelated to Actual Charges. Any waiver of a Covered Person's cost sharing obligations or Non-Network Liability by a Provider will be deemed an equivalent reduction of the Plan Allowance. The Plan Allowance may exceed Actual Charges in some circumstances.

Precertification. See Prior Authorization.

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

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

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

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

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

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

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

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

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

Qualified Employee. An employee who seeks to enroll in a QHP offered by a qualified employer through an Exchange and who is determined eligible by the Exchange.

Qualified Health Plan (QHP). A health plan that has met certification criteria established by the U.S. Department of Health and Human Service to offer health insurance coverage through an Exchange.

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

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

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

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

Retail Clinic. A small, consumer-driven, retail-based clinic that provides basic and preventive health care Services to all populations seven days a week, including evenings and weekends. The Clinic is generally staffed by Certified Registered Nurse Practitioners (CRNPs) that diagnose and treat common health problems, triage patients to appropriate levels of care, advocate for medical homes for all patients and reduce unnecessary visits to emergency rooms.

Serious Mental Illness. For purposes of Mental Health Parity, "Serious Mental Illness" means an illness included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, under the diagnostic categories or subclassifications of: (A) Schizophrenia and other psychotic disorders; (B) bipolar disorders; (C) depressive disorders; (D) substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; (E) anxiety disorders; and (F) anorexia and bulimia

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

Service Area. West Virginia and Washington County, Ohio

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

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

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

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

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

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

- Custodial Care, rest, ambulatory or part-time care; or
- Treatment for pulmonary tuberculosis.

Specialist Virtual Visit. A real time Office Visit with a specialist at a remote location, conducted via interactive audio and streaming video telecommunications, accessed by the Member at a physical site designated by the Member's Physician.

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

Supply. See Service.

Surgery.

- The performance of generally accepted operative and other invasive procedures.
- The correction of fractures and dislocations.
- Usual and related preoperative and postoperative care.

- Other procedures as reasonably approved by us.

Telemedicine Service. A real time interaction between a Member and a Participating Telemedicine Provider conducted by means or telephonic or webcam communications, for the purpose of providing specific outpatient medical care services.

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

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

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

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

Urgent Care Center. Center is a formally structured Hospital-based or freestanding full-Service, walk-in health care clinic that is accessible to all patients, 12 hours per day, Monday thru Friday and 8 hours each on Saturday and Sunday, no appointment required, outside of a Hospital-based emergency room (ER). Urgent Care Centers generally provide the same Services as a family or primary Medical Care Physician, such as Treatment of minor illnesses and injuries, physicals, x-rays, and immunizations.

Vision Care Services. Vision care services as specified in this Agreement rendered by a Participating Vision Provider which the Plan is contractually obligated to pay or provide as a benefit to a Member.

Vision Provider. A Physician or Professional Provider licensed, where required, and performing services related to the examination, diagnosis and treatment of conditions of the eye and associated structures.

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

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

Waiting Period. The period that must pass before an individual is eligible to enroll under the terms of the group health plan.

X. Prescription Drug Benefits

All terms and conditions of Sections I through IX shall apply to this Section X. In the event of a conflict involving Prescription Drug benefits, this Section X shall control. If you need more information on specific Prescription Drug coverage under your Policy, please contact Highmark WV at the phone number or the internet address shown on your ID Card.

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

1. **Prescription Drug Coinsurance** You must pay a certain percentage or dollar amount for each Medically Necessary Prescription Order or Refill. This payment is referred to as your Prescription Drug Coinsurance. The Prescription Drug Coinsurance for Prescription Drugs received from Network Pharmacies and Mail Order Prescription Drugs are indicated in Section III.

2. **Network Pharmacies** Under this Prescription Drug Program, **you must utilize Network Pharmacies to receive benefits.** If a Medically Necessary Prescription Drug is filled through a Network Pharmacy, you simply present your ID Card to the Pharmacy and pay only the Prescription Drug Coinsurance. You may review the Network Pharmacy List by contacting Highmark WV.

3. **Prescription Requirements.** All Prescription Drugs must be prescribed by a Physician or Professional Other Provider and dispensed for your use as an Outpatient

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

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

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

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

   The procedure is simple. Just take the following steps:

   - ***Know Your Benefits*.** Review this information to see if the Services you received are eligible under your prescription program.
   - ***Get an Itemized Bill*.** Itemized bills must include:
     - The name and address of the Pharmacy provider;
     - The patient's full name;
     - The date of Service or Supply or purchase;

- A description of the Service or medication/Supply;
- The amount charged;
- Drug and medicine bills must show the prescription name and number and the prescribing Provider's name.

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

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

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

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

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

8. Home Delivery (Mail Order) Prescription Drug Benefits Important Note: Refer to your Pharmacy Benefit Brochure for more specific details.

a. <u>Using the Mail Order Service for the first time</u>

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

- *<u>Requests for New Prescriptions by mail</u>*.

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

- *<u>Requests for New Prescriptions by fax.</u>*

  If you decide to order by fax, ask your Physician or Professional Other Provider to write a new prescription for the maximum Supply allowed by your Group Health plan, plus Refills (if appropriate) for up to one (1) year. Give your Physician or Professional Other Provider your Member ID number from your ID Card. Please ask your Physician or Professional Other Provider to call the phone number listed on your ID Card.

- *<u>Requests for New Prescriptions online.</u>*

  Refer to your packet for the internet address and how to register and order online.

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

b. <u>Refilling your Prescription</u>

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

You may use the Refill and order forms that will accompany your initial order. Mail the form also with your Prescription Drug Coinsurance in the return envelope. You may also phone and use the automated refill system. Should you choose to call, have your Member identification number (which is on your ID Card), the prescription number and your credit card number available.

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

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

B. FORMULARY

Your Prescription Drug benefits may include a Formulary (refer to Section III), which is a list of Brand Name Prescription Drugs that are preferred by your Plan. This list includes a wide selection of medications and is preferred because it offers you choice while helping keep the cost of your Prescription Drug benefits affordable. Every Prescription Drug on the Formulary is Food and Drug Administration (FDA) approved and reviewed by an independent group of doctors and pharmacists for safety and efficacy. We may remind your Physician or Professional Other Provider when a Formulary medication is available for a medication that is not on your Formulary. This may result in a change in your Prescription. However, your Physician or Professional Other Provider will always make the final decision on your medication. You will receive more detailed information about your Formulary in a separate mailing.

The Formulary is subject to change periodically (at least twice a year). If such a change affects you, your Physician or Professional Other Provider will always make the final decision on your medication. You may access the most up-to-date Formulary by contacting Member Service by phone or through our website. This information is located on your ID Card.

Covered Drugs (Incentive Formulary)

Covered drugs include;

- Those which, under federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription;"
- Legend drugs under applicable state law and dispensed by a licensed pharmacist;
- Prescription Drugs listed in your program's Prescription Drug Formulary including compounded medications, consisting of the mixture of at least two ingredients other than water, one of which must be a legend drug that requires a pharmacist dispenses it);
- Prescribed injectable insulin;

- Diabetic supplies, including needles and syringes; and
- Certain drugs that may require Prior Authorization.

To get additional information regarding your Formulary, please either visit www.mybenefitshome.com or contact Member Services. Their phone number is on the back of your ID Card.

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

Your program includes coverage for both formulary and non-formulary drugs.

C. RETAIL AND MAIL ORDER PRESCRIPTION DRUG MANAGEMENT

1. Preauthorization

The prescribing Physician must obtain Authorization from us prior to prescribing certain Prescription Drugs. The specific drugs or drug classifications which require Preauthorization may be obtained by calling the toll-free Member Service telephone number or accessing the internet address appearing on your ID Card.

2. Managed Prescription Drug Coverage

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

We may contact the prescribing Physician to determine if the Prescription Drug is Medically Necessary and appropriate. If it is determined by us that the prescription is Medically Necessary and appropriate, the Prescription Drug will be dispensed.

3. Quantity Level Limits

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

D. EXCLUSIONS AND LIMITATIONS SPECIFIC TO PRESCRIPTION DRUGS

In addition to the exclusions in Section VI, we do not provide benefits for the following Services, Supplies, or charges.

1. Therapeutic devices or for artificial appliances.
2. Prescription Drugs that are received as an Inpatient.
3. Hypodermic needles, syringes or comparable devices, unless stated as Covered Services.
4. Fees for administering or injecting Prescription Drugs.
5. More than a 34-day Supply of a Retail Prescription Drug or a 90-day supply of a Mail Order Prescription Drug.
6. Any Prescription Refill dispensed more than one year after the date of the original Prescription Order.

7. A Prescription Drug which is entirely consumed or administered at the time and place where the Prescription Order is issued.

8. Drugs you can buy without a Prescription Order.

9. Over the counter medications other than certain preventive drugs and only if prescribed in accordance with any State or Federal mandates.

10. Prescription Drugs dispensed for cosmetic purposes that are used solely for beautifying or altering one's appearance in the absence of any underlying injury, ailment, condition, disease, disorder or illness.

11. More than the number of Prescription Refills specified by a Physician or Professional Other Provider.

12. Prescription Drugs for the Treatment of obesity or for weight reduction.

13. Prescription Drugs that are Experimental or Investigational for a given Treatment, as determined by us.

14. Prescription Drugs not specified as Covered Services or which are specifically excluded in the text.

15. Prescription Drugs that are determined to be not Medically Necessary.

DEFINITIONS

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

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

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

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

Incentive Formulary. A Prescription Drug program that pays benefits for Prescription Drugs on three levels. Prescription Orders filled with Generic Prescription Drugs receive the highest level of benefit, Preferred Drugs the second highest level of benefits, and non-Preferred drugs the lowest level of benefits

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

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

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

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

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

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

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

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

Refill. See Prescription Order.

Prescription Mail Order Coinsurance. A certain percentage or dollar amount you are required to pay for each Medically Necessary Prescription Order or Refill.

XI. Statement of ERISA Rights

The following statement is required by government regulations and is not intended to enlarge or change your rights under the Plan

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including copies of the latest annual report (Form 5500 series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Eligible Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage.

You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, and when your COBRA continuation coverage ceases, if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should

happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

XII. Group Health Plan Information

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

- **Plan Year**
- **Name of Group Health Plan**
- **Name & Address of the Employer**
- **Plan Sponsor's Employer Identification Number (EIN)**
- **Group Health Plan Number**
- **Type of Welfare Plan**
- **Type of Administration of the Group Health Plan**
- **Name, Business Address, and Business Phone Number of the Plan Administrator**
- **Name, title and address of the principal place of business of each trustee of the Group Health Plan, if applicable.**
- **Name of person designated as agent for service of legal process.**
- **Participant eligibility requirements & conditions for receiving benefits.**
- **Group Health Plan's right to terminate or amend the benefits.**
- **Information regarding your health insurer or benefits administrator.**
- **How Group Health Plan is Funded**
- **Financial Plan Year**
- **Sources/Methods of Contributions**

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First produced April, 2014