MEMBER HANDBOOK

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Commonwealth of Virginia

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COVA Care Health Benefits Plan
IMPORTANT NOTICE

Your Health Plan benefits are administered by four Plan Administrators: Anthem Blue Cross and Blue Shield for Medical, and the optional vision and hearing benefits; Delta Dental of Virginia for routine Dental benefits, including the optional expanded Dental benefits; Medco Health Solutions, Inc. for Outpatient Prescription Drugs; and ValueOptions, Inc. for Behavioral Health and Employee Assistance Program (EAP) benefits.

This booklet tells You what may be eligible for Reimbursement under Your Health Plan. Throughout this booklet there are words which begin with capital letters. In most cases, these are defined terms. See the Definitions section for the meaning of these words.

Your Health Plan does not cover everything. There are specific Exclusions for which the program will never pay. Even more important, payment for services is almost always conditional. That is, payment may be reduced or even denied for a service if You received the service without observing all the conditions and limits under which the service is covered. Finally, You almost always have to pay for part of the cost of treatment.

Your health benefits are contractual in nature. This means, in part, that what You or your employer thinks is covered does not make it a covered service. Likewise, if You or your employer thinks a service should be covered, that does not make it a covered service. The same is true even when the issue is life or death: a service is not covered simply because You, your physician, or your employer believe You need the service, or because the service is the only remaining treatment which might (or might not) save your life. This booklet describes what services are eligible for Reimbursement, the conditions under which the services are covered, the limits of coverage, and the amounts which may be payable under the specified conditions. **You, and You alone, are responsible for knowing what is covered and the limits and conditions of coverage.** Furthermore, the terms and conditions of your coverage can be changed without your consent, if proper notice is given to You. This booklet may be printed at any time from the following Web site: **www.dhrm.virginia.gov**.

Your Health Plan pays part of the cost of health services needed to diagnose and treat illnesses and injuries. Services designed primarily to improve your personal appearance are not eligible for Reimbursement. Services which are not necessary for the diagnosis and treatment of illnesses or injuries are not eligible for Reimbursement unless, in the sole judgment of the Plan Administrator, such services can reasonably be expected to avoid future costs to Your Health Plan.

Still there is more You need to know. There are some rules which apply to all benefits. See General Rules Governing Benefits. In addition, there are some services for which the Plan Administrator will never pay. See the Exclusions section. Also, we have included some rules governing Your Health Plan. See the Basic Plan Provisions section. Finally, refer to the Definitions section for an explanation of many of the terms used in this booklet. These sections are important because they will be used to determine exactly what Your Health Plan covers.

Important Contacts:

All Plan Administrators offer language translation by calling Member Services. Anthem, ValueOptions and Delta Dental also provide written translation.

Todos los Administradores de Planes ofrecen servicios de traducción. Para recibirlos, debe comunicarse con el Servicio de Atención al Cliente. Anthem, ValueOptions y Delta Dental también ofrecen servicios de traducción escrita.

Anthem Blue Cross and Blue Shield - Medical, and Optional Vision and Hearing

800-552-2682
For the hearing impaired, please contact your state's relay service by dialing 711.

Hours of Operation:
Monday-Friday 8:00 a.m. to 6:00 p.m. ET
Saturday 9:00 a.m. to 1:00 p.m. ET
www.anthem.com/cova

Delta Dental of Virginia - Dental

888-335-8296

Hours of Operation:
Monday-Thursday 8:15 a.m. to 6:00 p.m. ET
Friday 8:15 a.m. to 4:45 p.m. ET
www.deltadentalva.com (Select the Commonwealth of Virginia link)

Medco Health Solutions, Inc. - Outpatient Prescription Drugs

800-355-8279

Hours of Operation:
24 hours a day, 7 days a week
www.medco.com

ValueOptions, Inc. - Behavioral Health and Employee Assistance Program (EAP)

866-725-0602

Hours of Operation:
24 hours a day, 7 days a week
www.achievesolutions.net/covacare

Department of Human Resource Management (DHRM)

www.dhrm.virginia.gov

ID Card Order Line

866-587-6713

How to find a Provider

A directory of participating Providers may be accessed online at each Plan Administrator's Web site.

COVA Care – Summary of Benefits

This chart is an overview of your benefits for covered services under the basic plan.

COVA Care is a non-grandfathered health plan as defined by the Patient Protection and Affordable Care Act (PPACA).

What will I pay?

This chart shows what You pay for Deductibles, Copayments, Coinsurance and Out-of-Pocket Expenses for covered services in one Plan Year.

	Single (You Only)	Plus One (You and One Family Member)	Family (You and Two or more Family Members)	**Page Number**
Plan Year Deductible (applies as indicated)	$225	$450	$450	10
Plan Year Out-Of-Pocket Expense Limit	$1,500	$3,000	$3,000	12

	You Pay In-network[1] Copayment	**You Pay In-network[1] Coinsurance**	**Page Number**
Ambulance Travel No Plan Year limit	$0	20% after Deductible	55
Behavioral Health and EAP			44
Inpatient treatment			
Facility Services	$300 per Stay	0%	
Professional Provider Services	$0	0%	
Partial Day Program	$300 per Stay	0%	
Outpatient Treatment Program			
Facility Services	$125	0%	
Non-medical professional[2]	$25	0%	
Medical professional	$25		
Employee Assistance Program Up to four Visits per incident (per rolling 12 months)	$0	0%	

Dental Services - Basic	Single (You Only)	Plus One (You and One Family Member)	Family (You and Two or more Family Members)	63
Plan Year Deductible	$50	$100	$150	
The most Your Health Plan pays per person per Plan Year	$2,000	$2,000	$2,000	

	You Pay In-network[1] Copayment	**You Pay In-network[1] Coinsurance**
Diagnostic and Preventive Services	$0, no Deductible	0%
Primary Services	$0	20% after Deductible

[1] Except in an Emergency, You do not have out-of-network benefits unless You purchased the Out-of-Network option.

[2] Includes licensed professionals with a master's or PhD degree.

Summary of Benefits continued	You Pay In-network[1] Copayment	You Pay In-network[1] Coinsurance	Page Number
Dental Services (non-routine Medical)	$0	20% after Deductible	66
Diabetic Equipment	$0	20% after Deductible	56
Diabetic Education	$0	0%	40
Diagnostic Tests, Labs and X-rays			30
Outpatient Surgery[3]	$0	0%	
Outpatient Diagnostic Services Only	$0	20% after Deductible	
Outpatient Emergency Room	$0	20% after Deductible	
Dialysis Treatments			30
Facility Services	$0	0%	
Doctor's Office	$0	0%	
Doctor's Visits (On an Outpatient basis)			39
Primary Care Physicians	$25	0%	
Specialty Care Providers	$40	0%	
Early Intervention Services	Copayment/Coinsurance determined by service received.		53
Emergency Room Visits			30
Facility Services	$125 per Visit (waived if admitted to hospital)	0%	
Professional Provider Services			
Primary Care Physicians	$25	0%	
Specialty Care Providers	$40	0%	
Diagnostic Tests, Labs and X-rays	$0	20% after Deductible	
Home Health Services 90-Visit Plan Year limit per member	$0	0%	36
Home Private Duty Nurse's Services	$0	20% after Deductible	56
Hospice Care Services	$0	0%	54
Hospital Services			30
Inpatient Care			
Facility Services	$300 per Stay	0%	
Professional Provider Services			
Primary Care Physicians	$0	0%	
Specialty Care Providers	$0	0%	
Diagnostic Services	$0	0%	
Outpatient Care			
Facility Services	$125	0%	
Professional Provider Services			
Primary Care Physicians	$25	0%	
Specialty Care Providers	$40	0%	
Maternity			39
Professional Provider Services			
Prenatal and Postnatal Care			
Primary Care Physicians	$25	0%	
Specialty Care Providers	$40	0%	
Delivery			
Primary Care Physicians	$0	0%	
Specialty Care Providers	$0	0%	

[1] Except in an Emergency, You do not have out-of-network benefits unless You purchased the Out-of-Network option.
[3] Diagnostic tests and X-rays are covered under the Outpatient Facility Copayment when billed by a Facility in conjunction with a surgery.

Summary of Benefits continued	You Pay In-network[1] Copayment	You Pay In-network[1] Coinsurance	Page Number
Maternity (continued)			39
Hospital Services for Delivery Delivery room, anesthesia, nursing care for newborn	$300 per Stay	0%	
Diagnostic Tests, Labs and X-rays	$0	20% after Deductible	
Medical Equipment (durable), Appliances, Formulas, Prosthetics and Supplies	$0	20% after Deductible	55
Outpatient Prescription Drugs			58
Retail Pharmacy			
Covered drugs per 34-day supply			
First Tier	$15	0%	
Second Tier	$25	0%	
Third Tier	$40	0%	
Fourth Tier (specialty drugs)[4]	$50	0%	
Home Delivery Services (Mail Order) Covered drugs for up to a 90-day supply			
First Tier	$30	0%	
Second Tier	$50	0%	
Third Tier	$80	0%	
Fourth Tier (specialty drugs)[4]	$100	0%	
Diabetic Supplies	$0	20%, no Deductible	
Shots At a doctor's office, Emergency room or Outpatient hospital department	$0	20% after Deductible	40
Skilled Nursing Facility Stays 180-day per Stay limit per member			34
Facility Services	$0 per Stay	0%	
Professional Provider Services	$0	0%	
Surgery			30, 39
Inpatient			
Facility Services	$300 per Stay	0%	
Professional Provider Services			
Primary Care Physicians	$0	0%	
Specialty Care Providers	$0	0%	
Diagnostic Services	$0	0%	
Outpatient			
Facility Services	$125 per Visit	0%	
Professional Provider Services			
Primary Care Physicians	$25	0%	
Specialty Care Providers	$40	0%	

[1] Except in an Emergency, You do not have out-of-network benefits unless You purchased the Out-of-Network option.
[4] Specialty drugs are typically higher cost brand-name drugs used to treat chronic and rare conditions.

Summary of Benefits continued	You Pay In-network[1] Copayment	You Pay In-network[1] Coinsurance	Page Number
Therapy – Outpatient Services			
Cardiac Rehabilitation Therapy			51
Facility Services	$0	0%	
Professional Provider Services	$0	0%	
Chemotherapy			51
Facility Services	$0	0%	
Professional Provider Services	$0	0%	
Chiropractic, Spinal Manipulations and Other Manual Medical Interventions 30-Visit Plan Year limit per member			47
Primary Care Physicians	$25	0%	
Specialty Care Providers	$35	0%	
Infusion (IV Therapy)			11, 51
Facility Services	$0	20% after Deductible	
Professional Provider Services	$0	20% after Deductible	
Home Health Services	$0	20% after Deductible	
Infusion Medications	$0	20% after Deductible	
Outpatient Settings	$0	20% after Deductible	
Home Settings	$0	20% after Deductible	
Occupational Therapy			51
Facility Services	$35	0%	
Professional Provider Services			
Primary Care Physicians	$25	0%	
Specialty Care Providers	$35	0%	
Physical Therapy			51
Facility Services	$35	0%	
Professional Provider Services			
Primary Care Physicians	$25	0%	
Specialty Care Providers	$35	0%	
Radiation Therapy			51
Facility Services	$0	0%	
Professional Provider Services	$0	0%	
Respiratory Therapy			51
Facility Services	$0	0%	
Professional Provider Services	$0	0%	
Speech Therapy			51
Facility Services	$35	0%	
Professional Provider Services		0%	
Primary Care Physicians	$25	0%	
Specialty Care Providers	$35	0%	

[1] Except in an Emergency, You do not have out-of-network benefits unless You purchased the Out-of-Network option.

Summary of Benefits continued	You Pay In-network[1] Copayment	You Pay In-network[1] Coinsurance	Page Number
Vision Correction After surgery or accident	$0	20% after Deductible	56
Wellness and Preventive Care Services			48
Well Child (birth to 18 years)			
Office Visits at specified intervals			
Primary Care Physicians	$0	0%	
Specialty Care Providers	$0	0%	
Immunizations[5]			
Primary Care Physicians	$0	0%	
Specialty Care Providers	$0	0%	
Screening Tests	$0	0%	
Routine Wellness (19 years and older)			48
Check-up Visit (one per Plan Year)			
Primary Care Physicians	$0	0%	
Specialty Care Providers	$0	0%	
Immunizations[5]			
Primary Care Physicians	$0	0%	
Specialty Care Providers	$0	0%	
Routine Lab and X-ray Services	$0	0%	
Wellness and Preventive Care Services (one of each per Plan Year)			49
Gynecological Exam			
Primary Care Physicians	$0	0%	
Specialty Care Providers	$0	0%	
Pap Test	$0	0%	
Mammography Screening	$0	0%	
Prostate Exam (digital rectal exam)			
Primary Care Physicians	$0	0%	
Specialty Care Providers	$0	0%	
Prostate Specific Antigen Test	$0	0%	
Colorectal Cancer Screenings	$0	0%	

[1] Except in an Emergency, You do not have out-of-network benefits unless You purchased the out-of-network option.
[5] Routine immunizations are only covered in the doctor's office.

Summary of Benefits continued

Optional Benefits – These options are available for an additional premium.	You Pay In-network Copayment	You Pay In-network Coinsurance		Page Number
Optional Expanded Dental	Single (You Only)	Plus One (You and One Family Member)	Family (You and Two or more Family Members)	68
Plan Year Deductible	$50	$100	$150	
The most Your Health Plan pays per person per Plan Year	$2,000	$2,000	$2,000	
Diagnostic and Preventive Services	$0 no Deductible	0%		
Primary Services	$0	20% after Deductible		
Complex Restorative Services	$0	50% after Deductible		
Orthodontic Services ($2,000 lifetime maximum)	$0	50% no Deductible		
Optional Out-of-Network Benefit	Plan payment is reduced by 25%. Provider may balance bill for amount above Allowable Charge.			71
Optional Routine Vision – Blue View Vision Network				72
You have an allowance for eyeglass lenses or contact lenses every 24 months if You have purchased this buy-up. You pay the remaining cost for frames and lenses after Your Health Plan's Reimbursement.				
Routine eye exam	$40 Copayment			
Eyeglass frames	$100 allowance then 20% off remaining balance			
Eyeglass lenses				
- Single vision lenses	$20 Copayment			
- Bifocal lenses	$20 Copayment			
- Trifocal lenses	$20 Copayment			
OR				
Contact lenses				
- Conventional	$100 allowance then15% discount off remaining balance			
- Disposable	$100 allowance, no additional discount			
- Non-elective	$250 allowance, no additional discount			
Contact lens fit and follow-up (standard)	You pay up to $55			
Contact lens fit and follow-up (premium)	10% off retail price			
Optional Routine Hearing				75
This benefit is available every 48 months. You pay the remaining cost for hearing aid services and supplies after Your Health Plan's Reimbursement.				
Routine hearing test	$40 Copayment	0%		
Purchase of hearing aids and other related hearing aid services and supplies except disposable hearing aids. (Your Health Plan pays a maximum of $1,200 during the 48 months.)	Balance after plan pays $1,200	0%		

DEFINITIONS

Throughout this booklet are words which begin with capital letters. In most cases, these are defined terms. This section gives You the meaning of most of these words.

Activities of Daily Living
Means walking, eating, drinking, dressing, toileting, transferring (e.g. wheelchair to bed), and bathing.

Acute Care
For Behavioral Health is Inpatient care in which the patient is in a Facility 24 hours a day under the care and direction of an attending physician.

Adverse Benefit Determination
Is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by Your Health Plan.

Allowable Charge
The maximum amount that the health plan will reimburse a provider for a specific service. This is also the amount on which the Deductible (if any), Copayment, and Coinsurance for eligible services are calculated.

Balance Billing
Any amount the non-network Provider or Facility charges over the Allowable Charge.

Behavioral Health
Is the promotion and maintenance of mental and emotional health and wellness.

Benefits Administrator
Is the person appointed by your employer to assist You with Your Health Plan. Your Benefits Administrator may also provide You information about your benefits. If there is a conflict between what your Benefits Administrator tells You and Your Health Plan itself, your benefits will, to the extent permitted by law, be determined on the basis of the language in this booklet. The Plan Administrators may send communications intended for You to the Benefits Administrator. You may be provided with brochures, employee communications, or other material that describes the benefits available under Your Health Plan. In the event of conflict between this type of information and Your Health Plan, your benefits will be determined on the basis of the language in this booklet.

Coinsurance
Is the percentage of the Allowable Charge You pay for some covered services.

Concurrent Care Claims
A claim for a benefit where Your Health Plan is reducing or ending a service that it previously approved.

Copayment
Is the fixed dollar amount You pay for some covered services.

Covered Person
You and enrolled eligible dependents.

Deductibles
Medical and Behavioral Health Services
The fixed dollar amount of certain covered services You pay in a Plan Year before Your Health Plan will pay for those remaining covered services during that Plan Year. The Allowable Charge amount for those covered services is applied to the Deductible.

The Deductible amount is for a twelve month period and begins again each Plan Year.

The Deductible applies to benefits subject to Coinsurance. For example: medical equipment and supplies, diagnostic tests, labs and x-rays. It does not apply to wellness, preventive, or drug benefits. Refer to the Summary of Benefits chart at the front of the handbook for specific benefits.

Family Limit on Deductibles:
Deductible amounts are calculated on an individual basis for each family member. This is how the deductible works for each coverage type:

You Only: If You have single-only coverage, You are responsible for satisfying the single deductible only.

You and One Family Member: Each of You must satisfy the individual deductible.

Family: For family coverage, deductible amounts for each individual member accumulate towards the family deductible limit. However, no individual family member can contribute more than the single-only deductible amount.

Carry Over Deductible:
The Deductible amount is for a 12 month period and begins again each Plan Year. Deductible amounts incurred from April 1 through June 30 carry over to the new Plan Year and are applied to the member's deductible for the new Plan Year.

Dental Services
There is a separate Plan Year Deductible for your Dental coverage which applies to certain Dental services. The Dental deductible works the same way as the medical deductible. The carry over provision does not apply to the Dental Deductible.

Dental
Covered services for the care of your teeth and gums.

Effective Date
Is the date coverage begins for You and/or your dependents enrolled under Your Health Plan.

Emergency
Is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity. This includes severe pain that without immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in:

- serious jeopardy to the mental or physical health of the individual;
- danger of serious impairment of the individual's bodily functions;
- serious dysfunction of any of the individual's bodily organs; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee Assistance Program (EAP)
Is a free, voluntary, confidential service to help You and your family members deal with personal challenges that can be addressed through short-term counseling, such as stress, anxiety, and marital or family difficulties.

Exclusions
This is a list of services which are not, under any circumstances, eligible for Reimbursement. See the Exclusions section.

Experimental/Investigative
Means any service or supply that is judged to be experimental or investigative at the Plan Administrators' sole discretion. Refer to Experimental/Investigative Criteria under General Rules Governing Benefits.

Extended Coverage (COBRA) Qualified Beneficiary
Is You or a covered dependent who is covered on the day before the qualifying event and loses coverage due to that event. A child born to or placed for adoption with the covered employee during Extended Coverage or a participant whose coverage was terminated in anticipation of a qualifying event is also a qualified beneficiary.

Facility
Covered facilities include:
- dialysis centers
- home health care agencies
- hospice Providers
- hospitals
- Skilled Nursing Facilities

First Tier Drug
Is a low cost drug, typically a generic drug.

High Dose Chemotherapy
Means a dose of chemotherapy or radiation so high that it predictably requires stem cell rescue.

Home Health Services
Are services rendered in the home Setting. Home Health care includes services such as skilled nursing Visits and physical, speech, and occupational therapy for patients confined to their homes. This also means home infusion services, which is therapy including such services as the intravenous and parenteral administration of medication to patients as well as enternal and parenteral nutrition. Home infusion therapy does not require that the patient is confined to his/her home.

Inpatient
When You are a bed patient in the hospital for at least 24 hours.

Inpatient Facilities
Are Settings where patients can spend the night, including hospitals, Skilled Nursing Facilities, and partial day programs.

Levels of Care
For Behavioral Health refers to the different types of treatment Settings available to patients such as Inpatient, partial, intensive Outpatient, and Outpatient care.

Maintenance Medications
Are those medications You take routinely to treat or control a chronic illness such as heart disease, high blood pressure, or diabetes.

Medical
Covered services for the screening, diagnosis and treatment of illness and disease.

Medical Equipment (durable)
Is used for a medical purpose, can withstand repeated use, and is appropriate for use in your home for daily living purposes.

Medically Necessary
To be considered Medically Necessary, a service must:
- be required to identify or treat an illness, injury, or pregnancy-related condition;
- be consistent with the symptoms or diagnosis and treatment of your condition;
- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the Provider.

Other Covered Services
This includes services such as:
- ambulance services;
- medical supplies and equipment (including diabetic equipment, such as lancet devices and insulin pumps); and
- medical formulas.

Refer to the Other Covered Services section for a complete listing.

Out-of-Pocket Expense Limit
The amount of money that You pay out of your pocket for certain allowable covered Medical and Behavioral Health expenses (combined) during the Plan Year. The following counts toward the Out-of-Pocket Expense Limit: Deductible, Copayments, and Coinsurance for covered services from Providers and Facilities in your Anthem, BlueCard PPO, or ValueOptions networks. Once the limit is reached, covered expenses are paid in full (100% of the Allowable Charge) for the rest of the Plan Year. The Out-Of-Pocket Expense Limit is for a twelve month period and begins again each July 1.

Outpatient
Is when You receive care in a hospital Outpatient department, Emergency room, professional Provider's office, or your home.

Outpatient Behavioral Health Services
Are for the diagnosis and treatment of psychiatric conditions and include individual psychotherapy, group psychotherapy, and psychological testing.

Outpatient Prescription Drugs
Are medicines, including insulin, that require a prescription order from your doctor.

Partial Day Hospitalization
For Behavioral Health is intensive treatment in a medically supervised Setting with the opportunity for the patient to return home or to another residential Setting at night.

Plan Administrator
A Plan Administrator, also known as a Third Party Administrator (TPA), is an organization that provides claims administration. Your Health Plan benefits are administered by four Plan Administrators: Anthem Blue Cross and Blue Shield for Medical, and the optional vision and hearing benefits; Delta Dental of Virginia for routine Dental benefits, including the optional expanded Dental benefits; Medco Health Solutions, Inc. for Outpatient Prescription Drugs; and ValueOptions, Inc. for Behavioral Health and Employee Assistance Program (EAP) benefits.

Plan Year
The period for which benefits are administered. For COVA Care, it is a 12-month period beginning July 1 through June 30 of the following year.

Plan's Limiting Age
The end of the calendar year in which the dependent child turns age 26.

Post-Service Claims
Are all claims other than Pre-Service Claims and Urgent Care Claims. Post-Service claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where You request authorization in advance.

Pre-Admission Testing
Is conducted to determine if You are physically able to undergo Inpatient surgery under general anesthesia. This can include tests for blood work, chest x-ray, and/or EKG and is usually done prior to the procedure to ensure the surgery can proceed.

Preauthorization
For Behavioral Health is the process of referring You to an appropriate Provider and reviewing your treatment plan against medical necessity criteria. The process also includes referring You to an appropriate Provider for your condition.

Pre-Service Claims
Are claims for a service where the terms of Your Health Plan require the member to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If You call to receive authorization for a service when authorization in advance is not required, that claim will be considered a Post-Service Claim.

Primary Care Physician (PCP)
Is a general or family practitioner, internist or pediatrician.

Providers (who may give care under Your Health Plan):
- audiologists
- certified nurse midwives
- chiropractors
- chiropodists
- clinical social workers, psychologists, clinical nurse specialists in psychiatric Behavioral Health, professional counselors, marriage and family therapists
- dentists
- doctors of medicine (MD), including osteopaths and other specialists
- independent clinical reference laboratories
- occupational therapists
- opticians
- optometrists

- podiatrists
- registered physical therapists
- retail health clinics
- speech pathologists

Reimbursement
Is the amount Your Health Plan pays for covered services.

Retail Health Clinic
Retail Health Clinics are walk-in clinics located in retail outlets such as pharmacies and grocery stores that provide a defined set of services for preventative health and basic health care problems. They are staffed by Physician Assistants or Nurse Practitioners under the supervision of an onsite or offsite Physician.

Second Tier Drug
Is a moderate cost drug, typically a multi-source brand name drug. A multi-source brand name drug is a brand name drug which has a generic equivalent.

Setting
Is the place where You receive treatment. It could be your home, your Provider's office, a hospital Outpatient department, a skilled nursing home, hospital Inpatient room, or a partial day program.

Skilled Nursing Facility
Is a Facility licensed by the state in which it operates to provide medically skilled services to Inpatients.

Specialty Care Providers
Are any covered Providers other than those defined as Primary Care Physicians.

Specialty Drugs
Are typically higher cost brand-name drugs, $500 and up, used to treat chronic and rare conditions.

Stay
Is the period from the admission to the date of discharge from a Facility. All hospital Stays less than 90 days apart for the same diagnosis are considered the same Stay, and a new hospital Inpatient Copayment will not apply. If You are readmitted within 90 days for a different diagnosis, a copay will apply.

Telemedicine
Means the use of interactive audio, video, or other telecommunications technology by a health care provider to deliver health care services within the scope of the provider’s practice at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the health care diagnosis or treatment of the patient.

Third Tier Drug
Is a higher cost drug, typically a single source brand name drug. A single source brand name drug is a brand name drug which does not have a generic equivalent.

Urgent Care Centers
Urgent Care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. An example of an urgent care Facility would be a Patient First Facility.

Urgent Care Claims
Are claims where care and services are actively ongoing and to which the application of time periods for making claim or appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain. Notwithstanding any provision of Your Health Plan, services for an Emergency medical condition do not require provider referrals or any type of advance approval.

Visit
A period during which a Covered Person meets with a Provider to receive covered services.

You
The enrolled member.

Your Health Plan
The COVA Care plan and any optional benefits chosen by You.

GENERAL RULES GOVERNING BENEFITS

1) **When a Charge Is Incurred**
   You incur the charge for a service on the day You receive the service.

2) **When Benefits Start**
   Benefits will not be provided for any charges You incur before your Effective Date.

3) **Services Must Be Medically Necessary**
   In all cases, benefits will be denied if the Plan Administrator determines, in its sole discretion, that care is not Medically Necessary.

4) **When Benefits End**
   Benefits will not be provided for charges You incur after your coverage ends. There are two exceptions. If You are an Inpatient the day your coverage ends, your hospital coverage will continue until You are discharged to the extent that services were covered prior to the end of coverage. Also, Other Covered Services such as rental of Medical Equipment (durable) will be provided for a limited time for a condition for which You received covered services before your coverage ended. The time will be the shorter of when You become covered under any other group coverage, or the end of the Plan Year your coverage ends, or a period equal to the time You were enrolled under Your Health Plan.

5) **Defining Services**
   When classifying a particular service, the Plan Administrator will use the most recent edition of a book published by the American Medical Association entitled Current Procedural Terminology (CPT). The Allowable Charge for a procedure will be based on the most inclusive code in “Current Procedural Terminology”. The Plan Administrator alone will determine the most inclusive code. No benefits will be provided for lesser included procedures or for procedures which are components of a more inclusive procedure.

6) **Payment to Network Providers**
   The Plan Administrator pays the Allowable Charge which remains after your Copayment, Coinsurance, or Deductible to the network Provider. These amounts may be collected at the time of service. When You receive services from a network Provider, the Plan Administrator will make payment for these services directly to the Provider. If You have already paid the Provider You will need to return to the Provider for any Reimbursement. A Provider who participates in a Plan Administrator’s network will accept the Plan Administrator’s allowance as payment in full for that service.

7) **Payment to Out-of-Network Medical or Behavioral Health Providers**
   When a member receives services from a non-network Medical or Behavioral Health services Provider, the Plan Administrator may choose to make payment directly to You or, at the Plan Administrator's sole option, to any other person responsible for payment of the Provider's charge. Payment will be made only after the Plan Administrator has received an itemized bill and the medical information the Plan Administrator decides is necessary to process the claim. If the payment is made directly to You, You will be responsible for sending payment to the Provider. You also will be responsible for the difference between Your Health Plan's allowance and the Provider's charge. Payment by the Plan Administrator will relieve it and Your Health Plan of any further liability for the non-network Provider's services.

8) Alternative Benefits

Your Health Plan may elect to offer benefits for an approved, alternative treatment plan for a patient who would otherwise require more expensive services, including, but not limited to, long term Inpatient care. Your Health Plan will provide such alternative benefits at its sole option and only when and for so long as Your Health Plan decides that the alternative services are Medically Necessary and cost effective. The total benefits paid for such services may not exceed the total which would otherwise be paid under this contract without alternative benefits. If Your Health Plan elects to provide alternative benefits for a member in one instance, it will not be required to provide the same or similar benefits for any member in any other instance. Also, this will not be construed as a waiver of the State's right to administer this contract in the future in strict accordance with its express terms.

9) Organ and Tissue Transplants, Transfusions

Your Health Plan covers some but not all organ and tissue transplants. Medical necessity review is required to determine if a specific organ or tissue transplant service will be covered. When a human organ or tissue transplant is provided from a living donor to a Covered Person, both the recipient and the donor may receive the benefits of Your Health Plan. However, benefits for these services are limited only to those not available to the donor from any other source, including, but not limited to, other insurance coverage or any government program.

When only the donor is a Covered Person under Your Health Plan, only the organ donation procedure itself, including services rendered at the time of the organ donation procedure, are covered services. Any services provided prior to the organ donation procedures are not covered, whether Inpatient or Outpatient, even if they are provided in anticipation of the organ donation or as preparation for the organ donation.

Covered services for the identification of a suitable donor to a Covered Person for an allogeneic bone marrow transplant will include a computer search of established bone marrow registries and laboratory testing necessary to establish compatibility of potential donors. Donors may be from the patient's immediate family or have been identified through the computer search. These services must be ordered by a doctor qualified to provide allogeneic transplants.

10) Complaint and Appeal Process

You have access to both a complaint process and an appeal process. Should You have a problem or question about Your Health Plan, the appropriate Plan Administrator's Member Services Department will assist You. Most problems and questions can be handled in this manner. **Anthem** is the Plan Administrator for medical and the optional vision and hearing benefits. **ValueOptions** is the Plan Administrator for Behavioral Health services and the Employee Assistance Program (“EAP”). **Delta Dental** is the Plan Administrator for routine Dental services. **Medco** is the Plan Administrator for your Outpatient Prescription Drug benefits.

You may file a complaint or appeal. **Complaints** typically involve issues such as dissatisfaction about Your Health Plan's services, quality of care, the choice of and accessibility to Your Health Plan's Providers and network adequacy. **Appeals** typically involve a request to reverse a previous adverse decision made by Your Health Plan. You may also request to reopen a claim without invoking the appeal process when there are claim errors or claims are denied for insufficient information.

Complaint Process

Upon receipt, your complaint will be reviewed and investigated. You will receive a response within thirty (30) calendar days of the appropriate Plan Administrator's receipt of your complaint. If the Plan Administrator is unable to resolve your complaint within this time frame, You will be notified by the 30th calendar day that more time is required to resolve your complaint. The Plan Administrator will then respond to You within an additional thirty (30) calendar days.

Important: Written complaints or any questions concerning your Medical, Behavioral Health, Dental or Outpatient Prescription Drug coverage may be filed to the following addresses:

Anthem Blue Cross and Blue Shield (for Medical, optional vision and hearing)
Attn: Member Services
P.O. Box 27401
Richmond, VA 23279

Delta Dental of Virginia (for Dental)
4818 Starkey Road, S. W.
Roanoke, VA 24018-8542

Medco Health Solutions, Inc. (for Outpatient Prescription Drug)
Attn: General Manager
8111 Royal Ridge Parkway
Irving, TX 75063

ValueOptions, Inc. (for Behavioral Health and EAP)
Attn: Complaints and Grievances
P. O. Box 12438
Research Triangle Park, NC 27709-2438

Claims Appeal Process

Your Health Plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider a coverage decision You find unacceptable.

There are two types of claims appeals, internal and external. **Internal appeals** are filed to the Plan Administrator responsible for handling the claim. **External appeals** are filed to the Department of Human Resource Management (DHRM).

You or your authorized representative may request claims appeals on your behalf. However, appeal requests submitted by authorized representatives must be accompanied by a signed written statement from You that allows your authorized representative to act on your behalf.

Internal Appeals

An internal appeal is a request to reconsider an adverse coverage decision of a:

- **Pre-Service Claim**- a claim for a benefit under Your Health Plan for which You have not received the service or for which You may need to obtain approval in advance.
- **Post-Service Claim**- a claim for any benefit under Your Health Plan for which You have received the service.
- **Concurrent Care Claim**- a claim for a benefit where Your Health Plan is reducing or ending a service that it previously approved. **Note:** For Concurrent Claim appeals, the

Plan Administrator must not reduce or terminate benefits prior to the resolution of the appeal.

What You may appeal

You or your authorized representative may appeal any adverse determination by a Plan Administrator (Anthem, Delta Dental, Medco, ValueOptions). An adverse determination is one that denies, reduces, or terminates a covered benefit. You may also appeal adverse decisions involving a determination that the requested service is Experimental or Investigational.

In some circumstances, You have the right to an expedited internal appeal. See **Expedited Internal Appeals** below for more information.

You have the right to request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on by the Plan Administrator in making the claim determination (including internal rules, guidelines, protocols, policies, guidance, or other criteria);
- was submitted, considered, or produced in the course of making the claim determination; or
- demonstrated that the claim determination was made in accordance with the terms of the plan.

The Plan Administrator will also provide You, free of charge, with copies of new or additional evidence considered. In addition, if You receive an adverse claim determination on review based on new or additional rationale, the Plan Administrator will provide You, free of charge, with the rationale.

How to request an internal appeal (with the Plan Administrator)

To file an internal appeal, You or your authorized representative must contact the Plan Administrator and provide the following information:

- Your full name
- Your identification number
- Your address
- Your telephone number
- The date(s) of the medical service
- Your specific medical condition(s) or symptom(s)
- Your provider's name
- The service or supply for which approval of benefits is being sought, and
- Any reasons why the appeal should be processed on an expedited basis.

When filing an internal appeal, You have the right to submit written comments, documents, records, and other information supporting your claim. The internal review will take into account all information that You submit, regardless of whether it was submitted or considered in the initial benefit determination.

You must file your appeal within 15 months of the date of service or 180 days from the date You were notified of the Adverse Benefit Determination, whichever is later.

Standard Internal Appeals

You or your authorized representative may request a **standard (non-expedited) internal appeal** of a Pre-Service Claim, Post-Service Claim, or a Concurrent Claim in writing by contacting the appropriate Plan Administrator at the address listed in **Addresses and Telephone Numbers for Appeals** below. (Note that Anthem will accept standard appeals in writing or orally—appeals to Anthem may be made by calling Anthem's telephone number below.)

Expedited Internal Appeals

You or your authorized representative may request, **either orally or in writing,** an **expedited internal appeal** of a Concurrent or Pre-Service Claim involving urgent medical care. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain.

To file an expedited appeal, contact the appropriate Plan Administrator at the address or telephone number listed in **Addresses and Telephone Numbers for Appeals** below. Please indicate on the envelope, fax cover sheet, or during the telephone call that you would like for the appeal to be expedited. **Note:** Appeals to Delta Dental may only be filed in writing.

Expedited internal appeals must be resolved within seventy-two (72) hours after receipt of the appeal request.

Addresses and Telephone Numbers for Appeals

Anthem Address**:**	Anthem Blue Cross and Blue Shield Attn: Corporate Appeals Department P.O. Box 27401 Richmond, VA 23279
Anthem Telephone Number:	**800-552-2682**
Medco Address:	Medco Health Solutions, Inc. Attn: Coverage Appeals 8111 Royal Ridge Parkway Irving, TX 75063
Medco Telephone Number: Medco Fax Number:	**800-753-2851** **888-235-8551**
Delta Dental Address:	Delta Dental of Virginia Attn: Appeals 4818 Starkey Road, S.W. Roanoke, VA 24018-8542
ValueOptions Address:	ValueOptions, Inc. Attn: Appeals and Grievances P.O. Box 1347 Latham, NY 12110
ValueOptions Telephone Number:	**866-725-0602**

How the Plan Administrator will handle your appeal

In reviewing your appeal, the Plan Administrator will take into account all the information You submit, regardless of whether the information was considered at the time the initial decision was made.

The Plan Administrator will resolve and respond in writing to your appeal within the following time frames:

- for expedited appeals, the Plan Administrator will respond orally within seventy-two (72) hours and will follow up with written confirmation of its decision within twenty-four (24) hours.
- for standard Pre-Service Claim appeals, the Plan Administrator will respond in writing within thirty (30) days after receipt of the request to appeal;
- for standard Post-Service Claim appeals, the Plan Administrator will respond in writing within sixty (60) days after receipt of the request to appeal;
- for Concurrent Claim appeals, the Plan Administrator will respond in writing within thirty (30) days after receipt of the request to appeal and prior to the benefits being reduced or terminated.

When the Plan Administrator has completed its review of your appeal, You will receive written notification of the outcome.

External Claims (DHRM) Appeals

After internal appeals are exhausted, You may request an external appeal to DHRM.

For external appeals, You may only appeal Adverse Benefit Determinations by the Plan Administrator that are based on Your Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or the failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational.

Just as with internal appeals, in some circumstances, You have the right to an expedited external appeal. See **Expedited External Appeals** below for more information.

You or your authorized representative must submit the following information to the Director of the Virginia Department of Human Resource Management (DHRM):

- Your full name
- Your identification number
- Your address
- Your telephone number
- The date(s) of the medical service
- Your specific medical condition(s) or symptom(s)
- Your provider's name
- The service or supply for which approval of benefits is being sought, and
- Any reasons why the appeal should be processed on an expedited basis.

You may also submit any additional information You wish to have considered in this review. However, You do not have to re-send any information that You sent to the Plan Administrator to consider during your internal appeal.

Claims appeals will be referred to an independent review organization that will render a written decision. The decision is binding on Your Health Plan, but if the decision is not in your favor, You have the right to further appeal to the circuit court under the Administrative Process Act. The circuit court ruling is binding on all parties. The Virginia Administrative Process Act addresses court review of administrative decisions at the Code of Virginia §2.2-4025 through Code of Virginia §2.2-4030. Part 2A of the Rules of the Virginia Supreme Court addresses appeals through the Administrative Process Act.

Standard External Appeals

Standard (non-expedited) external appeals must be submitted in writing to DHRM by traditional mail, e-mail or facsimile within four (4) months after the final adverse decision by your Plan Administrator.

You may download an appeals form at **www.dhrm.virginia.gov**

To appeal by traditional mail, send your request to the following address:
Director, Virginia Department of Human Resource Management
101 N. 14th Street – 13th Floor
Richmond, VA 23219

Please mark the envelope: Confidential – Appeal Enclosed.

To use e-mail, send your request to **appeals@dhrm.virginia.gov**

To use facsimile, fax your request to **804-786-0356**.

If your appeal request is incomplete or ineligible for external review, DHRM will inform You within six (6) business days of the reason(s) for ineligibility and what information or materials are needed to make your appeal request complete.

If your appeal request is complete and eligible for external review, DHRM will notify You within six (6) business days of the name and contact information of the independent review organization deciding your appeal. You will then have five (5) business days to provide any additional information to the independent review organization. The independent review organization has the discretion to accept additional information provided after this deadline.

Within forty-five (45) days after the independent review organization receives your appeal request, the independent review organization will send You or your authorized representative written notification of its decision.

Expedited External Appeals

Expedited external appeals may be submitted to DHRM by telephone, facsimile or e-mail at the time that You receive:

- An adverse decision from your Plan Administrator, if the adverse decision involves a medical condition for which the time frame for completing an expedited internal appeal (see **Expedited Internal Appeals** above) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and You or your authorized representative has requested an expedited internal appeal from the Plan Administrator;
- A final adverse decision of an internal appeal from the Plan Administrator, if the adverse decision involves a medical condition for which the time frame for completing a standard external appeal (see **Standard External Appeals** above) would seriously jeopardize

your life or health or would jeopardize your ability to regain maximum function, or if the final adverse decision concerns an admission, availability of care, continued stay, or health care service for which You received Emergency services, but have not been discharged from a Facility; or
- A final adverse decision of an internal appeal from the Plan Administrator, if the adverse decision involves prescriptions to alleviate cancer pain.

If You intend for your appeal to be expedited, clearly write "expedited" on the appeal request (and envelope, fax cover sheet, or e-mail subject line as appropriate).

To appeal by traditional mail, send your request to the following address:
Director, Virginia Department of Human Resource Management
101 N. 14th Street – 13th Floor
Richmond, VA 23219

Please mark the envelope: Confidential – Expedited Appeal Enclosed.

To use e-mail, send your request to **appeals@dhrm.virginia.gov**

To use facsimile, fax your request to **804-786-0356**.

To appeal by telephone, call **804-786-0353**.

If your appeal request is either incomplete or ineligible for external review, DHRM will promptly notify You of the reason(s) for ineligibility.

If your expedited appeal is complete and eligible for external review, the independent review organization will notify You or your authorized representative of its decision within 72 hours of the independent review organization's receipt of your appeal request. If this notification is given verbally, the independent review organization will send You or your authorized representative a written decision within 48 additional hours.

However, if the expedited appeal involves a determination that a requested medical service is Investigational or Experimental, then the following rules apply:
- The appeal must be accompanied by a written certification from your treating physician that the health care service or treatment would be significantly less effective if not promptly started.
- If your appeal request is either incomplete or ineligible for external review, DHRM will promptly notify You of the reason(s) for ineligibility.
- If your appeal is complete and eligible for external review, the independent review organization will notify You of its decision within seven (7) business days. If this notification is given verbally, a written notice will follow within 48 hours.

Other Appeals to DHRM

If an appeal involves an adverse eligibility determination (these are adverse determinations made by DHRM), then it should be submitted in writing to the Director of the Virginia Department of Human Resource Management (DHRM). Appeals to the Director must be filed within four (4) months of Your Health Plan's action or appropriate notification of that action, whichever is later.

To file such an appeal, You or your authorized representative must submit the following information to the Director of DHRM:

- Your full name
- Your identification number
- Your address
- Your telephone number
- A statement of the adverse decision You are appealing,
- What specific remedy You are seeking in filing this appeal, and
- Any reasons why the appeal should be processed on an expedited basis.

You may download an appeals form at **www.dhrm.virginia.gov**

To appeal by traditional mail, send your request to the following address:
Director, Virginia Department of Human Resource Management
101 N. 14th Street – 13th Floor
Richmond, VA 23219

Please mark the envelope: Confidential – Appeal Enclosed.

To use e-mail, send your request to **appeals@dhrm.virginia.gov**

To use facsimile, fax your request to **804-786-0356**.

You have the right to submit written comments, documents, records, and other information supporting your claim. The appeal will take into account all information that You submit, regardless of whether it was submitted or considered in the initial determination.

DHRM does not accept eligibility appeals for matters in which the sole issue is disagreement with policies, rules, regulations, contract or law. If You are unsure whether an eligibility determination can be appealed, call the Office of Health Benefits at **804-225-3642** or **888-642-4414.**

You are responsible for providing DHRM with all information necessary to review the denial of your claim. You will be allowed to submit any additional information You wish to have considered in this review, and You will have the opportunity to explain, in person or by telephone, why You think the determination should be overturned.

These appeals will be decided by the Director of DHRM, who will render a written decision. If the decision is not in your favor, You have the right to further appeal through the Administrative Process Act. The circuit court ruling is binding on all parties. The Virginia Administrative Process Act addresses court review of administrative decisions at the Code of Virginia §2.2-4025 through Code of Virginia §2.2-4030. Part 2A of the Rules of the Virginia Supreme Court addresses appeals through the Administrative Process Act.

11) Coordination of Benefits (COB)

COB helps to prevent duplicate payments from benefit plans for the same services. COB is an important provision because it helps to control the cost of your health care coverage. COB rules apply when You or members of your family have additional health care coverage through other group health plans, including:

- group insurance plans, other Blue Cross and Blue Shield Plans or HMO plans;
- labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

If You are a new hire, You will receive and will be required to respond to a COB inquiry letter following your enrollment in the health plan. All employees should notify Anthem if your coverage changes during your employment. You are responsible for ensuring that Anthem has accurate, up-to-date information on file. This means notifying Anthem if You add other coverage, change existing coverage or your other coverage cancels.

Primary Coverage and Secondary Coverage

When a Covered Person is also enrolled in another group health plan, one coverage will be primary and one will be secondary. The decision of which coverage will be primary or secondary is made using the order of benefit determination rules. Highlights of these rules are described below:

- If the other coverage does not have COB rules substantially similar to Your Health Plan's, the other coverage will be primary.
- If a Covered Person is enrolled as the employee under one coverage and as a dependent under another, generally the one that covers him or her as the employee will be primary.
- If a Covered Person is the employee under both coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the dependent is covered as a dependent on their parent(s) plan and they are also covered as a dependent on their spouse’s plan, the spouse’s plan is primary.
- If the Covered Person is enrolled as a dependent child under both coverages (for example, when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the calendar year will be the primary.
- Special rules apply when a Covered Person is enrolled as a dependent child under two coverages and the child's parents are living apart. Generally, the coverage of the parent or step-parent with custody will be primary. However, if there is a court order that requires one parent to provide health care for the child, that parent's coverage will be primary. If there is a court order that states that the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the Plan Year will be primary.
- If a covered active employee or employee's dependent is also covered by Medicare, the coverage provided by the employer is primary (unless Medicare eligibility is due to End Stage Renal Disease) and the coordination period has been exhausted.
- If a covered retiree, survivor, LTD participant or their covered dependent is eligible for Medicare, the Medicare-eligible member is no longer eligible for coverage under Your Health Plan (except during an End Stage Renal Disease coordination period). Refer to the section of the handbook “When You become eligible for Medicare” for more information.

When Your Health Plan is the primary coverage, it pays first. When Your Health Plan is the secondary coverage, it pays second as follows:

- The Plan Administrator calculates the amount Your Health Plan would have paid if it had been the primary coverage, then coordinates this amount with the primary plan's payment. Your Health Plan's payment in combination with the other plan's payment will never exceed the amount Your Health Plan would have paid if it had been your primary coverage.
- Some plans provide services rather than making a payment (i.e., a group model HMO). When such a plan is the primary coverage, Your Health Plan will assign a reasonable cash value for the services and that will be considered the primary plan's payment. Your Health Plan will then coordinate with the primary plan based on that value.
- In no event will Your Health Plan pay more in benefits as secondary coverage than it would have paid as primary coverage.

12) Overpayment of Benefits

If Your Health Plan overpays benefits because of COB, your Plan has the right to recover the excess from:

- any person to, or for whom such payments were made;
- any employer
- any insurance company; or
- any other organization.

You will be required to cooperate with Your Health Plan to secure this right.

13) Out-of-Pocket Expense Limit

For the **Basic Health Plan**, when You incur the Out-of-Pocket Expense Limit for covered Medical and Behavioral Health services in a Plan Year, almost all other covered Medical and Behavioral Health services are paid at 100% of the Allowable Charge for the rest of the Plan Year. If You have the **Out-of-Network** buy-up, refer to that section of the handbook for an explanation of the **Out-of-Pocket Expense Limit**.

*Expenses that **count** toward your Out-of-Pocket Expense Limit:*

- Deductible, Copayments and Coinsurance for covered services from Providers and Facilities in your Anthem, BlueCard PPO, or ValueOptions networks.

*Expenses that **do not count** toward your Out-of-Pocket Expense Limit:*

- services or supplies not covered by Your Health Plan;
- amounts above the Allowable Charge;
- amounts above the Health Plan limits;
- Copayments, Deductibles and Coinsurance for Outpatient Prescription Drugs, routine and expanded Dental services, and the optional routine vision and hearing services.

14) Notice from the Plan Administrator to You

A notice sent to You by the Plan Administrator is considered "given" when delivered to DHRM or your Benefits Administrator at the address listed in the Plan Administrator's records. If the Plan Administrator must contact You directly, a notice sent to You by the Plan Administrator is considered "given" when mailed to the member at the member's address listed in the Plan Administrator's records. Be sure that your Benefits Administrator has your current home address.

15) Notice from You to the Plan Administrator

Notice by You or your Benefits Administrator is considered "given" when delivered to the Plan Administrator. The Plan Administrator will not be able to provide assistance unless the member's name and identification number are in the notice.

16) Work-related Injuries or Diseases

Your Health Plan does not include benefits for services or supplies that are for work-related injuries or diseases when the employer, or worker if self-employed, must provide benefits by federal, state, or local law or when that person's work related health claims have been paid by the employer. This exclusion applies even if You waive your right to payment under these laws and regulations or fail to comply with procedures to receive the benefits. It also applies whether or not the Covered Person reaches a settlement with his or her employer or the employer's insurer or self-insurance association because of the Injury or disease.

17) Pre-existing Conditions

A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to enrollment in a health plan. Pre-existing conditions are covered under Your Health Plan. You do not have to satisfy a waiting period before services for pre-existing conditions are covered.

18) Fraud and Abuse

If You suspect fraud or abuse involving a claim, please notify the Plan Administrator by calling Member Services to report the matter for investigation.

19) Voluntary Health Services Review

For surgical services, it is recommended that You have your provider call Anthem to see if the service is covered in advance of receiving services and it's your obligation to check behind your provider to make sure the review has been done. You can also request a voluntary health services review directly with Anthem. If You sign a financial waiver from the provider or hospital then You may be responsible for services not covered by the health plan administrator.

20) Experimental/Investigative Criteria

Experimental/Investigative means any service or supply that is judged to be Experimental or Investigative at the Plan Administrator's sole discretion. Services which do not meet each of the following criteria will be excluded from coverage as Experimental/Investigative:

1) Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.

    a. This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the three standard reference compendia defined below:
        1) the U.S. Pharmacopoeia Dispensing Information
        2) the American Medical Association Drug Evaluations
        3) the American Hospital Formulary Service Drug Information

In substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or

b. In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

2) There must be enough information in the peer-reviewed medical and scientific literature to let the Plan Administrator judge the safety and efficacy.

3) The available scientific evidence must show a good effect on health outcomes outside a research Setting.

4) The service or supply must be as safe and effective outside a research Setting as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered Experimental/Investigative.

21) Clinical Trial Costs

Clinical trial cost means patient costs incurred during participation in a clinical trial when such a trial is conducted to study the effectiveness of a particular treatment of cancer where all of the following circumstances exist:

1) Coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer. Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

2) Treatment provided by a clinical trial is approved by:
   - The National Cancer Institute (NCI);
   - An NCI cooperative group or an NCI center;
   - The U.S. Food and Drug Administration in the form of an investigational new drug application;
   - The Federal Department of Veterans Affairs; or
   - An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

3) With respect to the treatment provided by a clinical trial:
   - There is no clearly superior, non-investigational treatment alternative;
   - The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; and
   - The Covered person and the physician or health care Provider who provides the services to the Covered person conclude that the Covered Person's participation in the clinical trial would be appropriate; and

4) The Facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise.

"Patient cost" under this paragraph means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Covered Person for purposes of a clinical trial. "Patient cost" does not include (i) the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer shall be determined in the same manner that reimbursement is determined for other medical and surgical procedures.

FACILITY SERVICES

HOSPITAL SERVICES

Medical services administered by Anthem Blue Cross and Blue Shield; Behavioral Health services administered by ValueOptions, Inc.

The charges made by a hospital for use of its facilities and services are eligible for Reimbursement under many circumstances.

Services Which Are Eligible for Reimbursement

1) Emergency room services leading directly to admission or which are rendered to a patient who dies before being admitted. In an Emergency, go to the nearest appropriate Provider or Medical Facility. For medical admissions, call Anthem to obtain Hospital Admission Review. For Behavioral Health admissions, contact ValueOptions.

2) Bed and board in a semi-private room, including general nursing services and special diets. A bed in an intensive care unit is eligible for Reimbursement for critically ill patients. Your Health Plan covers the charge for a private room if You need a private room because You have a highly contagious condition; You are at greater risk of contracting an infectious disease because of your medical condition; or if the hospital only has private rooms. Otherwise, You have coverage for a semi-private room. If You choose to occupy a private room, You will be responsible for paying the daily differences between the semi-private and private room rates in addition to any Copayment or Coinsurance that may apply.

3) Customary ancillary services for Inpatient Stays, including operating rooms, medications, oxygen and oxygen tents, dressings and casts, anesthesia, transfusions, diagnostic tests and therapy services, professional ambulance services for transportation between local hospitals when Medically Necessary, and routine nursery care of a newborn as part of a mother's covered maternity service.

4) If complications arise during a newborn’s confinement or if the newborn does not go home with the mother, a Hospital Admission Review would be required for the newborn. Eligibility criteria must be met for the newborn to receive benefits. Newborns must be added to the health plan within 60 days of the date of birth.

5) Detoxification and Partial Day Hospitalization for Behavioral Health services. These services are available on the same basis as Inpatient services.

6) Outpatient hospital services including Pre-admission Testing and other diagnostic tests, therapy services, shots, prescription medications received during treatment, surgical services, Inpatient ancillary services when unavailable in an Inpatient Facility, mammography, intensive Outpatient services for Behavioral Health services, and routine colonoscopy screening.

7) Dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis.

8) The cost of blood, blood plasma, blood derivatives, storage of blood by a hospital, or professional donor fees.

9) Your Health Plan offers an incentive if You enroll in the Future Moms maternity program within your first trimester. Refer to the section for Programs Included in Your Health Plan for more information about the program and incentive requirements.

Conditions for Reimbursement

1) Inpatient and Outpatient hospital services must be:

- prescribed by a Provider licensed to do so;
- furnished and billed by a hospital; and
- Medically Necessary.

2) In addition to any Copayment, Coinsurance and Deductible that apply, You may be financially responsible for the entire hospital bill if, after your admission to the hospital, the Plan Administrator finds that the Inpatient Stay was not Medically Necessary. In order to avoid this, You must comply with the following Hospital Admission Review procedure:

   a. You, your physician, the admitting physician, a family member, or a friend must contact the appropriate Plan Administrator by telephone or by letter prior to a non-Emergency Inpatient service and furnish the following information:

      - physician's name, address, and telephone number;
      - name and address of the hospital to which your admission is planned;
      - your name and member identification number;
      - anticipated admission date and length of Stay; and
      - medical justification for Inpatient treatment.

   After an Emergency admission, You, your physician, the admitting physician, a family member, or a friend must contact the appropriate Plan Administrator within 48 hours or, if later, the next business day after the admission to furnish the above information.

   b. You, your physician, the admitting physician, a family member, or a friend must receive a response from the appropriate Plan Administrator, either approval or disapproval, prior to the rendering of the non-Emergency Inpatient service.

   The Plan Administrator will respond to a Hospital Admission Review request within 24 hours after its receipt. The Plan Administrator may request additional information in order to determine whether to approve or disapprove benefits for an Inpatient service. In this case, the Plan Administrator will respond with an approval or disapproval within 24 hours after the necessary information is supplied.

   Hospital admissions for a covered laparoscopy-assisted vaginal hysterectomy will be approved for a period no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy will be approved for a period no less than 48 hours unless otherwise determined by your Provider.

   Admissions for maternity care do not initially require Hospital Admission Review. The length of Stay for maternity admissions is determined according to the Newborn’s and Mother’s Health Protection Act. The federal law allows for 48 hours for vaginal delivery and 96 hours for caesarian section. However, if complications develop and additional days are necessary, Hospital Admission Review is required. Have your doctor contact Anthem to establish eligibility.

Refer to the Basic Plan Provisions section for Women's Health and Cancer Rights.

If, as a part of the Hospital Admission Review program, the Plan Administrator determines that a contemplated Inpatient service is not Medically Necessary and the member elects to proceed with the Inpatient service despite this determination, the Plan Administrator will deny this service as not Medically Necessary unless additional information is provided indicating a contrary result is warranted. You are financially responsible for hospital services which are not Medically Necessary.

3) Members are encouraged to have all Behavioral Health services pre-authorized, unless the rules for emergencies apply. Authorization is required within 48 hours of an Emergency.

4) A health service review (pre-service review) is required for diagnostic imaging services including:

- Cardiac nuclear studies (such as cardiac stress tests);
- Computed tomography (CT), computed tomographic angiography (CTA) scans;
- Magnetic resonance imaging (MRI), magnetic resonance angiography (MRA);
- Magnetic resonance spectroscopy (MRS);
- Positron emission tomography (PET): and
- Single photon emission computed tomography (SPECT) scans

This list of services is only a sampling and may change, so always check with your Provider or Plan Administrator's Member Services for the most current and complete list. While there is no penalty if the pre-service is not performed in advance of receiving the service, the advantage of the pre-service review is that You and your Provider know beforehand whether the service is appropriate, Medically Necessary, and meets coverage guidelines. If advance approval is not obtained, payment of the claim may be delayed. Also, if the service is later determined not to be Medically Necessary, You may have to pay for the service.

5) If specialty care is required and it is not available from a Provider within the network, your Provider can call Anthem or ValueOptions in advance of your receiving care to request authorization for coverage.

6) Emergency Room services have an Outpatient Facility Copayment as well as Coinsurance for diagnostic services. If You are transferred from one Emergency Room to another and admitted at the second hospital, You are only responsible for the Inpatient Copayment to the second hospital. The first Emergency Room visit would be covered at 100% of the Allowable Charge.

Special Limits

1) None

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible, Copayment or Coinsurance for covered services in a network hospital during approved admissions.

Member Pays

Inpatient services	$300 per Stay[1]
Pre-admission testing	$0
Outpatient services	$125 per Visit (waived if admitted from Emergency room)
Diagnostic services	20% of the Allowable Charge after the Plan Year Deductible
Dialysis treatments	$0
Infusion services (IV therapy)	20% of the Allowable Charge after the Plan Year Deductible
Therapeutic injections (shots)	20% of the Allowable Charge after the Plan Year Deductible

[1] Is the period from the admission to the date of discharge from a Facility. All hospital Stays less than 90 days apart for the same diagnosis are considered the same Stay, and a new hospital Inpatient Copayment will not apply. If You are readmitted within 90 days for a different diagnosis, a Copayment will apply.

SKILLED NURSING FACILITY SERVICES

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

1) Your Health Plan will cover your semi-private room in a network Skilled Nursing Facility. The room charge includes your meals, any special diets, and general nursing services. You are also entitled to receive the same types of ancillary services which are available to a hospital Inpatient.

2) Your Health Plan will cover the private room charge if You need a private room because You have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your Inpatient benefits would cover the Skilled Nursing Facility's charges for a semi-private room. If You choose to occupy a private room, You will be responsible for paying the daily differences between the semi-private and private room rates in addition to your Copayment and Coinsurance (if any).

Conditions for Reimbursement

1) Care which is necessary for a person who does not have a treatable medical illness or injury is not covered. For example, a person is not eligible for covered care in a Skilled Nursing Facility simply because the person is unable to care for himself (that is, the person cannot perform several Activities of Daily Living, such as bathing or feeding).

2) Skilled Nursing Facility Services must also be:

   - medically skilled services;
   - prescribed by your Provider and listed in the plan of treatment;
   - furnished and billed for by the Skilled Nursing Facility; and
   - Medically Necessary.

3) You may be financially responsible for the entire Skilled Nursing Facility bill if, after your admission to the Skilled Nursing Facility, the Plan Administrator finds that the Inpatient Stay was not Medically Necessary. In order to avoid this, You must comply with the following procedure.

   a. You, your physician, the admitting physician, family member, or a friend must contact the Plan Administrator by telephone or by letter prior to a non-Emergency Inpatient service and furnish the following information:

      - physician's name, address, and telephone number;
      - name and address of the Skilled Nursing Facility to which your admission is planned;
      - your name and member identification number;
      - anticipated admission date and length of Stay; and
      - medical justification for Inpatient treatment.

   b. You or your physician must receive a response from the Plan Administrator, either approval or disapproval, prior to the rendering of the non-Emergency Inpatient service.

      The Plan Administrator will respond to a Skilled Nursing Facility admission review request within 24 hours after its receipt. The Plan Administrator may request additional

information in order to determine whether to approve or disapprove benefits for an Inpatient service.

In this case, the Plan Administrator will respond with an approval or disapproval within 24 hours after the necessary information is supplied.

- If, as a part of the Skilled Nursing Facility admission review procedure the Plan Administrator determines that a contemplated Inpatient service is not Medically Necessary and the member elects to proceed with the Inpatient service despite this determination, the Plan Administrator will deny this service as not Medically Necessary unless additional information is provided indicating a contrary result is warranted. You are financially responsible for Skilled Nursing Facility services which are not Medically Necessary.

c. The Plan Administrator may not require the Skilled Nursing Facility admission review procedure to be followed for admissions that arise over the weekend.

Special Limits

1) Days of Inpatient care 180 days per Stay[1]

Health Plan Reimbursement

Your Health Plan pays the Allowable Charge for services in a network Skilled Nursing Facility during approved admissions.

Member Pays

No Copayment or Coinsurance.

[1] A Stay is the period from the admission to the date of discharge from a Facility. If there is less than a 90 day break between two admissions, the days allowable for the subsequent admission are reduced by the days used in the first. If there are more than 90 days between the two admissions, the days available for the subsequent admission start over for a full 180 days.

HOME HEALTH SERVICES

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

Home Health Services include:

1) Professional Medical services.

2) Periodic skilled nursing care for needs that can only be met by a Licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) under the supervision of an R.N.

3) Therapy services.

4) Medical social services provided by a licensed clinical social worker or social services assistant under the guidance of a licensed clinical social worker.

5) Services eligible for coverage by a home health aide for personal care provided the member has a skilled need and the services are under the supervision of an R.N.

6) Nutritional guidance, but limited to individual consultation by an R.N. or qualified dietician.

7) Diagnostic tests, non-covered therapy services, and similar services which would be covered if You were an Inpatient in a hospital. These services are also covered when received in your Provider's office or the Outpatient department of a hospital, but the services must be arranged through the network home health care agency.

8) Ambulance services if prearranged by your physician and authorized by the Plan Administrator if, because of your medical condition, You cannot ride safely in a car when You go to your Provider's office or to the Outpatient department of the hospital. Ambulance services will be covered if your condition suddenly becomes worse and You must go to a local hospital's Emergency room.

9) Supplies normally used in a hospital for an Inpatient, but these supplies must be dispensed by the network home health care agency.

10) Administration of drugs prescribed by your Provider.

Conditions for Reimbursement

1) Home Health Services must be medically skilled services provided in your home and:

   - prescribed by a Provider licensed to do so;
   - listed in your plan of treatment filed with the Plan Administrator;
   - furnished and billed by a network home health care agency;
   - services that the Plan Administrator approved for payment before services are rendered, and Medically Necessary.

2) You must be homebound for medical reasons. You must be physically unable to obtain medical care as an Outpatient. You will still be considered homebound for medical reasons if You must go to the Outpatient department of the hospital because the services You need cannot be furnished in your home.

3) You must be under the active care of a Provider to be eligible for Home Health Services. Your Provider must certify to the Plan Administrator in writing that You would have to be admitted as an Inpatient to a hospital or Skilled Nursing Facility if Home Health Services were not available. Approval would be subject to review by the Plan Administrator for appropriateness in accordance with medical policy.

4) Home Health Services will be provided after your discharge from a hospital as an Inpatient only when the Plan Administrator has received and approved your plan of treatment in advance.

5) If You are not first confined in a hospital, Home Health Services will be provided only when the Plan Administrator has received and approved your plan of treatment in advance.

6) Services must follow your plan of treatment. Your plan of treatment must be included in your medical record. Your medical record must be reviewed by your Provider at regular intervals. A copy of your plan of treatment must be filed with the Plan Administrator before Home Health Services can begin. Any changes to your plan of treatment must be approved for payment in advance by the Plan Administrator.

7) Services must be furnished by trained health care workers employed by the network home health care agency. A network home health care agency may make arrangements with another health care organization to provide You with a Home Health Service, but the Plan Administrator must approve any such arrangement with another health care organization in writing in advance.

8) The following rules apply only to Visits for Home Health Services:

   - when a health care worker comes to your home more than once a day to provide Home Health Services, each Visit will be counted as a separate Visit;
   - when two or more health care workers come to your home at the same time to provide a single service, the joint Visit will be counted as one Visit;
   - when two or more health care workers come to your home to provide different types of Home Health Services, the Visit of each health care worker will be counted as a separate Visit; and
   - when special Medical Equipment is needed that cannot be brought into your home, each time You leave home to use the equipment will be counted as a separate Visit.

9) Approval of a plan of treatment, or any part of a plan of treatment, or any arrangement with another health care organization means only that the Plan Administrator will later consider these services for payment. The Plan Administrator's approval is neither an endorsement of the quality of the service nor a waiver of any term or condition of this contract.

10) Disapproval of a plan of treatment, or any part of a plan of treatment, or any arrangement with another health care organization means only that the Plan Administrator has determined in advance the services are not covered under this section. Some private duty nursing services, medical supplies, and Medical Equipment (durable) may be covered as separately listed under Other Covered Services. Please see the Other Covered Services section.

    You may still elect to receive any other services disapproved by the Plan Administrator, but these will be at your own expense.

11) Therapy services must be rendered by a therapist qualified to do so.

12) Your need for personal care must be determined by the R.N. working for the network home health care agency. The R.N. must assign duties to the home health aide. Personal care may include non-medically skilled services. The words "personal care" mean:

- helping You walk;
- helping You take a bath;
- helping You dress;
- giving You medicine; and
- teaching You self-help skills.

Special Limits

1) Visit maximum 90 Visits per Plan Year

2) Payment will not be made for:

- homemaker or housekeeping services;
- housing, food, home delivered meals, or "Meals on Wheels";
- services not listed in your attending Provider's plan of treatment, except for ambulance services to a hospital Emergency room;
- counselor's services;
- services which are or are related to diversional, recreational, or social activities; or
- prosthetic devices, appliances, and orthopedic braces.
- Convenience services or supplies that could be taken care of by the family (like simple dressing changes or a bedside table)

Health Plan Reimbursement

Your Health Plan pays the Allowable Charge.

Member Pays

There is no Copayment, Deductible or Coinsurance for services billed as Home Health Services.

Services billed in conjunction with Home Health Services are subject to the applicable Copayment, Deductible or Coinsurance.

PROFESSIONAL SERVICES

MEDICAL, SURGICAL, AND BEHAVIORAL HEALTH SERVICES

Medical services administered by Anthem Blue Cross and Blue Shield; Behavioral Health Services administered by ValueOptions, Inc.

This section explains which Medical, surgical, and Behavioral Health services from health professionals may be eligible for Reimbursement. In general, the professional services of authorized Providers are eligible for Reimbursement if they are Medically Necessary and rendered within the scope of the Provider's license.

Services Which Are Eligible for Reimbursement

1) Inpatient Medical, surgical, and Behavioral Health services. These services are specifically included:

    - surgical services;
    - reconstructive surgery to restore a body function, correct congenital or developmental deformity which causes functional impairment, or relieve pain;
    - operative procedures for sterilization or to reverse a sterile condition;
    - multiple surgeries;
    - assistant surgeon's services;
    - maternity services rendered during an Inpatient Stay:
        - routine delivery services (Cesarean birth is a surgical service);
        - anesthesia services to provide complete or partial loss of sensation before delivery;
        - services for complications of pregnancy;
        - services for miscarriage or other interruptions of pregnancy; and
        - services for the care of a newborn child if the child is an eligible dependent at the time the services are rendered such as:
            - initial examination of a newborn and circumcision of a covered male dependent
            - hospital services for non-routine nursery care for the newborn should complications arise that require the newborn to be admitted
            - newborns must be added to the health plan within 60 days of the date of birth
    - anesthesia services rendered by a second physician;
    - Medical and Behavioral Health Visits by a Provider, including:
        - intensive Medical services (when your Medical condition requires a Provider's constant attendance and treatment for a prolonged period of time);
        - concurrent care (treatment You receive from a Provider other than the operating surgeon for a medical condition separate from the condition for which You required surgery);
        - Behavioral Health evaluative and concurrent services; and
        - consultative services from a Provider other than the attending Provider.

2) Outpatient medical, surgical, and Behavioral Health services, including:

    - office visits;
    - surgical services;
    - Telemedicine
    - maternity services including Visits to a Provider for routine pre- and postnatal care;
    - delivery of a newborn at home by a Provider;
    - anesthesia services;

- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies;
- Medical services to diagnose or treat your illness or injury;
- diagnostic tests;
- therapy services;
- shots;
- diabetes Outpatient self-management training and education performed in person; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional. These services are only covered when billed by a medical provider or the outpatient department of a hospital. Diabetic education is covered at no cost to You;
- a Medical or surgical service if performed by a Provider's employee who is licensed to perform the service; and
- prescription medications that require administration by a health professional including contraceptive devices and injections.

3) Treatment of morbid obesity

Your Health Plan covers treatment of morbid obesity through gastric bypass, or other methods recognized by the National Institutes of Health (NIH). According to the NIH guidelines, gastric bypass surgery is effective for the long-term reversal of morbid obesity for a patient who:

- weighs at least 100 pounds over or twice the ideal body weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables;
- has a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- has a body mass index of 40 kilograms per meter squared, without such comorbidity.

As used above, body mass index equals weight in kilograms divided by height in meters squared.

Your Health Plan also covers some services (such as abdominoplasties, panniculectomies, and lipectomies) to correct deformity after a previous therapeutic process involving gastric bypass surgery, other bariatric surgery procedures, or other methods of weight loss.

In order to be covered, a service must be Medically Necessary. Before rendering any of these services, your Provider should contact the Plan Administrator and request a medical necessity review. Ultimately, it is your responsibility to ensure that the service is authorized for medical necessity.

If prior authorization is not obtained and the services are retrospectively denied, You are responsible for payment of non-covered service(s).

<u>Pre-surgery program</u>
If You are seeking bariatric surgery, You are required to participate in a 12 month pre-surgery program. The goal of this program is to help bariatric surgery candidates break through personal barriers to achieve safe and effective long-term weight loss.

Getting started: Your bariatric surgeon will contact Anthem to request prior authorization for your surgery. If You meet the surgery criteria, You must enroll in the 12 month pre-surgery program. After completing the program, You, your surgeon and an Anthem case manager will determine if bariatric surgery is the best option for You and whether it may be approved under the surgery guidelines.

Pre-surgery program components:
Weight coach: Once You enroll in the program, a ValueOptions weight management coach will provide 12 months of one-on-one goal-oriented support. Your weight coach will help You understand the emotional and behavioral issues that are often linked to weight problems, and work with You toward nutrition and exercise goals.

Weight loss program: You will be required to participate in 12 months of a weight loss program to help You make the best possible food and nutrition choices, and reach your weight loss goals. Enroll within 30 days of registering with your ValueOptions weight management coach.

Post-surgery program
If surgery takes place: You will have the option for continued weight coach support for up to 24 months after surgery. This will help You transition to the changes in your life required for a long-term successful outcome of your surgery. If You remain in the coaching program for 12 months, your plan will refund one-half of your Inpatient hospital Copayment or one-half of the Outpatient hospital Copayment. If You stay in the program for a full two years, You will receive a refund of the remaining amount.

The incentives offered with this program may be taxable under federal and state law.

Conditions for Reimbursement

1) Medical, surgical, and Behavioral Health services must be:

   - medically skilled services;
   - billed for by a Provider in private practice;
   - services which the Provider is licensed to render; and
   - Medically Necessary.

2) When two or more surgical services are performed during a single operative session, the Allowable Charge for the combined services will be calculated as follows:

   - the Allowable Charge for the primary, or major, surgical service performed; plus
   - a reduced percentage of what the Allowable Charge would have been for each additional surgical service if these services had been performed alone.

3) Assistant surgeon's services are covered if the operating surgeon explains to the Plan Administrator, upon request, why this surgical service requires the skills of two surgeons. When two or more surgeons provide a surgical service which could reasonably have been performed by one surgeon, the Allowable Charge for this surgical service will not exceed the Allowable Charge available to one surgeon.

4) Inpatient consultative services are covered provided that the services are requested by your attending Provider. The Provider rendering the consultative services must examine You and must enter a signed consultation note in your medical record.

5) If You are admitted to the hospital for an Emergency, You, your physician, the admitting physician, a family member, or a friend must contact the Plan Administrator within 48 hours or, if later, the next business day.

6) For maternity care, if your physician submits one bill for delivery, prenatal, and postnatal care services (global billing), payment will be made at the same level as Inpatient professional provider services. Services for diagnostic labs and X-rays are not part of the global maternity billing and are therefore considered under your Health Plan benefits for those services.

   If your physician bills for delivery, prenatal and postnatal care services separately (non-global billing) or if You change Providers during the course of your maternity care, your payment responsibility will be determined by the services received.

7) It is recommended that You have your Provider call the Plan Administrator to see if the service is covered in advance of receiving services and it is your obligation to check with your provider to make sure the review has been done. You can also request a voluntary health services review directly with the Plan Administrator. If You sign a financial waiver from the Provider or hospital then You may be responsible for services not covered by the Health Plan.

Special Limits

1) For maternity, You must add your newborn to your plan within 60 days of the date of birth, or your newborn will not be covered.

2) Inpatient professional services in a Skilled Nursing Facility are limited to 180 days per Stay.

3) The Employee Assistance Program provides up to four Visits per incident per year for members and eligible “household” members.

4) If a Visit is part of a Home Health Services program, it will reduce by one the maximum number of Visits available for Home Health Services.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible, Copayment or Coinsurance.

Separate benefits will not be provided for routine pre- and post-operative care. The Plan Administrator takes these services into account when determining its Allowable Charge for a surgical service.

When the same physician performs both the surgical or maternity service and the anesthesia service, the Allowable Charge for the anesthesia service will be 50% of what the Allowable Charge would have been if a second physician had performed the anesthesia service.

Member Pays

Inpatient care:	
Participating Providers	$0
Outpatient Medical services:	
Primary Care Physician	$25 per Visit
Specialty Care Providers	$40 per Visit
Outpatient Therapy Services: Physical, Occupational, Speech Therapy; Chiropractic, Spinal Manipulation, Manual Medical Intervention	$35 per Visit
Outpatient Behavioral Health services:	
Non-medical Professional[1]	$25 per Visit
Medical Specialty Provider	$25 per Visit
Outpatient diagnostic services	20% of the Allowable Charge after the Plan Year Deductible
EAP Visits (up to four Visits per incident per rolling 12 months)	$0

[1] A Non-medical Professional is a licensed professional with a master's or PhD degree.

BEHAVIORAL HEALTH SERVICES AND EMPLOYEE ASSISTANCE PROGRAM (EAP)

Administered by ValueOptions®, Inc.

Services Which Are Eligible for Reimbursement

Behavioral Health Services

1) Eligible Behavioral Health services are covered if Medically Necessary. Services for alcohol and substance abuse may be reimbursable when rendered in an Outpatient Setting such as an Intensive Outpatient program.

2) Detoxification and Partial Day Hospitalization may be reimbursable when rendered in an Inpatient Setting.

3) Telemedicine

Employee Assistance Program (EAP)

1) The Employee Assistance Program (EAP) is a free, voluntary, confidential service to help You and your family members deal with personal challenges that can be addressed through short-term counseling, such as stress, anxiety, and marital or family difficulties.

2) The EAP provides up to four counseling sessions per issue free of charge for You and any "household" members. Access to care starts with a phone call to ValueOptions at **866-725-0602**. Counselors are available to take your call 24 hours a day, seven days a week, to help You address:

   - marriage and family
   - stress
   - caregiving
   - staying healthy
   - daily life challenges

   After assessing your situation, a counselor will recommend whether your care should be provided through the EAP.

   You can also call the EAP for guidance on a number of legal and financial issues, including divorce, domestic violence, estate planning and family budgeting. If You need additional legal or financial assistance, the EAP counselor will refer You to a carefully screened attorney or financial counselor in your community.

3) All services through ValueOptions are voluntary and confidential in accordance with state and federal laws. ValueOptions will not disclose information to anyone without your explicit written authorization, except within federal and state guidelines for release of confidential information.

Conditions for Reimbursement

1) You are encouraged to have all Behavioral Health services preauthorized by calling ValueOptions at **866-725-0602** before receiving care, or within 48 hours of an Emergency admission. This includes all Inpatient, partial hospitalization, and Outpatient Behavioral Health services. While Preauthorization is not required, it does ensure that You are using a participating Provider and that services are covered and Medically Necessary. If services are not considered Medically Necessary to treat a condition, or if You use a non-ValueOptions participating Provider, benefits will not be payable. (See the **Optional benefits** section for information about the out-of-network optional benefit.)

2) When You receive care from a Provider to whom You have been referred by ValueOptions, the Provider works with a ValueOptions care manager to ensure that the services You receive are covered under Your Health Plan. Professional staff members are available 24 hours a day, every day, to answer questions, assist with referrals to participating Providers, and preauthorize care. When You do not obtain preauthorization, You are responsible for making sure that the services You receive are Medically Necessary for your condition.

3) In the event of a Behavioral Health or substance abuse crisis, Behavioral Health professionals are available at all times to assist You and to connect You to the appropriate local resources to ensure that your situation is managed safely.

Special Limits

1) Residential treatment is not a covered benefit.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible, Copayment or Coinsurance for covered services in a network hospital during approved admissions.

Member Pays

Inpatient services	$300 per Stay[1]
Partial Day Program	$300 per Stay[1]
Outpatient Facility services	$125 per Visit (waived if admitted from Emergency room)
Non-medical Professional[2]	$25 per Visit

[1] Is the period from the admission to the date of discharge from a Facility. All hospital Stays less than 90 days apart for the same diagnosis are considered the same Stay, and a new hospital Inpatient Copayment will not apply. If You are readmitted within 90 days for a different diagnosis, a Copayment will apply.

[2] A Non-medical Professional is a licensed professional with a master's or PhD degree.

Member Pays (cont.)

Medical Specialty Provider	$25 per Visit
Outpatient Diagnostic services	20% of the Allowable Charge after the Plan Year Deductible
EAP Visits (up to four Visits per incident per rolling 12 months)	$0

CHIROPRACTIC, SPINAL MANIPULATION AND OTHER MANUAL MEDICAL INTERVENTION SERVICES

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

1) Spinal manipulations and other manual medical interventions and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations are eligible for Reimbursement. These services are most commonly performed by a chiropractor, general practitioner, physical therapist or osteopath.

Conditions for Reimbursement

1) Services must be:

- performed by a licensed chiropractor or licensed medical Provider;
- billed for by a chiropractor in private practice or a Provider;
- those which the Provider is licensed to render; and
- Medically Necessary.

Special Limits

1) Reimbursement is limited to 30 visits per Plan Year per member.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Copayment.

Member Pays

Outpatient Medical services:

Primary Care Physician	$25 per Visit
Chiropractor, Physical Therapist	$35 per Visit

WELLNESS AND PREVENTIVE CARE SERVICES

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

Child Wellness and Preventive Care (Birth to 18 years)

The following wellness and preventive care screening services are covered:

- Newborn screenings
- Vision screening
- Hearing screening
- Developmental and behavioral assessments
- Oral health assessment
- Screening for lead exposure
- Hemoglobin or hematocrit (blood count)
- Blood pressure
- Height, weight and body mass index (BMI)
- Cholesterol and lipid level screening
- Screening for depression
- Screening and counseling for obesity
- Behavioral counseling to promote a healthy diet
- Screening for sexually transmitted infections
- Pelvic exam and Pap test, including screening for cervical cancer

The following wellness and preventive care immunizations are covered:

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DTap)
- Varicella (chicken pox)
- Influenza (flu)
- Pneumococcal (pneumonia)
- Human Papillomavirus (HPV)
- Haemophilus Influenza type b (Hib)
- Polio
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- Rotavirus

The following immunization schedule is recommended for children from birth through 6 years old by The U.S. Department of Health and Human Services Centers for Disease Control and Prevention in partnership with The American Academy of Family Physicians and the American Academy of Pediatrics:

- Birth
- 3-5 days
- 2-4 weeks
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- 4 years
- 5 years
- 6 years

Follow your Pediatrician’s recommendation for well child and immunization visits.

Adult Wellness and Preventive Care (19 years and older)

The following wellness and preventive care screening services are covered:

- Annual wellness check-up
- Gynecological examination
- Pap test
- Mammography screening
- Prostate exam (digital rectal exam)
- Prostate specific antigen test (PSA)
- Colorectal cancer screening, including
  - one fecal occult blood test; and
  - one flexible sigmoidoscopy, or colonoscopy or double contrast barium enema
- Eye chart vision screening
- Hearing screening
- Cholesterol and lipid level screening
- Blood pressure
- Height, weight and BMI
- Screening for depression
- Diabetes screening
- Screening for sexually transmitted infections
- HIV screening
- Bone density test to screen for osteoporosis
- Aortic aneurysm screening (men)
- Screenings during pregnancy (including but not limited to, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)

The following wellness and preventive intervention services (includes counseling and education) are covered:

- Screening and counseling for obesity
- Genetic counseling for women with a family history of breast and/or ovarian cancer
- Behavioral counseling to promote a healthy diet
- Primary care intervention to promote breastfeeding
- Counseling related to aspirin use, folic acid and iron, for the prevention of cardiovascular disease (does not include coverage for aspirin, folic acid and iron)
- Screening and behavioral counseling related to tobacco use
- Screening and behavioral counseling related to alcohol misuse

The following wellness and preventive immunizations are covered:

- Hepatitis A
- Hepatitis B
- Tetanus, Diphtheria, Pertussis (Tdap)
- Varicella (chicken pox)
- Influenza (flu)
- Pneumococcal (pneumonia)
- Human Papillomavirus (HPV)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- Zoster (shingles)

Conditions for Reimbursement

1) Services must be:

   - billed for by a Provider in private practice;
   - services which the Provider is licensed to render; and
   - deemed age appropriate by the Provider.

2) Wellness immunizations must be received in the Provider's office or through the outpatient pharmacy benefit. Routine immunizations are not covered in an Outpatient hospital Setting.

3) Colorectal cancer screenings are covered in the Provider's office or Outpatient hospital Setting.

Special Limits

1) Preventive services are limited to one each per Plan Year.

2) A preventive screening may identify abnormalities or problems that require immediate intervention or additional diagnosis. If this occurs, and your Provider performs additional necessary covered services, these additional services will generally be covered as diagnostic and/or surgical services and not as preventive care services. As such, they may be subject to a copayment and/or coinsurance. You are entitled to routine preventive benefits even if you have an existing medical condition or if you have a family history of a medical condition.

3) Immunizations, laboratory and x-ray services that are completed within five calendar days before or after the annual wellness check-up visit will be covered at 100%. It is your responsibility to inform the Provider when the purpose of your visit is for the annual wellness check-up.

Health Plan Reimbursement

Your Health Plan pays the Allowable Charge.

Member Pays

No Copayment, Deductible or Coinsurance.

THERAPY SERVICES

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

Therapy services include: [1]

1) Cardiac rehabilitation, which is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

2) Chemotherapy for the treatment of disease by chemical or biological antineoplastic agents.

3) Infusion therapy (IV therapy), which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.

4) Occupational therapy, which is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.

5) Physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. Your coverage includes benefits for physical therapy to treat lymphedema.

6) Radiation therapy, including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.

7) Respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

8) Speech therapy, which is treatment for the correction of a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment.

Conditions for Reimbursement

1) Your Health Plan covers therapy services when the treatment is Medically Necessary for your condition and provided by a licensed Provider.

Special Limits

1) None

[1] Chiropractic, Spinal Manipulation and Other Manual Medical Intervention Services have a dollar limit. This benefit is defined in its own section of this book.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Copayment.

Member Pays

• Cardiac rehabilitation therapy	$0
• Chemotherapy	$0
• Infusion therapy	20% Coinsurance after Deductible
• Occupational therapy	$25 per Visit, Primary Care Physician $35 per Visit, Specialty Care Provider
• Physical therapy	$25 per Visit, Primary Care Physician $35 per Visit, Specialty Care Provider
• Radiation therapy	$0
• Respiratory therapy	$0
• Speech therapy	$25 per Visit, Primary Care Physician $35 per Visit, Specialty Care Provider

EARLY INTERVENTION SERVICES

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

Early intervention services are for covered dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services (DBHDS) as eligible for services under Part C of the Individuals with Disabilities Education Act (IDEA). You are responsible for contacting your local DBHDS agency to initiate certification.

1) These services consist of:

- speech and language therapy;
- occupational therapy;
- physical therapy; and
- assistive technology services and devices; for example, hearing aids, glasses and durable Medical Equipment.

Conditions for Reimbursement

1) Early intervention services for the population certified by DBHDS are those services listed above which are determined to be Medically Necessary by DBHDS and designed to help an individual attain or retain the capability to function age-appropriately within his environment.

2) This shall include services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not Medically Necessary.

Special Limits

1) Physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal is only available for children under age 3 who qualify for early intervention services.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible, Copayment or Coinsurance.

Member Pays

Early intervention services determined by service received	Deductible/Copayment/Coinsurance

HOSPICE CARE SERVICES

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

1) Hospice care services are available if You are diagnosed with a terminal illness with a life expectancy of six months or fewer.

2) Hospice care services include a program of home and Inpatient care provided directly by or under the direction of a licensed hospice.

3) Hospice care programs include palliative and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team.

Conditions for Reimbursement

1) Hospice care services must be:

- prescribed by a Provider licensed to do so;
- furnished and billed by a licensed hospice; and
- Medically Necessary.

Special Limits

1) None

Health Plan Reimbursement

Your Health Plan pays the Allowable Charge.

Member Pays

No Copayment, Deductible or Coinsurance.

OTHER COVERED SERVICES

Medical services administered by Anthem Blue Cross and Blue Shield; Behavioral Health services administered by ValueOptions, Inc.

Services Which Are Eligible for Reimbursement

1) Professional ambulance services to or from the nearest Facility or Provider adequate to treat your condition. Air ambulance services are also covered when pre-authorized or in cases of threatened loss of life. In determining whether any ambulance services will be pre-authorized, the Plan Administrator will take into account whether appropriate, cost-effective care is being provided at the Facility where the Covered Person is located.

2) Medical supplies are covered if they are prescribed by a covered Provider. Examples of medical supplies are oxygen and equipment (respirators). Some medical supplies require medical necessity review. Contact Anthem Member Services at **800-552-2682.**

3) The cost of fitting, adjustment, and repair of the following items when prescribed by your doctor for Activities of Daily Living:

   - artificial limbs, including accessories;
   - orthopedic braces;
   - leg braces, including attached or built-up shoes attached to the leg brace;
   - arm braces, back braces and neck braces;
   - head halters;
   - catheters and related supplies;
   - orthotics, other than foot orthotics;
   - splints;
   - breast prostheses; and
   - wigs.

4) The rental (or purchase if that would be less expensive) of Medical Equipment (durable) when prescribed by your doctor. Also covered are maintenance and necessary repairs of Medical Equipment (durable) except when damage is due to neglect. Network Medical Equipment (durable) Providers are shown in the Anthem Commonwealth of Virginia and The Local Choice Medical Provider Directory under Ancillaries, Durable Medical Equipment. If You obtain equipment from a non-network Medical Equipment (durable) Provider, You will still have coverage. However, in addition to your Deductible and Coinsurance, the non-network Provider may bill You for the difference between the Allowable Charge and the Provider's charge.

   Coverage includes equipment such as:

   - nebulizers;
   - hospital-type beds;
   - wheelchairs;
   - traction equipment;
   - walkers; and
   - crutches.

   In addition, rental of Medical Equipment (durable) will be provided for a limited time for a condition for which You received covered services before your coverage ended. The time

will be the shorter of when You become covered under any other group coverage, or the end of the Plan Year your coverage ends, or a period equal to the time You were enrolled under Your Health Plan.

Medical necessity review is required. Contact Anthem Member Services at **800-552-2682** for assistance with medical necessity review.

5) Special medical formulas which are the primary source of nutrition for Covered Persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

6) Covered diabetic equipment includes:

   - insulin pumps and associated supplies;
   - lancet devices; and
   - calibrator solution.

7) Home private duty nursing services when the medically skilled services are provided by a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in your home and the nurse is not a relative or member of your family. Your doctor must certify to Anthem that private duty nursing services are Medically Necessary for your condition, and not merely custodial in nature.

8) The following prescribed eyeglasses or contact lenses are eligible for Reimbursement only when required as a result of surgery or for treatment of accidental injury:

   a. eyeglasses or contact lenses which replace human lenses lost as the result of intra-ocular surgery or accidental injury to the eye;
   b. "Pinhole" glasses used after surgery for a detached retina; or
   c. lenses used instead of surgery, such as:
      - contact lenses for the treatment of infantile glaucoma;
      - corneal or sceleral lenses in connection with keratoconus;
      - sceleral lenses to retain moisture when normal tearing is not possible or is not adequate; or
      - corneal or sceleral lenses to reduce a corneal irregularity (other than astigmatism).

   A maximum of one set of eyeglasses or one set of contact lenses will be covered for your original prescription or for any change in your original prescription. Examination and replacement for a prescription change are covered only when the change is due to the condition for which You needed the original prescription.

Conditions for Reimbursement

1) With respect to private duty nursing services, only services by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) are covered. Also,
   - these services must be Medically Necessary;
   - the nurse may not be a relative or member of your family;
   - your Provider must explain why the services are required; and
   - your Provider must describe the medically skilled service provided.

2) For Medical Equipment (durable), your Provider must, upon request, explain why the equipment is needed and how long it will be used.

3) For coverage of ambulance services:

- The trip to the Facility or office must be to the nearest one recognized by the Plan administrator as having services adequate to treat your condition.
- The services You receive in that Facility or Provider's office must be covered services.
- If the Plan Administrator requests it, the attending Provider must explain why You could not have been transported in a private car or by any other less expensive means.
- Ambulance services billed through the Facility are covered the same as all other Facility services.

4) The Other Covered Services discussed in this section are not eligible for Reimbursement if the same service is available under some other section of this booklet. The Plan Administrator will pay only once for a service and will not increase or extend benefits available under other sections of this contract.

Special Limits

1) Prescribed services eligible for coverage may be subject to medical policy limits. For example, wigs and prostheses. Always check with Your Plan Administrator in advance of receiving services.

2) The following and similar items are not eligible for Reimbursement as Medical Equipment (durable):

- blood pressure cuffs;
- exercise equipment;
- air conditioners;
- dehumidifiers and humidifiers;
- whirlpool baths;
- handrails;
- ramps;
- elevators;
- telephones; or
- adjustments made to a vehicle.

3) Your Health Plan will not pay for any equipment which has both a non-therapeutic and therapeutic use. Your Health Plan will pay for the least expensive item of equipment required by your medical condition. If Your Health Plan determines that purchase of the Medical Equipment (durable) is less expensive than rental, or if the equipment cannot be rented, Your Health Plan may approve the purchase as a covered service.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible and Coinsurance.

Member Pays

Other Covered Services	20% Coinsurance after the Plan Year Deductible

OUTPATIENT PRESCRIPTION DRUGS
(Mandatory Generic Program)

Administered by Medco Health Solutions, Inc.

Services Which Are Eligible for Reimbursement

1) Outpatient Prescription Drugs received through a retail pharmacy or the Medco Health Home Delivery Pharmacy Service.

2) Outpatient Prescription Drugs and devices approved by the Food and Drug Administration (FDA), including contraceptives and certain prescription smoking cessation drugs. Contact Medco for detailed coverage information.

3) The following items for the treatment of diabetes:

   - insulin;
   - lancets;
   - hypodermic needles and syringes;
   - blood glucose test strips; and
   - blood glucose meters.

Conditions for Reimbursement

1) The drugs must:

   - by federal or state law, require a prescription order to be dispensed;
   - be approved for general use by the U. S. Food and Drug Administration;
   - be prescribed by a Provider licensed to do so;
   - be furnished and billed by a pharmacy for Outpatient use; and
   - be Medically Necessary.

Special Limits

1) Up to a 34-day supply will be eligible for Reimbursement from a retail pharmacy.

2) Up to a 35- to 90-day supply is eligible for Reimbursement from a retail pharmacy.

3) A supply of up to 90 days may be obtained from the mail service pharmacy.

4) Only in documented cases of extended foreign travel will a supply of more than 90 days be prior authorized.

5) Replacement drugs for supplies lost, stolen, etc. are not eligible for Reimbursement.

6) Benefits for any refill of a prescription drug will not be provided until the amount of time has elapsed from the previous dispensing of the prescription drug which would result in at least 75% of the drug being used if taken consistently with the prescribing Provider's directions.

7) Prior authorization is required for certain medications. You will be notified in writing when a prescription is denied for coverage. Your physician will be notified of both approval and denial decisions.

8) Certain drugs may not be available through the home delivery pharmacy service due to distribution restrictions imposed by the drug manufacturer. However, these drugs are available through the network retail pharmacies at their appropriate retail Copayment level.

9) Pharmacy claim Reimbursement requests must be received within 12 months after the end of the calendar year in which the services were received.

10) A prescription is needed for the purchase of diabetic supplies.

11) The Prescription Drug Program requires that certain medications need a coverage review. In these cases, Clinical criteria based on current medical information and appropriate use must be met. Information must be provided before coverage is approved. You, your doctor, or your local pharmacist may call **800-753-2851** toll-free to initiate a coverage review. When You use Medco By Mail, Medco will call your doctor to start the coverage review process. The review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective. Members with questions pertaining to a prescription drug coverage review should contact Medco Member Services at **800-355-8279** for more information. For a list of drugs that require a coverage review see the Four-Tier Drug Program Guide available at **www.dhrm.virginia.gov** or call Medco Member Services.

12) The Prescription Drug Program has set quantity limitations for some drugs. You must obtain a coverage review to obtain quantities in excess of these limitations. Please see your Four-Tier Drug Program Guide for a list of drugs that have quantity limitations.

Health Plan Reimbursement

1) Your Health Plan pays the remaining Allowable Charge after You pay the Copayment or Coinsurance. The Plan Administrator will determine whether a particular generic Outpatient Prescription Drug is equivalent to a brand name Outpatient Prescription Drug. If You or your Provider determine to fill the prescription with a brand name drug when a generic equivalent is available, You will be responsible not only for the Copayment, but also the difference between the Allowable Charge for the brand name drug and the Allowable Charge of its generic equivalent. There is a maximum Out-of-Pocket cost each time a member purchases a brand name drug when a generic is available in the immunosuppressant, anticonvulsant, and psychotherapeutic drug categories.

2) If the dispensing pharmacy is a network pharmacy, the Plan Administrator will direct benefit payment to that pharmacy. If the dispensing pharmacy is a non-network pharmacy, the Plan Administrator will direct payment to the member.

   - A network pharmacy is a pharmacy listed as a network pharmacy by the Plan Administrator at the time the Outpatient Prescription Drug is dispensed.
   - A non-network pharmacy is any other pharmacy. You may be required by a non-network pharmacy to pay not only the Copayment, but also the difference between the pharmacy's charge for the Outpatient Prescription Drug and the Allowable Charge for the Outpatient Prescription Drug.

3) The benefits provided for services under this section are in lieu of any other benefits for the same services listed in any other section of this booklet. Any Copayment or Coinsurance listed for Outpatient Prescription Drug services will not be eligible for Reimbursement as a covered service under any other section.

4) The Plan Administrator may receive, directly or indirectly, financial credits from drug manufacturers whose products are included on formulary lists. Credits are received based on the utilization of the manufacturer's products by persons enrolled under contracts insured by or administered by the Plan Administrator. Credits received by virtue of the benefits provided under this section are retained by the Plan Administrator as a part of its compensation from the state for administrative services. Payments to pharmacies are not adjusted as a result of these credits.

Member Pays

Prescription medications can be received in a Facility Setting or from a Professional Provider. Some medications are covered as a Medical service. See the **Hospital Services** and **Medical, surgical, and Behavioral Health** services sections of this booklet.

When using your prescription drug benefit, covered brand-name and generic drugs are categorized into specific tiers and each tier is assigned a Copayment level.

Tier 1 – Lowest Copayment, typically generic drugs
Tier 2 – Moderate Copayment, typically lower-cost brand-name drugs
Tier 3 – Higher Copayment, typically higher-cost brand-name drugs
Tier 4 – Highest Copayment, Specialty Drugs that are higher-cost brand-name drugs used to treat chronic and rare conditions

Retail up to a 34-day supply	Tier 1 - $15 Tier 2 - $25 Tier 3 - $40 Tier 4 - $50
Retail up to a 90-day supply	Tier 1 - $45 Tier 2 - $75 Tier 3 - $120 Tier 4 - $150
Mail Service up to a 90-day supply	Tier 1 - $30 Tier 2 - $50 Tier 3 - $80 Tier 4 - $100
Diabetic Supplies	20% Coinsurance, no Deductible

Maximum Out-of-Pocket cost for a brand name drug when a generic is available in the immunosuppressant, anticonvulsant, and psychotherapeutic drug categories. Members pay no more than $100 for up to a 34-day supply at retail and $200 for up to a 90-day supply at mail service. This includes the standard brand name drug Copayment.

Medco Specialty Pharmacy Service

When You receive your specialty Outpatient Prescription Drugs through the Medco By Mail home delivery pharmacy, the Medco Specialty Pharmacy program provides You with personal counseling from nurses, registered pharmacists and patient care representatives who are trained in specialty medications. Specialty medications are drugs such as Procrit® to treat anemia, Betaseron® for multiple sclerosis and Enbrel® or Remicade® for rheumatoid arthritis. The program includes 24-hour access to a Medco Specialty Pharmacy pharmacist and free supplies needed to administer your medicine, such as needles and syringes.

"Specialty Drugs" means those covered drugs that typically cost $500 or more per dose or $6,000 or more per year and have one or more of the following characteristics:
(1) complex therapy for complex disease;
(2) specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy;
(3) unique patient compliance and safety monitoring requirements;
(4) unique requirements for handling, shipping and storage; and
(5) potential for significant waste due to the high cost of the drug.

Exceptions to the price threshold may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a Specialty Drug. Some examples of the disease categories currently in Medco's specialty pharmacy programs include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency, hemophilia, immune deficiency, Hepatitis C, multiple sclerosis, rheumatoid arthritis and RSV prophylaxis.

In addition, a follow-on biologic or generic product will be considered a Specialty Drug if the innovator drug is a Specialty Drug.

Call toll-free **800-803-2523** to order your specialty medication. Medco will call your doctor for a new prescription. Or if You prefer, your doctor's office may call the Medco Specialty Pharmacy directly at **800-987-4904**. More information is available at **www.medco.com**.

Prescription Drug Refills When Traveling

If You are planning to travel on vacation or leaving home for an extended period, You may need one or more early refills of your medication. Participating retail pharmacies and the Medco by Mail service may routinely provide one early refill (up to a 34-day or a 90-day supply, as appropriate) to accommodate travel. However, for extended travel, members should complete the Prescription Drug Refill Exception Request form available on the DHRM Web site at **www.dhrm.virginia.gov** or from your Benefits Administrator. Send the completed form by fax or U.S. Mail to:

The Department of Human Resource Management (DHRM)
Office of Health Benefits
Attention: Policy and Instruction
101 North 14th Street, 13th Floor
Richmond, VA 23219
Fax: (804) 371-0231

DHRM will approve all valid requests and forward them to Medco Health Solutions, Inc. A member of Medco's Member Services team will contact You to obtain specific medication

information. Once You provide the medication information, a prior authorization will be entered for each medication requested and You will have 14 days to complete your purchase.

Please note:

- The maximum supply You may purchase at one time is 12 months;
- You will not be allowed to purchase more refills than prescribed. For example, if your one-year prescription expires six months from the date of your request, You cannot purchase more than a six-month supply of medication;
- You will be charged the appropriate Copayment for refills requested on the form. For example, You will be charged for a 6-month supply of medication if You requested a 6-month supply on the form and later decided to purchase only a 3-month supply at the pharmacy;
- The Food and Drug Administration limits early refills on certain medications;
- Allow at least two weeks for complete processing of your request; and
- The Commonwealth reserves the right to bill a member for any months of medication remaining if employment terminates.

General Information

To contact Member Services
Member Services is available 24 hours a day, 7 days a week (except Thanksgiving and Christmas) by calling toll-free **800-355-8279**.

Member Services representatives can:

- help You find a participating retail pharmacy;
- send your order forms, claim forms, and envelopes; and
- answer questions about your prescriptions or plan coverage.

TTY is available for hearing-impaired members. Call **800-355-8279**.

To order prescription labels printed in Braille
Braille labels are available for mail-order prescriptions. Call **800-355-8279**.

Online Services
If You have Internet access, You can take advantage of Medco's Web site and register at **www.medco.com** to:

- compare the cost of brand name and generic drugs at retail and via mail order;
- access plan highlights, as well as health and wellness information;
- obtain order forms, claim forms, and envelopes;
- submit mail order refills; and check the status of Medco By Mail orders.

DENTAL SERVICES – BASIC

Administered by Delta Dental of Virginia

Services Which Are Eligible for Reimbursement

1) Diagnostic and preventive care

Your Health Plan provides coverage for You to see your dentist twice a year for a checkup. This allows your dentist to identify any possible problems and to try and prevent cavities and serious Dental problems. The following services are generally covered, but in some specific situations certain exclusions and limitations apply. See Special Limits in this section and the Exclusions section of this booklet.

- two routine oral evaluations per Plan Year;
- two Dental prophylaxes (cleanings) per Plan Year, including scaling and polishing of teeth;
- Dental x-rays (except x-rays needed to fit braces);
- space maintainers used to keep teeth from moving into space left when deciduous teeth are pulled;
- two tests to see if a tooth is still alive (pulp vitality tests) every 12 months (the 12-month count starts the month in which You receive the pulp vitality test);
- care for a toothache (palliative Emergency care);
- two sets of bitewing x-rays (two or more films) per Plan Year (vertical bitewings are considered a full mouth series and are allowed once every 36 months);
- one complete full mouth x-ray series (vertical bitewings are considered a full mouth series), or a panorex every 36 months (the 36-month count starts the month in which You receive the x-ray series or panorex);
- two topical fluoride applications per Plan Year only to Covered Persons under age 19;
- Dental pit/fissure sealants to the unrestored occlusal surface of the first and second permanent molars (limited to one application per tooth). Dental pit/fissure sealants are available only to Covered Persons under age 19;
- occlusal adjustments, bite planes or splints for temporomandibular joint disorders; and
- Occlusal night guards for demonstrated tooth wear due to bruxism; or occlusal orthotic device for treatment of temporomandibular joint dysfunction (TMJ). Services are limited to once every five-year period.

2) Basic Dental care

After your dentist has examined your teeth, You may need additional Dental work. Your Health Plan includes coverage for the following:

- fillings (amalgam or tooth-colored materials);
- pin retention;
- simple extractions of natural teeth and surgical extractions of fully erupted teeth;
- root canal therapy (endodontics);
- care for abscesses in the mouth (excision and drainage);
- repair of broken removable dentures;
- surgical preparation of ridges for dentures;
- re-cementing existing crowns, inlays and bridges (once every 12 months);

- removing infected parts of the gum and replacing them with healthy tissue (gingivectomy and gingivoplasty);
- scaling and root planing of the gum;
- stainless steel crowns for primary teeth only;
- sedative fillings;
- therapeutic pulpotomy for primary "baby" teeth only;
- periodontal evaluation (not in addition to periodic evaluations);
- an operation to remove diseased portions of bone around the teeth (osseous surgery);
- soft tissue grafts;
- bone graft (only around natural teeth);
- guided tissue regeneration;
- general anesthesia in connection with a covered surgical Dental service is covered when three or more surgical extractions are performed. Not covered for deciduous teeth;
- crown lengthening when bone is removed and at least six weeks are allowed for healing;
- frenectomies;
- hemisection and root amputations;
- apicoectomies;
- periodontal maintenance limited to two per Plan Year; and
- trips by the dentist to your home if You need any of the services You see listed here.

Conditions for Reimbursement

1) Should You decide to receive Dental care from a dentist who is not a member of the Delta Dental Premier network, You will still receive benefits from your dental plan, but your share of the cost will likely be higher than if You received care from a network dentist.
   - You may have to file any claims yourself.
   - Payment will be made directly to You unless your dentist agrees to accept payment from Delta Dental.
   - You must pay the applicable Coinsurance and the difference between the non-network dentists' charges and Delta Dental's payment for covered benefits.

Special Limits

1) A Plan Year Dental Deductible applies to routine Dental coverage. The Deductible is $50 for single membership, $100 for employee plus one membership, and $150 for family membership.

2) Benefits for routine Dental services are limited to $2,000 per member each Plan Year.

3) If You transfer from the care of one dentist to another during a course of treatment, the Plan Administrator will only pay the amount it would pay to one dentist for the same treatment.

4) If more than one dentist renders services for one procedure, the Plan Administrator will only pay the amount it would pay to one dentist for the same treatment.

5) If Dental services for a single procedure or series of procedures cost more than $250, it is recommended that your dentist submit a predetermination plan to Delta Dental before services are provided.

6) By submitting a predetermination plan, You and your dentist will be informed of: the total costs associated with the procedure(s); the exact amounts that will be covered by your Health Plan; and the portion of the charges for which You will be responsible. A predetermination plan is not required by Your Health Plan, but recommended when extensive Dental work is expected. A claim will not be denied for failure to obtain a predetermination plan.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible and Coinsurance for Dental services.

Member Pays

Diagnostic and Preventive Care	$0, no Deductible
Basic Dental Care	20% Coinsurance after Dental Deductible

Dental Services – Non-Routine Medical

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

1) Non-Routine Medical Benefits for Oral Surgery:

   - surgical removal of impacted teeth;
   - maxillary or mandibular frenectomy when not related to a Dental procedure;
   - alveolectomy when related to tooth extraction;
   - orthognathic surgery that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part;
   - surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures; and
   - the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
   - Dental services and Dental appliances furnished when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and
   - Dental services to prepare the mouth for Radiation Therapy to treat head and neck cancer.

2) Non-Routine Medical Benefits for Accidental Injury:

   - Medically Necessary Dental services when required to diagnose and treat an accidental injury to the teeth if the accident occurs while You are covered under Your Health Plan.
   - the repair of Dental appliances damaged as a result of accidental injury to the jaw, mouth or face.

Conditions for Reimbursement

1) A health services review is recommended prior to an oral surgery procedure.

2) Dental services resulting from an accidental injury are covered, provided that, for an injury occurring on or after your Effective Date of coverage You:

   - seek treatment within 60 days after the injury; and
   - submit a plan of treatment from your dentist or oral surgeon for prior approval by Anthem.

   Services and appliances are covered for adults if rendered within a two-year period after the accidental injury. The two-year restriction may be waived for children under age 18. Actual treatment may be delayed if tooth/bone maturity is in question and standard industry protocols are followed. However, a treatment plan must be filed within six months of the accident and treatment must be completed within two years of active treatment commencement and prior to age 20. For the waiver to be granted, continuous coverage under Your Health Plan is required.

3) Your Health Plan provides coverage for the following services through the Medical benefits:

- Covered general anesthesia and hospitalization services for children under the age of 5, Covered Persons who are severely disabled, and Covered Persons who have a medical condition that requires admission to a hospital or Outpatient surgery Facility.

- Services for general anesthesia and hospitalization services are only provided when it is determined by a licensed dentist, in consultation with the Covered Person's treating physician, that such services are required to effectively and safely provide Dental care.

Special Limits

1) Non-routine Dental services covered under the medical benefit are subject to the Medical Plan Year Deductible and Out-of-Pocket Expense Limit.

2) Injury as a result of chewing or biting is not considered an accidental injury and would not be covered by the Health Plan under medical services.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible, Copayment or Coinsurance.

Member Pays

Oral Surgery	$40 per Visit, Specialty Care Provider
Accidental Injury	20% Coinsurance, after Medical Plan Year Deductible

OPTIONAL BENEFITS

The following optional benefits are available for additional premium as follows:

- COVA Care *plus Expanded Dental; or*
- COVA Care *plus* Out-of-Network; or
- COVA Care *plus* Expanded Dental and Out-of-Network; or
- COVA Care *plus* Expanded Dental and Routine Vision/Routine Hearing; or
- COVA Care *plus* Expanded Dental, Out-of-Network, and Routine Vision/Routine Hearing

Following is a detailed description of what is covered for each of the options.

EXPANDED DENTAL

Administered by Delta Dental of Virginia

These services are covered only if You have selected the Expanded Dental option and pay additional premium.

Services Which Are Eligible for Reimbursement

1) Major Dental care

If preventive care fails to save a tooth, major Dental care is provided as follows:

- inlays (limited to the benefit for a resin restoration unless part of partial or bridge abutment);
- onlays (limited to the benefit for a metallic restoration);
- crowns, crown repair, and post and core build-ups for crowns (once every 5 years);
- labial veneers involving the incisal edge of anterior teeth, porcelain laminate (laboratory processed);
- Dental implants (once every 5 years);
- dentures (full and partial), and denture adjustments and relining; and
- fixed bridges and repair.

2) Orthodontic benefits

This provides coverage for orthodontic benefits. Benefits are available if the problem is a handicapping malocclusion. That means it prevents normal chewing or eating. Your coverage includes:

- orthodontic appliances (installing only, no replacement or repair);
- services needed to diagnose the problem, including x-rays, study model and diagnostic casts;
- tooth guidance and harmful habit appliances;
- interceptive treatment;
- surgical access of unerupted teeth when performed for orthodontic purposes; and
- orthodontic evaluations when no treatment is initiated.

Conditions for Reimbursement

1) Delta Dental must approve permanent crowns for Covered Persons under age 16 in advance.

2) Replacement of prosthetic appliances, dentures, crowns, crown buildups, post and core to support crowns, onlays and bridges are limited to once every five-year period. There is one exception: Replacement of a bridge will be provided prior to the end of the five-year period if one or more abutment teeth are extracted.

3) Should You decide to receive Dental care from a dentist who is not a member of the Delta Dental Premier network, You will still receive benefits from your dental plan, but your share of the cost will likely be higher than if You received care from a network dentist.
   - You may have to file any claims yourself.
   - Payment will be made directly to You unless your dentist agrees to accept payment from Delta Dental.
   - You must pay the applicable Coinsurance and the difference between the non-network dentists' charges and Delta Dental's payment for covered benefits.

Special Limits

1) A Plan Year Dental Deductible applies to routine Dental services (Basic and Expanded combined). The Deductible is $50 for single membership, $100 for employee plus one membership, and $150 for family membership.

2) Reimbursement for routine Dental services (diagnostic and preventive care, basic Dental care and major Dental care combined) is limited to $2,000 per member per Plan Year.

3) Reimbursement for routine orthodontic services is limited to $2,000 per member per lifetime.

4) If You transfer from the care of one dentist to another during a course of treatment, the Plan Administrator will only pay the amount it would pay to one dentist for the same treatment.

5) If more than one dentist renders services for one procedure, the Plan Administrator will only pay the amount it would pay to one dentist for the same treatment.

6) If routine Dental services for a single procedure or series of procedures cost more than $250, it is recommended that your dentist submit a predetermination plan to Delta Dental before services are provided.

7) By submitting a predetermination plan, You and your dentist will be informed of the total costs associated with the procedure(s); the exact amounts that will be covered by Your Health Plan; and the portion of the charges for which You will be responsible. A predetermination plan is not required by Your Health Plan, but recommended when extensive Dental work is expected. A claim will not be denied for failure to obtain a predetermination plan.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible and Coinsurance for Dental services.

Member Pays

Major Dental care	50% Coinsurance, after Dental Deductible
Orthodontic services[1]	50% Coinsurance, no Dental Deductible

[1]Note: Orthodontic Services

- If listed as a covered benefit, Your Health Plan makes periodic payments for covered orthodontic services up to the benefit maximum over the entire course of treatment. Your Health Plan will pay up to $500 at the time of initial banding. Your Health Plan pays the balance of its obligation over the remainder of the treatment period. In the event You make payment in full at the time of initial banding, Your Health Plan will pay as if You are making periodic payments over the treatment period.
- If orthodontic treatment begins before your Effective Date, Your Health Plan reduces its total allowance. Your Health Plan reduces its allowance by the amount paid by a prior carrier, or the prior carrier is obligated to pay.
- If your coverage ends during orthodontic treatment, Your Health Plan covers:
  1) The banding portion of the service only if the bands are installed before the date your coverage ends; or
  2) Follow-up visits if enrolled on the first day of the month when the visit takes place.

OUT-OF-NETWORK

Administered by Anthem Blue Cross and Blue Shield

These services are covered only if You have selected the Out-of-Network option and pay additional premium.

Under the COVA Care Basic plan, except in an Emergency, You do not have coverage for the services of Providers and Facilities outside of the Anthem Medical and ValueOptions Behavioral Health networks. This option gives You coverage if You choose to go outside of those networks.

The out-of-network benefits will always be the in-network benefit less a 25% reduction in the amount paid by Your Health Plan. You will be responsible for any Deductible, Coinsurance or Copayment that applies. You also pay any amount the non-network Provider or Facility charges over the Allowable Charge. Payments for out-of-network claims are paid directly to You rather than to the Provider. It is your responsibility to pay the out-of-network Provider or Facility.

The Out-of-Network option allows the accumulation of Deductible, Copayment and Coinsurance amounts for out-of-network Providers and Facilities toward your Out-of-Pocket Expense Limits. **However, the 25% reduction in the amount paid by Your Health Plan does *not* count toward your Out-of-Pocket Expense Limits.**

Under the Out-of-Network option, the following expenses **count** toward your Out-of-Pocket Expense Limit:

- Deductible, Copayments and Coinsurance for covered services from Providers and Facilities not in your Anthem, BlueCard PPO, or ValueOptions networks.

These expenses **do not count** toward your Out-of-Pocket Expense Limit under the Out-of-Network option:

- expenses for services or supplies not covered by Your Health Plan;
- amounts above the Allowable Charge;
- amounts above the Health Plan limits;
- Copayments, Deductibles and Coinsurance for Outpatient Prescription Drugs, routine and expanded Dental services, and the optional routine vision and hearing services; and
- the 25% reduction for out-of-network benefits paid by Your Health Plan.

ROUTINE VISION

Administered by Anthem Blue Cross and Blue Shield (Blue View Vision network)

These services are covered only if You have selected the Routine Vision and Hearing option and pay additional premium. The Blue View Vision network is for routine eye care only and is a separate network from the Anthem Medical network. Non-routine vision care is covered under your Anthem Medical benefits.

Services Which Are Eligible for Reimbursement

1) Routine vision examination.

2) Frames, eyeglass lenses and contact lenses to correct vision.

Conditions for Reimbursement

1) Vision services must be:

- billed for by a licensed ophthalmologist, optometrist, or optician.
- services which the Provider is licensed to render.
- services received in-network will be covered according to in-network benefits.
- services received out-of-network will be reimbursed according to the out-of-network allowance.

Special Limits

1) This benefit is available once every 24 months with the optional Routine Vision and Hearing buy-up. The 24-month count starts the date You receive an eye exam or purchase eyewear.

2) Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the plan design; however, these materials and any items not covered below may be purchased at preferred pricing from a Blue View Vision Provider.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge for the routine vision examination and other covered materials after your benefit payment.

Member Pays

Routine vision examination	$40 Copayment
Eyeglass frames	$100 allowance off total cost then 20% off remaining balance

Eyeglass lenses *(one of the following)*

• Standard plastic single vision lenses (1 pair)	$20 Copayment
• Standard plastic bifocal lenses (1 pair)	$20 Copayment
• Standard plastic trifocal lenses (1 pair)	$20 Copayment

Note: Polycarbonate lenses included for children under 19 years old.

Eyeglass lens upgrades (eyeglass lens Copayment applies)

• UV Coating	$15
• Tinted Lenses *(Solid and Gradient)*	$15
• Standard Scratch-Resistance	$15
• Standard Polycarbonate	$40
• Standard Progressive *(add-on to bifocal)*	$65
• Standard Anti-Reflective Coating	$45
• Other Add-ons and Services	20% off retail price

Contact lenses
You may choose to receive contact lenses instead of eyeglass lenses.

• Elective Conventional lenses[1]	$100 allowance off total cost then 15% off the remaining balance
• Elective Disposable lenses[1]	$100 allowance off total cost (no additional discount)
• Non-Elective Contact lenses[1]	$250 allowance off total cost (no additional discount)

Contact lens fitting and follow-up
A contact lens fitting, and up to two follow-up visits are available to You once a comprehensive eye exam has been completed.

Standard contact fitting — You pay up to $55
A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement lenses.

Premium contact lens fitting — 10% off of retail price
A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal lenses.

Additional Savings on Eyewear and Accessories
After You use your initial frame or contact lens benefit allowance, You can take advantage of discounts on additional prescription eyeglasses, conventional contact lenses, and eyewear accessories at Blue View Vision network Providers at any time. The 24-month restriction does not apply. Blue View Vision's Additional Savings Program is subject to change without notice.

• Additional complete pair of eyeglasses (as many as You like)	40% off retail
• Conventional Contact Lenses (materials only)	15% off retail
• Additional Eyewear & Accessories (Includes eyeglass frames and eyeglass lenses purchased separately, some non-prescription sunglasses, eyeglass cases, lens cleaning supplies, contact lens solutions, etc.)	20% off retail

[1] Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when glasses are not an option for vision correction.

Out-of-network services
You can choose to receive care outside of the Blue View Vision network. The following allowances apply.

• Routine eye exam	$50 allowance
• Eyeglass frames	$80 allowance
• Standard plastic single vision lenses (1 pair)	$50 allowance
• Standard plastic bifocal lenses (1 pair)	$75 allowance
• Standard plastic trifocal lenses (1 pair)	$100 allowance
• Standard Progressive *(add-on to bifocal)*	$75 allowance
• Elective Conventional and Disposable lenses[1]	$80 allowance
• Non-Elective Contact lenses[1]	$210 allowance

You must pay in full at the time of service and then submit a claim and itemized receipt for Reimbursement. Go to **www.anthem.com/cova** for an out-of-network claim form.

How to find a Blue View Vision provider

Before You seek routine vision services, be sure to locate a Blue View Vision provider. Go to Find a Doctor at **www.anthem.com/cova** or call Member Services at **800-552-2682** for help.

Always tell your routine vision provider if You have Anthem's Blue View Vision. Network providers can check your eligibility and automatically file your claims. When You receive care from a Blue View Vision participating provider, You receive the greatest benefits and money-savings discounts.

You may print a convenient wallet card to present to your Blue View Vision provider. Simply go to **anthem.com/cova** and select Blue View Vision Benefits.

[1] Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when glasses are not an option for vision correction.

ROUTINE HEARING

Administered by Anthem Blue Cross and Blue Shield

These services are covered only if You have selected the Routine Vision and Hearing option and pay additional premium.

Services Which Are Eligible for Reimbursement

1) Routine hearing examination.

2) Hearing aids and other related hearing aid services and supplies except disposable hearing aids. Examples of covered supplies necessary for the use of the hearing aid include ear molds, ear buds (not required for all hearing aids), filter and batteries.

Conditions for Reimbursement

1) Hearing services must be:

   - billed for by a Provider in private practice such as an audiologist or doctor of medicine;
   - services which the Provider is licensed to render; and
   - submitted with a routine hearing diagnosis or the service will be considered under the Medical benefit.

2) Hearing testing services and hearing aids do not have to be purchased from an in-network Provider. Services are considered at the same benefit level regardless of Provider network status. However, You may be held responsible for any amounts over and above the Allowable Charge up to the Provider's charge.

Special Limits

1) Hearing benefits are available once every 48 months with the optional Routine Vision and Hearing buy-up. The 48-month count starts the month You receive your hearing examination or purchase your hearing aid(s) or related hearing services. Benefits include:

   - one routine hearing examination; or
   - hearing aids and other related hearing aid services and supplies.

2) Reimbursement is limited to $1,200 for the hearing aid and first set of batteries.

3) Services required by your employer as a condition of employment or rendered through a medical department, clinic, or other similar services provided or maintained by the employer are excluded.

4) Disposable hearing aids, even if by prescription, are excluded.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Copayment for the routine hearing examination.

Member Pays

Routine hearing examination	$40
Hearing aids and other hearing aid services and supplies	You pay the remaining cost after You have exhausted Your Health Plan's Reimbursement of $1,200

INDIVIDUAL CASE MANAGEMENT PROGRAM

Medical services administered by Anthem Blue Cross and Blue Shield; Behavioral Health Services administered by ValueOptions, Inc.

Individual case management is included under your Medical and Behavioral Health benefits. In addition to the covered services listed in this booklet, Your Health Plan may elect to offer benefits for an approved alternate treatment plan for a patient who would otherwise require more expensive covered services. This includes, but is not limited to, long term Inpatient care. Your Health Plan will provide alternate benefits at its sole discretion.

It will do so only when and for so long as it decides that the services are Medically Necessary and cost effective. The total benefits paid for such services may not exceed the total that would otherwise be paid without alternate benefits. If Your Health Plan elects to provide alternate benefits for a Covered Person in one instance, it will not be required to provide the same or similar benefits for any Covered Person in any other instance. Also, this will not be construed as a waiver of Your Health Plan's right to enforce the terms of Your Health Plan in the future in strict accordance with its express terms.

Also, from time to time Your Health Plan may offer a Covered Person and/or their Provider or Facility information and resources related to disease management and wellness initiatives. These services may be in conjunction with the Covered Person's medical condition or with therapies that the Covered Person receives, and may or may not result in the provision of alternative benefits as described in the preceding paragraph.

BLUECARD PROGRAM

For Medical services administered by Anthem Blue Cross and Blue Shield

BlueCard® PPO for Care within the United States

If You need Medical care outside the Anthem network and within the United States, You will have access to care from a BlueCard PPO Provider. Through the BlueCard PPO program, your Anthem Blue Cross and Blue Shield ID card is accepted by physicians and hospitals throughout the country who participate with another Blue Cross Blue Shield company. These Providers accept your Copayment or Coinsurance at the time of service instead of requiring full payment. They file claims directly to their local Blue Cross Blue Shield company for You, and have agreed to accept the Allowable Charge established by the local company as payment in full.

To locate a BlueCard PPO physician or hospital call **800-810-BLUE (2583)**. You may obtain this information on the Web at **www.bcbs.com** and select the "Healthcare Coverage" tab, or call BlueCard Access at **800-810-BLUE (2583)** for assistance locating a BlueCard provider.

Simply present your Anthem ID card when You receive care. The PPO suitcase logo at the top of your card tells the physician or hospital that your Medical plan includes the BlueCard PPO program.

How Charges Are Calculated for BlueCard PPO Services

If the amount You pay for a covered service is based on the charge for that service, the charge used to calculate your part will be the lower of:

- the billed charge for the covered service; or
- the negotiated price passed on to Anthem by the local Blue Cross and/or Blue Shield Plan.

Often, this "negotiated price" will consist of a simple discounted price, but it can also be an estimated or average price allowed under the BlueCard Program and applied under the terms of your Medical plan.

An estimated price takes into account special arrangements with a Provider or Provider group that include settlements, withholds, non-claims transactions (such as Provider advances) and other types of variable payment. An average price is based on a discount that takes into account these same special arrangements. Of the two, estimated prices are usually closer to the actual prices. Negotiated prices may be adjusted going forward to correct for over-or underestimation of past prices. However, the amount You pay is considered a final price. More detailed information about negotiated prices is included in the group policy.

Laws in a small number of states may require the local Blue Cross and/or Blue Shield Plan to:

- use another method for, or
- add a surcharge to, your liability calculation.

If any state laws mandate other liability calculation methods, including a surcharge, Anthem Blue Cross and Blue Shield would then calculate your liability for any covered health care services according to the applicable state law in effect when You received care.

BlueCard Worldwide® for Care outside the United States

If You live or travel outside the United States, the BlueCard Worldwide program assists You to obtain Inpatient and Outpatient hospital care and physician services.

Follow these steps before You travel:

1) Obtain a list of BlueCard Worldwide hospitals located where You will be traveling or staying. You may obtain this information on the Web at **www.bcbs.com** and select the "Healthcare Coverage" tab, or call BlueCard Access at **800-810-BLUE (2583)** for assistance locating a BlueCard provider.

2) Be sure to carry your Anthem Medical ID card with You and present it when You need Inpatient care.

If You need care once You arrive at your destination, follow these simple steps:

Inpatient hospital care (non-Emergency):

1) Call the BlueCard Worldwide Service Center at **804-673-1177** (use a local operator to set up a collect call to the U.S.). A BlueCard Worldwide Service Center representative will accept the charges and will facilitate hospitalization at a BlueCard Worldwide hospital. It is important that You call the Service Center in order to obtain cash-less access for Inpatient care. The hospital will submit your claim for You. The Service Center is staffed with multilingual representatives and is available 24 hours a day, seven days a week.

2) Call Anthem Member Services at **804-355-8506** for Hospital Admission Review.

Inpatient hospital care (Emergency):

Bypass the above steps. Go to the nearest hospital. Call the BlueCard Worldwide Service Center at **804-673-1177** (use a local operator to set up a collect call to the U.S.) if You are admitted to arrange cash-less access (available in most cases). A BlueCard Worldwide Service Center representative will assist You. A family member or friend can make this call for You.

Outpatient hospital care/physicians services:

1) Call the BlueCard Worldwide Service Center at **804-673-1177** (or use a local operator to set up a collect call to the U.S.) if You would like information on physicians or the charges, and if You want, make an appointment with a doctor for You, or will direct You to a hospital.

2) You will need to pay for your care and then submit a claim using the International Claim Form to the BlueCard Worldwide Service Center (address is on the claim form). Contact the Service Center for the form, or You may download the form on the Web at **www.bcbs.com**. Select the "Healthcare Coverage" tab, or call BlueCard Access at **800-810-BLUE (2583)** for assistance locating a BlueCard provider.

PROGRAMS INCLUDED IN YOUR HEALTH PLAN

Future Moms

You (or your covered dependent) are eligible to participate in the Future Moms program. This program is designed to help women have healthy pregnancies and healthy babies. A Future Moms registered nurse is assigned to women identified as having greater risk of premature delivery. The nurse works with the mother and her doctor throughout the pregnancy to help avoid complications and to help ensure that the baby is born at a healthy weight.

As soon as pregnancy is confirmed, sign up for the program by calling **800-828-5891**. You will receive:

- toll-free access to a registered nurse, any time day or night, in case You have questions or concerns along the way;
- a prenatal book to help You follow your pregnancy week by week, materials to help You handle the unexpected; and
- postpartum support and guidance in areas like breastfeeding and depression.

Your Health Plan may waive the maternity hospital Stay Copayment when You enroll in Future Moms. To be eligible, You must:

- Enroll in Future Moms during the first trimester of pregnancy;
- Have one dental prophylaxes (cleaning) during your pregnancy; and
- Actively participate and complete all program requirements.

Call **800-828-5891** to enroll and receive additional information.

You must add your newborn to your plan within 60 days of the date of birth, or your newborn will not be covered.

ConditionCare

If You or a family member are living with asthma, diabetes, coronary artery disease (CAD), heart failure, chronic obstructive pulmonary disease (COPD), hypertension, hyperlipidemia, or obesity, You know the impact that it has on your life. This confidential disease management program will provide the tools and support needed to minimize your condition's effects, improve your health and help You feel better.

ConditionCare is a voluntary program. To register for this program, call **800-445-7922**. A dedicated nurse will be available to answer your questions, help You coordinate your benefits, and provide support to help You follow your doctor's plan of treatment. When You call, please be sure to have your health insurance ID card and physician's name and address available.

In addition to members calling to enroll, the program receives the names of members who may have certain chronic health conditions from medical and pharmacy claims, and case managers. You may be contacted by a ConditionCare enrollment specialist to find out if You or any of your eligible family members would like to participate in this program. With your permission, your health care information will be verified and will be shared with the ConditionCare staff and your physician. If your condition is under control or You are not interested in participating in the

program, feel free to contact ConditionCare at **800-445-7922** to notify an enrollment specialist that You are not interested and do not wish to be contacted further.

24/7 NurseLine and AudioHealth Library

Illness or injury can happen, no matter what time of day. As an Anthem health plan member, You have access to a team of nurses to assist with your questions or concerns 24 hours a day, seven days a week. These registered nurses can discuss symptoms You are experiencing, how to get the right care in the right Setting and more. You can call as often as You like. Call **800-337-4770**.

For those who aren't comfortable discussing their health concerns with someone else or those just looking for more information on a health topic, the AudioHealth Library has more than 300 recorded health topics. Call **800-337-4770** to access this line. For the list of topics, go to **anthem.com/cova** and select 24/7 NurseLine under Special Programs.

Healthy Smile, Healthy You™

Growing evidence connects oral health to overall general health. Delta Dental of Virginia's Healthy Smile, Healthy You™ program provides additional benefits for three important health conditions connected to oral health: pregnancy, diabetes and high risk cardiac conditions.

- Pregnant members enrolled in the Future Moms program are eligible for one additional cleaning and exam, or periodontal maintenance visit (if the member has a history of periodontal surgery) during the term of their pregnancy, in addition to the normal plan frequency limits.
- Diabetic members enrolled in the ConditionCare program are eligible for one additional cleaning and exam, or periodontal maintenance visit (if the member has a history of periodontal surgery) during the Plan Year.
- High Risk Cardiac members are eligible for one additional cleaning and exam, or periodontal visit (if the member has a history of periodontal surgery) during the Plan Year.

See the information in this section on enrolling in the Future Moms or ConditionCare programs.

Employee Assistance Program (EAP)

In today's fast-paced world, juggling work, your personal life and all the associated demands and pressures can feel overwhelming. Fortunately, You have somewhere to turn - the Employee Assistance Program (**EAP**) administered by ValueOptions provides up to four visits per incident per rolling 12 months!

The EAP helps You resolve personal problems before they negatively affect your health, relationships with others, or job performance. You can contact the EAP 24 hours a day, 365 days a year, by simply calling **866-725-0602**.

The EAP provides confidential, professional counseling, education, and referral services to You and your family members on a variety of issues including:

- marital and family problems
- child or adult care issues
- alcohol and/or drug abuse
- balancing work and family
- depression and anxiety
- work-related concerns
- career transition issues
- personal growth and development

Information is also available on the **Achieve Solutions** website, which includes a wealth of educational materials and resources related to Behavioral Health and wellness issues. The site offers information, interactive tools and resources on topics including balancing work and family, your health, taking care of dependents, relationships and life skills. To access the site, log on to **www.achievesolutions.net/covacare**.

CommonHealth Wellness Program

Helping individuals get and stay healthy is the main objective of CommonHealth, the Commonwealth's workforce wellness program. CommonHealth offers free programs delivered to participants wherever they are, and in a format best for them, whether at work, through video, or online. It includes Medical screenings, such as cholesterol and blood pressure checks; help to quit smoking and stay tobacco-free; health education on a variety of topics and other activities. For more information, visit **www.commonhealth.virginia.gov.**

EXCLUSIONS

The following services are not eligible for Reimbursement under any circumstances.

A

Your coverage does not include benefits for **acupuncture**.

B

Exclusions for **Behavioral Health** services, administered by ValueOptions, are listed here and within the body of the book. Check both places for a complete listing.

- Inpatient treatment or Inpatient Stay for conditions requiring only observation, diagnostic examinations, or diagnostic laboratory testing;
- Inpatient treatment which might safely and adequately be rendered in a less intensive level of institutional care;
- Inpatient rehabilitation for the sole treatment of a chemical dependency diagnosis;
- services provided as a result of failure or refusal to obtain treatment or follow a plan of treatment prescribed or directed by a practitioner;
- court ordered psychiatric or substance abuse treatment except when ValueOptions determines that such services are Medically Necessary for the treatment of a DSM-IV mental health diagnosis;
- any testing, therapy, service, supply or treatment of organic disorders, dementia, and primary neurological/neurodevelopmental/neurocognitive disorders, except for associated treatable and acute behavioral manifestations;
- therapies which do not meet national standards for mental health professional practice or which have not been found to be effective or beneficial;
- examination in an Inpatient Setting that is not related to the Behavioral Health diagnosis;
- any testing, therapy, service supply or treatment for personal or professional growth, development, or training for professional certification or treatment relating to employment, regardless of whether investigational or pre or post employment;
- pastoral counseling;
- psychological testing for educational purposes;
- Experimental or Investigative therapies;
- Custodial Care, defined as any services, supplies, care or treatment rendered to a beneficiary or member who:
    - is disabled mentally or physically as a result of a DSM-IV-TR (or ICD-9) mental health/substance abuse diagnosis, and such disability is expected to continue and be prolonged, and
    - requires a protected, monitored or controlled environment whether Inpatient, Outpatient, or at home, and
    - requires assistance with Activities of Daily Living, and
    - Is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the beneficiary to function outside the protected, monitored, controlled environment.

- any testing, therapy, service, supply, or treatment for conditions that are identified by the DSM-IV as not being attributable to a mental disorder but are additional conditions that may be a focus of clinical attention (i.e., V-codes)

Your coverage does not include benefits for **biofeedback therapy**.

Your coverage does not include storage of **blood** by any Provider or Facility other than a hospital.

C

Your coverage does not include benefits for:

- over-the-counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, and ice bags; or
- **cosmetic surgeries and procedures** performed mainly to improve or alter a person's appearance including body piercing and tattooing. A cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process, or to correct congenital abnormalities that cause functional impairment. The patient's mental state will not be considered in deciding if the surgery is cosmetic.

D

Exclusions for **Dental** services, administered by Delta Dental, are listed here and within the body of the book. Check both places for a complete listing.

- Dental supplies;
- brush biopsies of the oral cavity;
- services rendered after the date of termination of the Covered Person's coverage. There is one exception. Covered prosthetic services which are prepped or ordered before the termination date are covered if completed within 30 days following the termination date;
- gold foil restorations;
- athletic mouth guards;
- temporary dentures, crowns or duplicate dentures;
- oral, inhalation or intravenous (IV) sedation;
- bleaching of discolored teeth;
- Dental pit/fissure sealants on other than first and second permanent molars;
- root canal therapy on other than permanent teeth;
- pulp capping (direct or indirect);
- upgrading of working Dental appliances;
- precision attachments for Dental appliances;
- tissue conditioning;
- separate charges for infection control procedures and procedures to comply with OSHA requirements;
- separate charges for routine irrigation or re-evaluation following periodontal therapy;
- analgesics (nitrous oxide);
- general anesthesia except in conjunction with oral surgery, surgical periodontia, or surgical endodontia and then only when the underlying Dental service is a covered benefit;
- diagnostic photographs;
- periodontal splinting and occlusal adjustments for periodontal purposes;

- occlusal analysis;
- controlled release of medicine to tooth crevicular tissues for periodontal purposes;
- tooth desensitizing treatments;
- care by more than one dentist when You transfer from one dentist to another during the course of treatment;
- care by more than one dentist for one Dental procedure, or by someone other than a dentist or qualified Dental hygienist working under the supervision of a dentist;
- preventive control programs, or oral hygiene instructions;
- complimentary services or Dental services for which the member would not be obligated to pay in the absence of the coverage under Your Health Plan or any similar coverage;
- Dental services for lost, misplaced or stolen prosthetic devices including orthodontic retainers, space maintainers, bridges and dentures (among other devices);
- services that Delta Dental determines are for the purpose of cosmetic surgery or dentistry for cosmetic purposes;
- services that Delta Dental determines are for the purpose of correcting congenital malformations or replacing congenitally missing teeth;
- Dental services for increasing vertical dimension, restoring occlusion, correcting developmental malformations, or for esthetic purposes;
- services billed under multiple Dental service procedure codes which Delta Dental, in its sole discretion, determines should have been billed under a single, more comprehensive Dental service procedure code. Delta Dental's payment is based on the allowance for the more comprehensive code, not on the allowances for the underlying component codes; and
- any services not listed as covered under **Dental services** in the **What is covered** section or services determined by Delta Dental, in its sole discretion, to be not necessary or customary for the diagnosis or treatment of the condition. Delta Dental will take into account generally accepted Dental practice standards in the area in which the Dental service is provided. In addition, a Covered Person must have a valid need for each covered benefit. A valid need is determined in accordance with generally accepted standards of dentistry.

E

Your coverage does not include:

- benefits for **educational** services except as otherwise specified in this benefit booklet or when received as part of a covered wellness services visit or screening.
- any services covered by Individuals with Disabilities Education Act (IDEA) except as covered by Early Intervention Services.

Your Medical coverage does not include benefits for **Experimental/Investigative** procedures, except for Clinical Trial Costs for cancer. The criteria for deciding whether a service is Experimental/Investigative or a Clinical Trial Cost for cancer are described in the Definitions section of this booklet.

Your Behavioral Health coverage does not include benefits for **Experimental/Investigative** testing, therapy, service, supply or treatment as determined by ValueOptions in its sole discretion. The criteria for this determination is whether any supply or drug has received final approval to market by the U.S. Food and Drug Administration; whether there is sufficient information in the peer-reviewed medical and scientific literature for ValueOptions to judge safety and efficacy; whether available scientific evidence shows a good effect on health outcomes outside of a research Setting; and whether the service or supply is safe and effective outside a research Setting as a current diagnostic or therapeutic option.

F

Your coverage does not include benefits for **family planning** services. These include:

- services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception, including any drugs administered in connection with these procedures;
- medications used to treat infertility even if they are used for an indication other than fertility; or
- services for abortions, except in the following circumstances and only if not otherwise contrary to law: when Medically Necessary to save the life of the mother; when the pregnancy occurs as a result of rape or incest which has been reported to a law enforcement or public health agency; or when the fetus is believed to have an incapacitating physical deformity or incapacitating mental deficiency which is certified by a Provider.

Your coverage does not include benefits for palliative or cosmetic **foot care** including:

- flat foot conditions;
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;
- foot orthotics;
- subluxations of the foot;
- corns (except as treatment for patients with diabetes or vascular disease);
- bunions (except capsular or bone surgery);
- calluses (except capsular or bone surgery);
- care of toenails (except capsular or bone surgery);
- fallen arches;
- weak feet;
- chronic foot strain; or
- symptomatic complaints of the feet.

H

Your coverage does not include benefits for **routine hearing care** for a hearing loss that is not due to a specific illness or injury, hearing aids, hearing supplies and routine hearing examinations, except as covered under **Well Child** care**.** If You have purchased the vision and hearing option, additional hearing benefits are described in the **Hearing Services** section.

Your coverage does not include benefits for the following **Home Health Services**:

- homemaker services;
- maintenance therapy;
- food and home-delivered meals; or
- custodial care and services.

Your coverage does not include benefits for the following **Hospital Services**:

- guest meals, telephones, televisions, and any other convenience items received as part of your Inpatient Stay; or
- care by interns, residents, house physicians, or other Facility employees that are billed separately from the Facility.

M

Your coverage does not include benefits for the following **Maternity** services:

- breast pumps
- doulas (labor assistants)
- lactations consultants
- childbirth classes
- birthing centers

Your coverage does not include benefits for **Medical Equipment (durable), appliances and devices, and medical supplies** that have both a non-therapeutic and therapeutic use, such as:

- blood pressure cuffs;
- exercise equipment;
- air conditioners, dehumidifiers, humidifiers, and purifiers;
- hypoallergenic bed linens;
- whirlpool baths;
- handrails, ramps, elevators, and stair glides;
- telephones;
- adjustments made to a vehicle;
- foot orthotics;
- changes made to a home or place of business; or
- repair or replacement of equipment You lose or damage through neglect.

Your coverage does not include benefits for Medical Equipment (durable) that is not appropriate for use in the home.

Your coverage does not include benefits for services and supplies if they are deemed not **Medically Necessary** as determined by Anthem or ValueOptions at their sole discretion. Nothing in this exclusion shall prevent You from appealing Anthem's or ValueOptions' decision that a service is not Medically Necessary.

However, if You receive Inpatient or Outpatient services that are denied as not Medically Necessary, or are denied for failure to obtain the required authorization, the following professional Provider services that You receive during your Inpatient Stay or as part of your Outpatient services will not be denied under this exclusion in spite of the medical necessity denial of the overall services:

For Inpatients

1. services that are rendered by professional Providers who do not control whether You are treated on an Inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.

2. services rendered by your attending Provider other than Inpatient evaluation and management services provided to You. Inpatient evaluation and management services include routine Visits by your attending Provider for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management Visits do not include surgical, diagnostic, or therapeutic services performed by your attending Provider.

For Outpatients - services of pathologists, radiologists and anesthesiologists rendering services in an (i) Outpatient hospital Setting, (ii) Emergency room, or (iii) ambulatory surgery Setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician.

O

Your coverage does not include benefits for care of **obesity** or services related to weight loss or dietary control. This includes weight reduction therapies/activities, even if there is a related medical problem.

The exception to this exclusion is for morbid obesity as set forth in the **Professional Services** section. A 12-month pre-surgery education program is required before being considered for bariatric surgery.

Your coverage does not include benefits for **organ or tissue transplants** except as outlined under the **General Rules Governing Benefits** section.

Your **Outpatient Prescription Drug** benefit does not include coverage for:

- over-the-counter drugs;
- any per unit, per month quantity over the Plan's limit;
- drugs used mainly for cosmetic purposes;
- drugs that are Experimental, Investigational, or not approved by the FDA;
- cost of medicine that exceeds the Allowable Charge for that prescription;
- drugs for weight loss, except in conjunction with covered treatment of morbid obesity;
- therapeutic devices or appliances;
- injectable Outpatient Prescription Drugs that are supplied by a Provider other than a pharmacy;
- charges to inject or administer drugs;
- drugs not dispensed by a licensed pharmacy;
- drugs not prescribed by a licensed Provider;
- any refill dispensed after one year from the date of the original prescription order;
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies;
- medicine furnished by any other drug or medical service;
- medications used to treat infertility even if they are used for an indication other than fertility; or medications used to treat short stature syndrome;
- non-sedating antihistamines (NSAs); or
- prescription drugs to treat erectile dysfunction (ED) such as Viagra, Cialis and Levitra.

P

Your coverage does not include benefits for **paternity testing**.

Your coverage does not include benefits for **private duty nurses** in the Inpatient Setting.

Your coverage does not include benefits for **Providers** not listed in the definition section of this handbook. For example, a naturopathic doctor is not considered a Provider.

R

Your coverage does not include **repatriation** (transportation to the United States from a foreign country) for medical emergencies**.**

Your coverage does not include benefits for rest cures, custodial, **residential**, halfway house or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether You receive active 24-hour skilled professional nursing care, daily physician Visits, daily assessments, and structured therapeutic services. Your coverage does not include benefits for care from institutions or facilities that are licensed solely as **residential treatment centers**, intermediate care facilities, or other non-skilled, sub-acute Inpatient Settings.

S

Your coverage does not include benefits for **services or supplies** as follows:

- student health centers;
- ordered by a doctor whose services are not covered under Your Health Plan;
- care of any type given along with the services of an attending Provider whose services are not covered;
- not listed as covered under Your Health Plan;
- not prescribed, performed, or directed by a Provider licensed to do so;
- received before the Effective Date of coverage or after a Covered Person's coverage ends;
- telephone consultations or consultations by other electronic means, except as defined by **Telemedicine**, charges for not keeping appointments, or charges for completing claim forms;
- for travel, whether or not recommended by a physician;
- given by a member of the Covered Person's immediate family;
- provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not You waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor including TriCare, after benefits under this policy have been paid.
- provided under a U. S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government;
- received from an employer mutual association, trust, or a labor union's dental or medical department;

- for diseases contracted or injuries caused because of participation in war, declared or undeclared, voluntary participation in civil disobedience, or other such activities;
- services for which a charge is not usually made. This includes services for which You would not have been charged if You did not have health care coverage.
- amounts above the Allowable Charge for a service;
- self-administered services or self-care;
- self-help training; and
- biofeedback, neurofeedback, and related diagnostic tests.

Your coverage does not include benefits for surgeries for **sexual dysfunction**. In addition, your coverage does not include benefits for services for **sex transformation**. This includes Medical and Behavioral Health services.

Your coverage does not include benefits for the following **Skilled Nursing Facility** Stays:

- treatment of psychiatric conditions and senile deterioration;
- a private room unless it is Medically Necessary; or
- Facility services during a temporary leave of absence from the Facility.

T

Your coverage does not include benefits for the following **therapy services**:

- physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services;
- group speech therapy;
- group or individual exercise classes or personal training sessions; or
- recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

Your coverage does not include benefits for **Telemedicine** as follows:

- an audio-only telephone conversation, electronic mail message, or facsimile transmission between a health care provider and a patient.

V

Your Medical coverage does not include benefits for the following **vision services**:

- surgery to correct nearsightedness and/or farsightedness including keratoplasty and Lasik procedure;
- vision training and orthoptics;
- needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer; or
- any other vision services not specifically listed as covered in accordance with Anthem's Medical policy.

Exclusions for **Routine Vision** services, administered by Anthem's Blue View Vision, are listed here and within the body of the book. Check both places for a complete listing.

- Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.
- Benefits cannot be combined with any offer, coupon, or in-store advertisement.
- Prescription sunglasses of any type; however, discounts are available for non-prescription sunglasses.
- Discounts are not available for certain brand-name frames in which the manufacturer imposes a no discount policy.
- Services required by your employer in connection with employment or benefits that would be covered under worker's compensation.
- Safety glasses and accompanying frames.
- Hospital Care - Inpatient or Outpatient hospital vision care.
- Orthoptics or vision training and any associated supplemental testing.
- Any non-prescription lenses, eyeglasses, contacts, Plano lenses or lenses that have no refractive power.
- Any other vision services not specifically listed as covered in accordance with Anthem Blue View Vision policy.

W

Your Health Plan does not include benefits for services or supplies if they are for **work-related** injuries or diseases when the employer, or worker if self-employed, must provide benefits by federal, state, or local law or when that person's work-related health claims have been paid by the employer. This exclusion applies even if You waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the Covered Person reaches a settlement with his or her employer or the employer's insurer or self-insurance association because of the injury or disease.

BASIC PLAN PROVISIONS

1) The Department's Right to Change, End, and Interpret Benefits

Your Health Plan is sponsored by the Commonwealth of Virginia (State) and administered by the Department of Human Resource Management. The Department is authorized to, and reserves the right to, change or terminate Your Health Plan on behalf of the Commonwealth at any time. These retained rights extend, without limit, to all aspects of Your Health Plan, including benefits, eligibility for benefits, Provider networks, premiums, Copayments and contributions required of employees. The Department is also authorized and empowered to exercise discretion in interpreting the terms of Your Health Plan and such discretionary determination will be binding on all parties.

2) You and Your Provider

You have the right to select your own Provider of care. Services provided by an institutional Provider are subject to the rules and regulations of Your Health Plan You select. These include rules about admission, discharge, and availability of services. Neither the Plan Administrator, the State, nor the COVA Care Plan guarantees admission or the availability of any specific type of room or kind of service. Neither the Plan Administrator, the State, nor the COVA Care Plan will be responsible for acts or omissions of any Facility. Neither the Plan Administrator, the State, nor the COVA Care Plan will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a Facility. Neither the Plan Administrator, the State, nor the COVA Care Plan will be liable for breach of contract because of anything done, or not done, by a Facility.

Similarly, the Plan Administrator is obligated only to pay, in part, for the services of your professional Provider to the extent the services are covered. Neither the Plan Administrator, the State, nor the COVA Care Plan guarantees the availability of a Provider's services. Neither the Plan Administrator, the State, nor the COVA Care Plan will be responsible for acts or omissions of any Provider. Neither the Plan Administrator, the State, nor the COVA Care Plan will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a Provider. Neither the Plan Administrator, the State, nor the COVA Care Plan will be liable for breach of contract because of anything done, or not done, by a Provider. The same limitations apply to services rendered or not rendered by a Provider's employee.

You must tell the Provider that You are eligible for services. When You receive services, show Your Health Plan identification card. Show only your current card.

3) Privacy Protection and Your Authorization

Information may be collected from other people and facilities. This is done in order to administer your coverage. The information often comes from medical care facilities and medical professionals who submit claims for You. Collected information is disclosed to others only in accordance with the guidelines set forth in the Health Insurance Portability and Accountability Act (HIPAA) and in the Virginia Insurance Information and Privacy Protection Act.

When You apply for coverage under the COVA Care Plan, You agree that the Plan Administrator may request any medical information or other records from any source when related to claims submitted to the Plan Administrator for services You receive.
By accepting coverage under the COVA Care Plan, You authorize any individual, association, or firm which has diagnosed or treated your condition to furnish the Plan

Administrator with necessary information, records, or copies of records. This authorization extends to any person or organization which has any information or records related to the service received or to the diagnosis and treatment of your condition.

If the Plan Administrator asks for information and does not receive it, payment cannot be made. The claim will be processed only when the requested information or record has been received and reviewed.

Medical information is often highly confidential. You are entitled to review or receive only copies of medical information which applies to You. But, subject to the above, a member may review copies of medical records which pertain to enrolled dependent children under age 18 as allowed by law.

4) The Personal Nature of These Benefits (Assignment of Benefits)

Plan benefits are personal; that is, they are available only to You and your covered dependents. You may not assign (give to another person) your right to receive services or payment, except as provided in law. Prior payments to anyone will not constitute a waiver of or in any way restrict the Plan Administrator's right to direct future payments to You or any other individual or Facility, even if there has been an assignment of payment in the past. This paragraph will not apply to assignments made to dentists and oral surgeons.

You and the Plan Administrator agree that other individuals, organizations, and health care practitioners will not be beneficiaries of the payments provided under this contract. This explanation of services and payments available to You is not intended for anyone else's benefit. As such, no one else (except for your personal representative in case of your death or mental incapacity) may assert any rights described in this booklet or provided under Your Health Plan.

5) Proof of Loss

In many cases, the Facility or Provider will submit your claim to the Plan Administrator. However, the Plan Administrator cannot process claims for You unless there is satisfactory proof that the services You received are covered. In most cases, "satisfactory proof " is a fully itemized bill which gives your name, date of the service, cost of the service, and the diagnosis for the condition. In some cases, the Plan Administrator will need additional proof, such as medical information or explanations. Your cooperation may be requested. Your claim cannot be processed until the needed information is received. All claims information and explanations submitted to the Plan Administrator must be in writing.

6) Timely Filing of Claims

No claim (proof of loss) will be paid if the Plan Administrator receives it more than 12 months after the end of the calendar year in which the services were received.

7) Payment Errors

Every effort is made to process claims promptly and correctly. If payments are made to You, or on your behalf, and the Plan Administrator finds at a later date the payments were incorrect, the Plan Administrator will pay any underpayment. Likewise, You must repay any overpayment. A written notice will be sent to the member if repayment is required.

8) Benefits Administrator and Other Plan Information

Your Benefits Administrator is the person appointed by your employer to assist You with your health care benefits. Your Benefits Administrator may also provide You information about your benefits. If there is a conflict between what your Benefits Administrator tells You and Your Health Plan, your benefits will, to the extent permitted by law, be determined on the basis of the language in this booklet. The Benefits Administrator is never the agent of the Plan Administrator.

The Plan Administrator may send communications intended for You to your Benefits Administrator. You may be provided with another booklet, brochure, employee communication, or other material which describes the benefits available under Your Health Plan. In the event of conflict between this type of information and Your Health Plan, your benefits will be determined on the basis of the language in this booklet.

9) Health Insurance Portability and Accountability Act (HIPAA) of 1996 and Certificate of Creditable Coverage

In the event that You leave this health plan and go to a health plan that includes a pre-existing condition waiting period, You may be eligible for creditable coverage. The following list is considered creditable coverage and your new health plan may reduce the pre-existing condition waiting period by the amount of time, if any, You were covered by the following similar plans:

- Medicare, Medicaid, Tricare, a medical care program of the Indian Health Service Program or a tribal organization, a Health Benefit Plan under the Peace Corps Act, a State health benefits risk pool, or any other similar publicly-sponsored program;
- a group Health Benefit Plan;
- a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et. Seq.);
- a public health plan (as defined in federal regulations);
- your current employer's eligibility waiting period;
- health insurance coverage consisting of benefits for medical care issued by an insurer, a health maintenance organization, a health service plan, or a fraternal benefit society; or
- individual health insurance coverage.

If You should leave the COVA Care Plan, your Benefits Administrator will provide You with proof of prior coverage (certificate of coverage) for your new health plan if needed.

10) Plan Administrator's Continuing Rights

On occasion, the Plan Administrator or the State may not insist on your strict performance of all terms of Your Health Plan. Failure to apply terms or conditions does not mean the Plan Administrator or the State waives or gives up any future rights it may have. The Plan Administrator or the State may later require strict performance of these terms or conditions.

11) Time Limits on Legal Actions and Limitation on Damages

No action at law or suit in equity may be brought against the Plan Administrator, the State, or the COVA Care Plan in any matter relating to (1) Your Health Plan, (2) the Plan Administrator's performance or the State's performance under Your Health Plan; or (3) any statements made by an employee, officer, or director of the Plan Administrator, the State, or the COVA Care Plan concerning Your Health Plan or the benefits available if the matter in dispute occurred more than one year ago.

In the event You or your representative sues the Plan Administrator, the State, the COVA Care Plan, or any director, officer, or employee of the Plan Administrator, the State, or the COVA Care Plan acting in a capacity as a director, officer, or employee, your damages will be limited to the amount of your claim for covered services. The damages will not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. In no event will this contract be interpreted so that punitive or indirect damages, legal fees, or damages for emotional distress or mental anguish are available.

12) Services After Amendment of Your Health Plan

A change in Your Health Plan will change covered services available to You on the Effective Date of the change. This means that your coverage will change even though You are receiving covered services for an ongoing illness, injury, pregnancy-related condition, or if You may need more services or supplies in the future. There is only one exception. If You are an Inpatient on the day a change becomes effective, covered services your hospital provides You will not be changed for that admission. In this case, the change in your coverage will be effective immediately after your discharge for that admission.

13) Misrepresentation

A member's coverage can be canceled by the Plan Administrator, the State, or the COVA Care Plan if it finds that any information needed to accept the member or process a claim was deliberately misrepresented by, or with the knowledge of, the member. The Plan Administrator, the State, or the COVA Care Plan may also cancel coverage for any other family members enrolled with the member. When false or misleading information is discovered, the Plan Administrator, the State, or the COVA Care Plan may cancel coverage retroactive to the date of misrepresentation.

14) Non-Payment of Monthly Charges

If You are required to pay monthly charges to maintain coverage, and such charges are late, the Plan Administrator has the right to suspend payment of your claims. The Plan Administrator will not be responsible for claims for any period for which full monthly charges have not been paid. If your monthly charges remain unpaid 31 days from the date due, the State may instruct the Plan Administrator to cancel your coverage.

15) Death of a Member

Covered family members of active employees retain coverage until the last day of the month immediately following the month the employee’s death occurred. The employee’s family members may elect Extended Coverage. Refer to the Eligibility, Enrollment and Changes section of this booklet.

16) Divorce

Coverage will end for the enrolled spouse of a member on the last day of the month in which the final divorce decree is granted unless continuation of coverage is properly elected and maintained. Refer to the Eligibility, Enrollment and Changes section of this booklet.

17) End of Dependent Coverage

When a dependent is no longer eligible for coverage, the dependent must notify the Plan Administrator in writing that he/she wishes to continue coverage under another contract or certificate rather than through the State Health Benefits Program. Refer to the Eligibility, Enrollment and Changes section of this booklet.

18) Women's Health and Cancer Rights

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1988 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and the reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other Medical and surgical benefits provided under this plan. Your Health Plan is required to provide You with a notice of your rights under WHCRA when You enroll in the Health Plan, and then once each year.

ELIGIBILITY, ENROLLMENT AND CHANGES

Who Is Eligible for Coverage

You are eligible for coverage if You are a part- or full-time, salaried, classified employee, or similarly situated employee at an independent state agency; or a regular, full-time or part-time salaried faculty member. A full-time salaried employee is one who is scheduled to work at least 32 hours per week, or carries a faculty teaching load considered to be full time at his institution. Your eligible dependents also may be covered. Retirees, LTD participants and survivors may also be eligible for coverage as described later in this section.

You may choose your type of membership as follows:
Employee/retiree single – to cover yourself only
Employee/retiree plus one – to cover yourself and one eligible dependent
Family – to cover yourself and two or more eligible dependents

Participants who fail to take off ineligible persons within 60 days of the dependent's loss of eligibility may be removed from the program for a period of up to three years. In addition, the participant will be responsible for claims paid in error and will be unable to reduce health benefits membership except during open enrollment or with a consistent qualifying mid-year event.

The Following Dependents are Eligible for Coverage Under Your Health Plan

The Employee's Legal Spouse
The marriage must be recognized as legal in the Commonwealth of Virginia.

The Employee's Children
Under the health benefits program, the following eligible children may be covered to the end of the calendar year in which they turn age 26 (the Plan's Limiting Age). The age requirement is waived for adult incapacitated children:

Natural children
Adopted children, and children placed for adoption.

Stepchildren
A stepchild is the natural or legally adopted child of the participant's legal spouse. Such marriage must be recognized by the Commonwealth of Virginia.

Incapacitated dependents
Adult children who are incapacitated due to a physical or mental health condition, as long as the child was covered by Your Health Plan and the incapacitation existed prior to the termination of coverage due to the child attaining the Plan's Limiting Age. The employee must make written application, along with proof of incapacitation, prior to the child reaching the Plan's Limiting Age. Such extension of coverage must be approved by Your Health Plan and is subject to periodic review. Should Your Health Plan find that the child no longer meets the criteria for coverage as an incapacitated child, the child's coverage will be terminated at the end of the month following notification from Your Health Plan to the enrollee. The child must live with the employee as a member of the employee's household, not be married, and be dependent upon the employee for financial support. In the cases where the natural or adoptive parents are living apart, living with the other parent will satisfy the condition of living with the employee. Furthermore, the support

test is met if either the employee or other parent or combination of the employee and other parent provide over one-half of the child's financial support.

Adult incapacitated children of new employees who have been continuously incapacitated may also be covered provided that:

- The enrollment form is submitted within 30 days of hire;
- The child has been covered continuously as an incapacitated dependent on a parent's group employer coverage since the incapacitation first occurred; or as a Medicaid/Medicare recipient;
- The incapacitation commenced prior to the child attaining the limiting age of Your Health Plan; and
- The enrollment form must be accompanied by a letter from a physician explaining the nature of the incapacitation, date of onset and certifying that the dependent is not capable of financial self-support. This extension of coverage must be approved by the Health Plan in which the employee or spouse is enrolled.

Adding Adult incapacitated dependents as a Qualifying Mid-Year Event

Adult incapacitated dependents that are enrolled as an incapacitated dependent on a parent's group employer coverage, or in Medicare or Medicaid, may be enrolled in the State Health Benefits Program with a consistent qualifying mid-year event (as defined by the Office of Health Benefits) if the dependent remained continuously incapacitated, eligibility rules are met, required documentation is provided and the administrator for the plan in which the employee is enrolled approves the adult dependent's condition as incapacitating. Eligibility rules require that the incapacitated dependent live at home, is not married, and receives over one-half of his or her financial support from the employee.

The following documentation is required by the plan administrator to approve the dependent's coverage:

- Evidence that the dependent has been covered continuously as an incapacitated dependent on a parent's group employer coverage, or covered under Medicaid or Medicare, since the incapacitation first occurred;
- Proof that the incapacitation commenced prior to the dependent attaining age 26; and
- An enrollment form adding the dependent within 60 days of the qualifying mid-year event accompanied by a letter from a physician explaining the nature of the incapacitation, date of onset and certifying that the dependent is not capable of financial self-support. Additionally the plan reserves the right to request additional medical information and to request an independent medical examination.

If an incapacitated dependent leaves the State Health Benefit Program and later wants to return, the review will take into consideration whether or not the same disability was present prior to them reaching the Plan's Limiting Age of 26 and continued throughout the period that the child was not covered by the State Health Benefits Program. If the dependent was capable of financial self-support as an adult, and then backtracked into disability, the disability is considered to have begun after the Plan's Limiting Age and the person cannot be added to the State Health Benefits Program.

Other Children

An unmarried child in which a court has ordered the employee (and/or the employee's legal spouse) to assume sole permanent custody. The principal place of residence is with the employee, the child is a member of the employee's household, the child receives

over one-half of his or her support from the employee, and the custody was awarded prior to the child's 18th birthday.

Additionally, if the employee or spouse shares custody with their minor child who is the parent of the "other child", then the other child may be covered. The other child, the parent of the other child, and the spouse, if the spouse is the one who has shared custody, must be living in the same household as the employee.

When the minor child, who is the parent of the other child, reaches age 18, the employee must obtain sole permanent custody of the other child and provide this documentation to the Benefits Administrator.

You cannot cover a person as a dependent unless that person is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico. However, there is an exception for certain adopted children. If You are a U.S. citizen or U.S. national who has legally adopted a child who is not a U.S. citizen, U.S. resident alien, or U.S. national, You may cover the child, if the child lived with You as a member of your household all year. This exception also applies if the child was lawfully placed with You for legal adoption.

Documentation Requirements
You must provide proof of a dependent's eligibility anytime You add a dependent to health care. The chart below shows the documentation required. In addition, documentation is required for each qualifying mid-year event.

Dependents	Eligibility Definition	Documentation Required
Spouse	The marriage must be recognized as legal in the Commonwealth of Virginia. **Note: Ex-spouses will not be eligible, even with a court order.**	➢ Photocopy of marriage certificate, **and** ➢ Photocopy of the top portion of the first page of the employee's most recent Federal Tax Return that shows the dependent listed as "Spouse". NOTE: All financial information and Social Security Numbers can be redacted.
Natural or Adopted Son/Daughter	A son or daughter may be covered to the end of the year in which he or she turns age 26.	➢ Photocopy of birth certificate or legal adoptive agreement showing employee's name (Note: If this is a legal pre-adoptive agreement, it must be reviewed and approved by the Office of Health Benefits.)
Stepson or Stepdaughter	A stepson or stepdaughter may be covered to the end of the year in which he or she turns age 26.	➢ Photocopy of birth certificate (or adoption agreement) showing the name of the employee's spouse; **and** ➢ Photocopy of marriage certificate showing the employee and dependent parent's name; **and** ➢ Photocopy of the most recent Federal Tax Return that shows the dependent's parent listed as "Spouse". NOTE: All financial information and Social Security Numbers can be redacted**.**

Dependents	Eligibility Definition	Documentation Required
Other Female or Male Child - Exception	If the employee (or employee's spouse) shares custody with their minor child who is the parent of an "other female or male child", then that "other child" may also be covered if the other child, the minor child (who is the parent), **and** the employee's spouse (if applicable) ✓ all live in the same household as the employee; ✓ both children are unmarried; **and** ✓ both children received over one-half of their support from the employee. The minor child must meet all of the eligibility requirements for a dependent child. Once the minor child turns 18, the employee or spouse if applicable, must receive sole custody of the other child.	➢ Photocopy of the other child's birth certificate showing the name of the minor child as the parent of the other child; ➢ Photocopy of the birth certificate (or adoptive agreement) for the minor child showing the name of the employee; **and** ➢ Photocopy of the Final Court Order with presiding judge's signature.
Incapacitated Adult Dependents	The employee's adult children who are incapacitated due to a physical or mental health condition may be covered beyond the end of the year in which he or she turns age 26 if: ✓ they are unmarried; ✓ reside full-time with the employee (or the other natural/adoptive parent); ✓ the employee provides more than half of the dependent's support; ✓ they are deemed incapacitated prior to the end of the year in which they reach age 26; **and** ✓ they have maintained continuous coverage under an employer-sponsored plan of the employee (or the other natural/adoptive parent). Coverage through Medicare or Medicaid will be deemed coverage through the employee.	➢ Photocopy of birth certificate or legal adoptive agreement showing employee's name. ➢ In the case of a new employee, copy of the HIPAA Certificate showing prior employer-sponsored coverage. ➢ Other medical certification and eligibility documentation as needed.

When a child loses eligibility, coverage terminates at the end of the month in which the event that causes the loss of eligibility occurs.

Coverage for Retirees and Long Term Disability (LTD) Participants
Retirees and LTD participants who enroll within 31 days of starting retirement or losing eligibility for coverage as an active employee may be eligible for coverage under the Health Plan until they become eligible for Medicare (either due to age or disability). Dependent eligibility for the retiree group does not differ from that of active employees. See your Benefits Administrator for more information about eligibility for coverage in the retiree group.

Who Is Not Eligible For Coverage
There are certain categories of persons who may not be covered as dependents under the program. These include dependent siblings, grandchildren, nieces, and nephews except where the criteria for "other children" are satisfied. Parents, grandparents, aunts, and uncles are not eligible for coverage regardless of dependency status.

Enrollment and Changes
There are only certain times when You may enroll yourself and eligible dependents in a health benefits plan, or change your type of membership or plan. You must remove anyone who is no longer eligible for the plan within 60 days of losing eligibility. You risk suspension from the health benefits program for up to three years if You cover individuals who do not qualify.

When Newly Eligible
You have up to 30 calendar days to enroll from your date of hire or becoming eligible. The 30-day countdown period begins on the first day of employment and ends 30 days later. If the enrollment action is received within the 30 calendar day time frame, coverage will be effective the first of the month coinciding with or following the date of employment.

There is no discretion allowed in this area. Coverage will always be effective as described above. In no case will coverage begin before your first day of employment. In addition, once You have submitted an election within 30 days of employment, that election is binding and may not change after it takes effect.

Full-time to Part-time
When your employment status changes from full-time to part-time, your health care election automatically terminates at the end of the month that You cease to be a full-time employee because the State does not contribute to the premium for part-time employees. You continue to be eligible for health care coverage as a part-time employee; however, You must re-enroll in coverage within 60 days of the last day You are in full-time employment status. As a part-time classified employee, You are responsible for paying the total health care premium.

Retirement
Retirees eligible for coverage in the State Retiree Health Benefits Program but not eligible for Medicare due to age may elect coverage under the Health Plan if they enroll in the retiree group within 31 days of their retirement date. Eligible retirees who did not participate in the Health Plan as an active employee prior to retirement may enroll in single coverage at the time of retirement if they do so within 31 days of their retirement date. New retirees may increase membership with the occurrence of a separate qualifying mid-year event that would allow the increase. Non-Medicare eligible retiree group participants may make membership and plan changes upon the occurrence of a qualifying mid-year event and at open enrollment. Retiree group participants may reduce membership level at any time, and the Effective Date will be the first day of the month after the notification is received by their Benefits Administrator. However, retirees who cancel their own coverage may not return to the program.

Long Term Disability
Long Term Disability (LTD) participants eligible for coverage in the State Retiree Health Benefits Program but not eligible for Medicare may elect coverage under the Health Plan if they enroll in the retiree group within 31 days of the date that their coverage or eligibility for coverage as an active employee ends.

Like non-Medicare eligible retirees, non-Medicare eligible LTD participants may make membership and plan changes upon the occurrence of a qualifying mid-year event or at open enrollment, and they may reduce their membership level at any time. However, LTD participants who cancel their own coverage outside of open enrollment and without a qualifying mid-year event, or who are terminated for non-payment of premiums while enrolled in the retiree group, will not be reinstated at any level for the duration of the LTD period.

During Open Enrollment
Health benefits open enrollment occurs in the spring for employees and retirees who are not eligible for Medicare. The spring open enrollment is your opportunity to make changes in your health benefits plan and/or type of membership. The benefits and premiums associated with your open enrollment elections will be effective July 1 through June 30 of the following Plan Year.

Qualifying Mid-Year Events (Changes Outside Open Enrollment)
You may make membership and plan changes during the Plan Year that are based on qualifying mid-year events. You must submit your change within 60 calendar days of the event. The countdown begins on the day of the event. Normally the change will be effective the first of the month after the date the submission of an election change is received.

The following events permit a change outside open enrollment. You may change a benefit election when a valid qualifying mid-year event occurs, but only if your change is made on account of, and corresponds with, a qualifying mid-year event that affects your own, your spouse's or your dependent's eligibility for coverage. If You have questions about these events, contact your Benefits Administrator.

- Birth, Adoption, or Placement for Adoption*
- Child Covered under You Health Plan Lost Eligibility
- Death of Child
- Death of Spouse
- Dependent Care Cost or Coverage Change
- Divorce
- Employment Change – Full-time to Part-time
- Employment Change – Part-time to Full-time
- Employment Change – Unpaid Leave of Absence
- Gained Eligibility under Medicare or Medicaid
- HIPAA Special Enrollment
- Judgment, Decree, or Order to Add Child
- Judgment, Decree, or Order to Remove Child
- Lost Eligibility under Governmental Plan
- Lost Eligibility under Medicare or Medicaid
- Marriage
- Move Affecting Eligibility for Health Care Plan
- Other Employer's Open Enrollment or Plan Change
- Spouse or Child Gained Eligibility under Their Employer's Plan
- Spouse or Child Lost Eligibility under Their Employer's Plan

* Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation. An agreement for full or partial support of a child will constitute a legal obligation only if the obligation is enforceable in a court of competent jurisdiction, which depends on the facts and circumstances associated with the agreement. The employee must be party to the support agreement and the agreement must extend beyond the obligation to provide medical coverage.

HIPAA Special Enrollment
If You are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, under a *HIPAA Special Enrollment* You may be able to enroll yourself and your dependents in this plan if You or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, You must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if You have a new dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll yourself and your dependents. However, You must request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

If You are eligible for health coverage, but not covered in a state health plan, there are two additional circumstances under the Health Insurance Portability and Accountability Act (HIPAA) that will permit You to enroll. You may enroll when:

- You or your dependent lose coverage in Medicaid or the State Children's Health Insurance Program (CHIP) and You request coverage under the plan within 60 days of the time your coverage ends; or
- You or your dependent become eligible for a Medicaid or CHIP premium assistance subsidy and You request coverage under the plan within 60 days after your eligibility is determined.

Special Enrollment Provisions for Birth, Adoption or Placement for Adoption
An exception to prospective changes is health plan coverage for newborns, adopted children, and those children placed for adoption. In these events, health plan coverage will be retroactive to the date of birth, adoption or placement for adoption.

However, in some cases, employees may make the health plan coverage election on a prospective basis. If the employee can provide documentation of coverage for the month of birth, adoption or placement for adoption, then their coverage in the State's plan can be effective the first of the month following receipt of the enrollment action.

In all cases the employee has 60 days from the date of the event to decide which option to choose (retroactive or prospective enrollment).

Terminations Required by the Plan
You can only provide coverage for family members who meet the health plan's eligibility definition. Terminations required by the plan would include events such as divorce, death of a dependent and when a child loses eligibility. In cases where there is a loss of dependent eligibility, the effective date of the change is based on the date of the event.

You still have 60 calendar days to submit the enrollment action to remove the ineligible dependent. However, the change is effective the end of the month in which the dependent lost eligibility. Once the dependent has been removed from coverage, your membership may be reduced. If the membership is reduced, the agency needs to refund premiums paid for the higher membership following the dependent's loss of eligibility. If You do not make an enrollment action within the 60 day time frame, then the current membership level will be maintained and there will be no refund of premium.

After Coverage Ends

Coverage ends on the last day of the month during which eligibility ceases. Unless otherwise agreed to in writing by the Commonwealth of Virginia, Department of Human Resource Management, the Covered Person's coverage ends on the last day of the month for which full payment is made. When a Covered Person ceases to be eligible or the required premiums are not paid, the Covered Person's coverage will end.

Examples of when a Covered Person's eligibility may cease include:

- when You leave your job with the employer, or change from full-time to hourly employment; (Note: Employees changing from full-time to part-time employment remain eligible; however, coverage for an employee making this change is cancelled and the employee must re-enroll if continued coverage is desired. Part-time employees are responsible for paying the total health benefits premium.)
- when a dependent child becomes self-supporting or marries;
- when a dependent child reaches the end of the year in which the child turns 26;
- in the case of an incapacitated dependent, when the child is no longer incapacitated; or
- in the case of your spouse, when You and your spouse divorce.

There are two exceptions. If You are an Inpatient the day your coverage ends, your Facility and Professional Provider coverage will continue until You are discharged to the extent that services were covered prior to the end of coverage. This would include all types of confinement: Acute Care, rehabilitation and Skilled Nursing Facility. All services must continue to meet medical necessity guidelines. Also, Other Covered Services such as rental of Medical Equipment (durable) will be provided for a limited time for a condition for which You received covered services before your coverage ended. The time will be the shorter of when You become covered under any other group coverage, or the end of the Plan Year your coverage ends, or a period equal to the time You were enrolled under Your Health Plan.

When You Become Eligible for Medicare
You may remain enrolled under this Health Plan as long as You continue working and meet the other eligibility requirements. See your Benefits Administrator for more information. Contact the nearest Social Security Office or go to **www.ssa.gov** when You or a family member becomes eligible for Medicare (usually at age 65) if You need more information or would like to enroll. Medicare benefits are secondary to benefits payable under the state plan for individuals who have state coverage as a result of their own or their spouse's active employment status with the state since the state has 20 or more employees.

The state plan is required to offer to their active employees who age 65 or over, or otherwise eligible for Medicare, and their Medicare-eligible dependents the same coverage as they offer to employees and their dependents who are not eligible for Medicare (except when Medicare eligibility is due to End Stage Renal Disease and the coordination period is exhausted, Medicare becomes primary to the state plan, even if the coverage is due to active employment). Medicare beneficiaries may terminate active employee coverage within 31 days of Medicare entitlement or reject employer plan coverage in which case they may retain Medicare as their primary coverage. When Medicare is primary payer, employers cannot offer such active employees or their dependents secondary coverage for items and services covered by Medicare. Employers may not sponsor or contribute to individual Medigap or Medicare Supplement policies for beneficiaries who have coverage based on current employment status.

Participating retirees, LTD participants, survivors and their dependents who become eligible for Medicare, whether due to age or disability, and wish to continue participation in the State Retiree Health Benefits Program, must immediately enroll in one of the program's Medicare-coordinating plans. To ensure access to supplemental benefits, they must enroll in Medicare Parts A and B immediately upon eligibility. Failure to enroll in Parts A and B may result in coverage deficits since the program's Medicare-coordinating plans will not pay any part of a claim that would have been covered by Medicare had the participant been properly enrolled in Medicare. If it is determined that a retiree group participant is eligible for Medicare but has continued coverage in a non-Medicare coordinating plan, primary claim payments made in error may be retracted.

For more information about coordination of benefits with Medicare, call **800-MEDICARE** or go to **www.Medicare.gov**.

When the Member Dies

Covered family members of active employees retain coverage until the last day of the month immediately following the month the employee's death occurred. The employee's family members may elect Extended Coverage. Survivor benefits may be available –refer to the section of the handbook "Survivors of State Employees."

Upon the death of a retiree or LTD participant, covered survivors are covered until the last day of the month in which the death occurs, and eligible survivors may obtain additional retiree group coverage as follows:

- Surviving family members for whom VRS survivor benefits have been provided may enroll in survivor coverage within 60 days of the retiree's/LTD participant's death, regardless of whether they had coverage prior to the retiree's/LTD participant's death (provided the retiree/LTD participant was still eligible for coverage at the time of death). Annuitant surviving spouses may continue coverage as long as the conditions outlined in the policies and procedures of the Department of Human Resource Management are met. Eligible surviving children may be covered through the end of the year in which they turn age 26 if they continue to meet all other conditions for eligibility stated in the policies and procedures of the Department of Human Resource Management.
- Surviving family members who are enrolled in the program at the time of the retiree's/LTD participant's death may continue coverage in the retiree group by enrolling as survivors within 60 days of the retiree's/LTD participant's death. Non-annuitant surviving spouses may continue coverage until the end of the month in which they remarry, obtain alternate health plan coverage, or cease to meet any other applicable condition outlined in the policies and procedures of the Department of Human Resource Management. Eligible surviving children may be covered until the year in which they turn age 26 if they continue to meet all other conditions for eligibility stated in the policies and procedures of the Department of Human Resource Management.

Participating survivors who become eligible for Medicare must enroll in a Medicare-coordinating plan.

Survivors of State Employees

If a state employee dies while in service, benefits may be available to survivors who either will immediately receive a retirement benefit from the Virginia Retirement System, or per the Code of Virginia, who are covered under the State Health Benefits Program at the time of the employee's death and wish to continue coverage. The deadline to enroll as a survivor is 60 days

from the date of the employee's death. Current health coverage may continue for at least 30 days after the death of a state employee.

Contact the Benefits Administrator of the agency in which the state employee worked to enroll in coverage.

Survivors of retirees and LTD participants may also be eligible for coverage. See the section entitled "When the Member Dies" for more information.

Continuing Coverage When Eligibility Ends
You and your dependents (including children under their own names) may be eligible for Extended Coverage under the Public Health Service Act (see the General Notice of Extended Coverage Rights) below.

General Notice of Extended Coverage Rights
This notice generally explains Extended Coverage, when it may become available to You and your family, and what You need to do to protect the right to receive it.

The right to Extended Coverage was created for private employers by federal law through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and these rights are reflected in the continuation coverage provisions of the Public Health Service Act which covers employees of state and local governments. Extended Coverage can become available to You when You would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under Your Health Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under Your Health Plan and under the law, You should contact your designated Benefits Administrator.

What Is Extended Coverage?
Extended Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, Extended Coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under Your Health Plan is lost because of the qualifying event. These rights are also available to children covered through a Qualified Medical Child Support Order (QMCSO). Under Your Health Plan, qualified beneficiaries who elect Extended Coverage must pay the full cost for Extended Coverage. Time limitations for making Extended Coverage premium payments will be included in the Election Notice provided at the time of the qualifying event.

If You are an employee, You will become a qualified beneficiary if You lose your coverage under Your Health Plan because of either one of the following qualifying events:

- your hours of employment are reduced. This would include periods of leave without pay (even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage) and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage.
- your employment ends for any reason other than your gross misconduct.

If You are the spouse of an employee or retiree group participant, You will become a qualified beneficiary if You lose your coverage under Your Health Plan because of any one of the following qualifying events:

- your spouse dies;
- your spouse's hours of employment are reduced (including periods of leave without pay, even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage, and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage);
- your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under Your Health Plan because of any one of the following qualifying events:

- the parent/employee/retiree dies;
- the parent's/employee's hours of employment are reduced (including periods of leave without pay, even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage, and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage);
- the parent's/employee's employment ends for any reason other than his or her gross misconduct;
- the parents become divorced, resulting in loss of dependent eligibility;
- the child stops being eligible for coverage as a dependent child under Your Health Plan.

Coverage that is terminated in anticipation of a qualifying event (e.g., divorce) is disregarded when determining whether the event results in a loss of coverage. If termination occurs under this condition but notification of the qualifying event is received from the employee, qualified beneficiary or a representative within 60 days of the date coverage would have been lost due to the qualifying event, Extended Coverage must be made available and effective on the date coverage would have been lost due to the event, but not before.

When Is Extended Coverage Available?

Your Benefits Administrator will automatically offer Extended Coverage to qualified beneficiaries upon the occurrence of the following qualifying events:

- termination of employment;
- reduction in hours of employment resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage, including leaves without pay;
- death of the employee.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse or a dependent child's loss of eligibility for coverage as a dependent child), You or your representative must notify your Benefits Administrator within 60 days of the qualifying event (or within 60 days of the date coverage would be lost due to the qualifying event) by submitting written notification to include the following information:

- the type of qualifying event (e.g., divorce, loss of dependent child's eligibility--including reason for the loss of eligibility);
- the name of the affected qualified beneficiary (e.g., spouse's and/or dependent child's name/s);
- the date of the qualifying event;

- documentation to support the occurrence of the qualifying event (e.g., final divorce decree);
- the written signature of the notifying party;
- if the address of record is incorrect, an address for mailing the Election Notice.

Failure to provide timely notice of these qualifying events will result in loss of eligibility for continuation coverage. One notice will cover all affected qualified beneficiaries. Notice will be considered furnished when mailed or, in the case of hand delivery, on the date it is received by your Benefits Administrator.

How Is Extended Coverage Provided?
Once the designated Commonwealth of Virginia Benefits Administrator becomes aware or is notified that the qualifying event has occurred, Extended Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect Extended Coverage. Covered employees may elect Extended Coverage on behalf of an eligible spouse, and parents may elect Extended Coverage on behalf of their eligible children.

Extended Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee/retiree, your divorce, or a dependent child's loss of eligibility as a dependent child, Extended Coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, Extended Coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before his coverage ends due to termination of employment, Extended Coverage for his covered spouse and/or children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date that coverage was lost due to termination of employment (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of employee's hours of employment, Extended Coverage may last for only up to a total of 18 months. There are two ways in which this 18-month period can be extended.

1) Disability extension of 18-month period of continuation coverage
You and anyone in your family covered under the Extended Coverage provisions of Your Health Plan (due to termination of employment or reduction of hours) may be entitled to receive up to an additional 11 months of continuation coverage if it is determined by the Social Security Administration that any covered family member is disabled at some time during the first 60 days of continuation coverage, and the disability lasts at least until the end of the 18-month initial period of continuation coverage. The Office of Health Benefits Extended Coverage Administrator must receive notification of the disability determination within 60 days of either 1.) the date of the disability determination; 2.) the date of the qualifying event; 3.) the date on which coverage would be lost due to the qualifying event; or, 4.) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through this General Notice), AND within the first 18 months of Extended Coverage. Notification must be presented in writing and include the following information:
- the name of the disabled qualified beneficiary;
- the date of the determination;
- documentation from the Social Security Administration to support the determination;
- the written signature of the notifying party (qualified beneficiary or representative);
- if the address of record is incorrect, a correct mailing address.

2) Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 18 months of Extended Coverage, the spouse and dependent children in your family can get up to 18 additional months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given (in the format and time frame specified below) to the Office of Health Benefits Extended Coverage Administrator. The extension may be available to the spouse and any dependent children receiving continuation coverage if the employee/former employee dies, the employee/former employee becomes divorced from the covered spouse, or the covered dependent child ceases to be eligible under Your Health Plan, but only if the event would have caused the spouse or dependent child to lose coverage under Your Health Plan had the first qualifying event not occurred. Written notification must be given within 60 days of the date coverage would have been lost due to the second qualifying event and should include the following information:

- the type of second qualifying event (e.g., divorce, loss of dependent eligibility);
- the name of the affected qualified beneficiary (e.g., spouse and/or dependent child);
- the date of the second qualifying event;
- documentation to support the occurrence of the second qualifying event (e.g., final divorce decree);
- the written signature of the notifying party;
- if the address of record is incorrect, a correct mailing address.

Failure to furnish timely and complete notification of the second qualifying event or disability determination will result in loss of additional Extended Coverage eligibility. Notice will be considered furnished when mailed or, in the case of hand delivery, on the date it is received by your Benefits Administrator.

Separate guidelines apply to continuation coverage under the provisions of the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA). If these provisions apply to you, see your Benefits Administrator for more information.

If You Have Questions
Questions concerning Your Health Plan or your Extended Coverage rights should be addressed to the contact listed under “Plan contact information.”

Keep your Benefits Administrator Informed of Address Changes
In order to protect your family’s rights, You should keep your Benefits Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices You send to your Benefits Administrator or the Office of Health Benefits Extended Coverage Administrator.

Plan Contact Information
For information about Extended Coverage, initial notification of qualifying events, and initial enrollment, contact your agency Benefits Administrator.

To make changes to Extended Coverage after initial enrollment, contact:

Office of Health Benefits
Extended Coverage Administrator
101 N. 14th Street, 13th Floor
Richmond, VA 23219

Health Insurance Portability and Accountability Act (HIPAA)

Certificate of Group Health Plan Coverage

Date of this certificate: _____

Name of participant: _____

Name of health care plan: _____

Participant's identification number: _____

Membership level (Single, Employee + One, Family): _____

Name of individuals to whom this certificate applies: _____

Was the period of creditable coverage more than 18 months? (disregard periods of coverage before a 63-day break.) (Yes/No): _____

If less than 18 months, date coverage began: _____

Date coverage ended: _____

Date waiting period began: Not applicable

Person preparing this certificate and to whom questions should be addressed:

Name: _____

Address: _____

_____

Telephone number: _____

Email address: _____

Agency: _____

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

Statement of HIPAA Portability Rights
This certificate is evidence of your coverage under the plan. You may need evidence of coverage to reduce a pre-existing condition exclusion period under another plan, to help You get special enrollment in another plan, or to get certain types of individual health coverage even if You have health problems. This certificate, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is furnished to everyone leaving the State Health Benefits Program or the State Retiree Health Benefits Program (except for Medicare Supplement Plans). You may obtain additional certificates for You or your covered family members from your Agency Benefits Administrator (or the Virginia Retirement System for retirees) should You need them during the 24 months following your termination from the plan.

Pre-Existing Condition Exclusions
Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if You are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, Extended Coverage (COBRA), coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If You do not receive a certificate for past coverage, talk with your new Plan Administrator.

You can add up any creditable coverage You have, including the coverage shown on this certificate. However, if at any time You went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage You had before the break.

- Therefore, once your coverage ends, You should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if You enroll in another plan.

Right to Get Special Enrollment in Another Plan
Under HIPAA, if You lose your group health plan coverage, You may be able to get into another group health plan for which You are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if You request enrollment within 30 days. (Additionally, special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if You are eligible for coverage in another plan (such as a spouse's plan), You should request special enrollment as soon as possible.

Prohibition Against Discrimination Based on a Health Factor
Under HIPAA, a group health plan may not keep You (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge You (or

your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Rights to Individual Health Coverage
Under HIPAA, if You are an "eligible individual," You have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, You must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for Extended Coverage (COBRA) or You have exhausted your Extended Coverage (COBRA) benefits; and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether You are laid off, fired, or quit your job.

Therefore, if You are interested in obtaining individual coverage and You meet the other criteria to be an eligible individual, You should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

For More Information
If You have questions, You may contact the person who prepared this certificate (contact information included). You may also contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at **866-444-3272** (for free HIPAA publications ask for publications concerning changes in health care laws) or the CMS publications hotline at **800-633-4227** (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at **www.dol.gov/ebsa**, the U.S. Department of Labor's interactive web pages – Health Elaws, or **www.cms.hhs.gov/HealthinsReformforConsume.**

Request for Certificate of Group Health Plan Coverage

Use this form to request a Certificate of Group Health Plan Coverage from your Benefits Administrator. You may obtain additional certificates for You or your covered family members upon request while You are covered by the plan and during the 24 months following your termination from the plan.

Date of request: _____

Name of participant: _____

Address: _____

_____

Telephone number: _____

Email address: _____

Name and relationship of any dependents for whom certificates are requested (and their address if different from above:

_____

_____

_____

_____

HIPAA Privacy Practices

Disclosure of Protected Health Information (PHI) to the Employer
(1) Definitions. Whenever used in this Article, the following terms shall have the respective meanings set forth below.

(a) Plan - means the “State Health Benefits Programs.”
(b) Employer - means the “Commonwealth of Virginia.”
(c) Plan Administration Functions - means administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.
(d) Health Information - means information (whether oral or recorded in any form or medium) that is created or received by a health care Provider, health plan (as defined by the Health Insurance Portability and Accountability Act of 1996, subsequently referred to as HIPAA, in 45 CFR Section 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined by HIPAA in 45 CFR Section 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.
(e) Individually Identifiable Health Information - means Health Information, including demographic information, collected from an individual and created or received by a health care Provider, health plan, employer, or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.
(f) Summary Health Information - means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed: (1) names; (2) geographic information more specific than state; (3) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older); (4) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers; (5) facial photographs or biometric identifiers (e.g., finger prints); and (6) any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.
(g) Protected Health Information ("PHI") means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

(2) The Plan, and the agents acting on its behalf, may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

(3) The Plan, and the agents acting on its behalf, will disclose PHI to the Employer only in accordance with HIPAA in 45 CFR Section 164.504(f) and the provisions of this Section.

(4) The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to the Employer and acknowledges receipt of written certification from the Employer that the Plan has been so amended. Additionally, the Employer agrees:

(a) not to use or further disclose PHI other than as permitted in Section (4) or as required by law;
(b) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;
(c) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;
(d) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in Section (4);
(e) to make PHI available to individuals in accordance with HIPAA in 45 CFR Section 164.524;
(f) to make PHI available for individuals' amendment and incorporate any amendments in accordance with HIPAA in 45 CFR Section 164.526;
(g) to make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA in 45 CFR Section 164.528;
(h) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan and its agents available to the Department of Health and Human Services upon request; and
(i) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.
(j) to ensure that adequate separation between the Plan and the Employer, as required by HIPAA in 45 CFR Section 164.504(f), is established and maintained.

(5) The Plan will disclose PHI only to the following employees or classes of employees:

- Director, Department of Human Resource Management
- Director of Finance, Department of Human Resource Management
- Staff Members, Office of Health Benefits

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

(6) Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section (5) shall be considered “failure to comply with established written policy” (a Group II offense) and must be addressed under the Commonwealth of Virginia’s Policy 1.60, Standards of Conduct Policy. The appropriate level of disciplinary action will be determined on a case-by-case basis by the agency head or designee, with sanctions up to or including termination depending on the severity of the offense, consistent with Policy 1.60.

(7) A health insurance issuer, HMO or third party administrator providing services to the Plan is not permitted to disclose PHI to the Employer except as would be permitted by the Plan in this Article and only if a notice is maintained and provided as required by HIPAA in 45 CFR Section 164.520.

Important Notice from the Commonwealth of Virginia Health Benefits Program About Your Prescription Drug Coverage and Medicare

If You are an active employee of the Commonwealth of Virginia who is covered under this plan, and You and/or any of your covered dependents are also eligible for Medicare, please read the following information carefully and keep it where You can find it. This notice has information about your current prescription drug coverage with the Commonwealth of Virginia Health Benefits Program and about your options under Medicare's prescription drug coverage. This information can help You decide whether or not You want to join a Medicare drug plan. Information about where You can get help in making decisions about your prescription drug coverage is at the end of this notice.

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if You join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- The Commonwealth of Virginia Health Benefits Program has determined that the prescription drug coverage offered by the COVA Care Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, You can keep this coverage and not pay a higher premium (a penalty) if You later decide to join a Medicare drug plan.

You can join a Medicare drug plan when You first become eligible for Medicare and each year during the Annual Coordinated Election Period designated by Medicare. This may mean that You have to wait to join a Medicare drug plan and that You may pay a higher premium (a penalty) if You join later and do not have creditable coverage for 63 or more days. You may pay that higher premium (a penalty) as long as You have Medicare prescription drug coverage. However, if You lose creditable prescription drug coverage through no fault of your own, You will be eligible for a sixty (60) day Special Enrollment Period (SEP) to join a Medicare drug plan (a Part D plan). In addition, if You lose or decide to leave employer or union-sponsored coverage, You will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage under the Commonwealth of Virginia Health Benefits Program, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area to determine the plan that is best for You.

If You decide to join a Medicare drug plan, your Commonwealth of Virginia coverage based on active employment (yours or your spouse's) will generally not be affected. See below for more information about what happens to your current coverage if You join a Medicare drug plan.

If You do decide to join a Medicare drug plan and drop your Commonwealth of Virginia coverage as an active employee or dependent of an active employee (based on the policies and procedures of the Department of Human Resource Management and applicable law), be aware that You and/or your dependent(s) will not be able to return to this coverage except with the occurrence of a consistent qualifying midyear event or at open enrollment. The Commonwealth of Virginia Health Benefits Program does not offer a medical plan to active employees that excludes prescription drug coverage. Consequently, You must either maintain full coverage under an available Commonwealth of Virginia plan (including prescription drug

coverage) or terminate coverage completely. You do not have the option of terminating only the prescription drug benefit under your Commonwealth of Virginia plan. Your employing agency's Benefits Administrator can provide additional information about making plan/membership changes or terminating coverage.

At the time an Enrollee and/or covered dependent becomes eligible for Medicare, he/she may keep his/her state plan coverage based on current/active employment or may terminate coverage under the Commonwealth of Virginia Health Benefits Program based on that event if termination is requested within 31 days of eligibility for Medicare. However, once coverage has been terminated, neither the employee nor the dependent may re-enroll in the state program except upon the occurrence of a consistent qualifying midyear event (for example, loss of eligibility for Medicare) or at open enrollment. An eligible dependent may not enroll unless the employee is enrolled. If an active employee or the covered dependent of an active employee has both the state program's coverage and Medicare, except in limited circumstances, the state plan coverage will be primary and Medicare will be secondary.

You should also know that if You drop or lose your coverage with the Commonwealth of Virginia Health Benefits Program for active employees and their eligible dependents and don't join a Medicare drug plan before 63 continuous days after your current coverage ends, You may pay a higher premium (a penalty) to join a Medicare drug plan later.

If You go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that You did not have that coverage. For example, if You go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as You have Medicare prescription drug coverage. In addition, You may have to wait until the following Annual Coordinated Election Period to join a plan, and coverage will generally not begin until the following January.

For more information about this notice or to obtain a personalized notice, contact your agency Benefits Administrator. For more information about your current prescription drug coverage, consult the appropriate section of this Member Handbook or your drug plan's Member Services Department.

NOTE: You will get this notice prior to the Medicare Part D annual enrollment period each year that You participate in the Commonwealth of Virginia Health Benefits Program for active employees and are eligible for Medicare (or cover a dependent who is eligible for Medicare). You will also receive a notice if prescription drug coverage is no longer offered under your Commonwealth of Virginia plan, or your coverage ceases to be creditable. You may also request a copy at any time.

<u>For more information about your options under Medicare prescription drug coverage</u>

More detailed information about Medicare plans that offer prescription drug coverage is in the *"Medicare & You"* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *"Medicare & You"* handbook for the telephone number) for personalized help,
- Call **800-MEDICARE** (**800-633-4227**). TTY users should call **877-486-2048**.

If You have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For more information, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **800-772-1213** (TTY **800-325-0778**).

Remember: If You decide to join one of the Medicare drug plans, You may be required to provide a copy of this notice when You join to show whether or not You have maintained creditable coverage and whether or not You are required to pay a higher premium (a penalty).

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