

Important Information About Your Medicare Complementary Member Handbook

This Medicare Complementary Member Handbook describes your benefits under the Plan. Because you are enrolled through The Local Choice program, the following information applies to you specifically.

Page 1 – Introduction

The following sentence on page 1, paragraph 3 is deleted:

The Commonwealth of Virginia, together with Enrollee contributions, funds the benefits provided under this health care Plan.

It is replaced with the following sentence:

The Local Choice employers, together with Enrollee contributions, fund the benefits under this health care Plan.

Page 4 – Who To Contact For Assistance

Contact The Local Choice Health Benefits Program Web site at www.thelocalchoice.state.va.us for information. If you use the State’s Department of Human Resource Management Web site, click on The Local Choice.

Page 22 – Article II. Eligibility

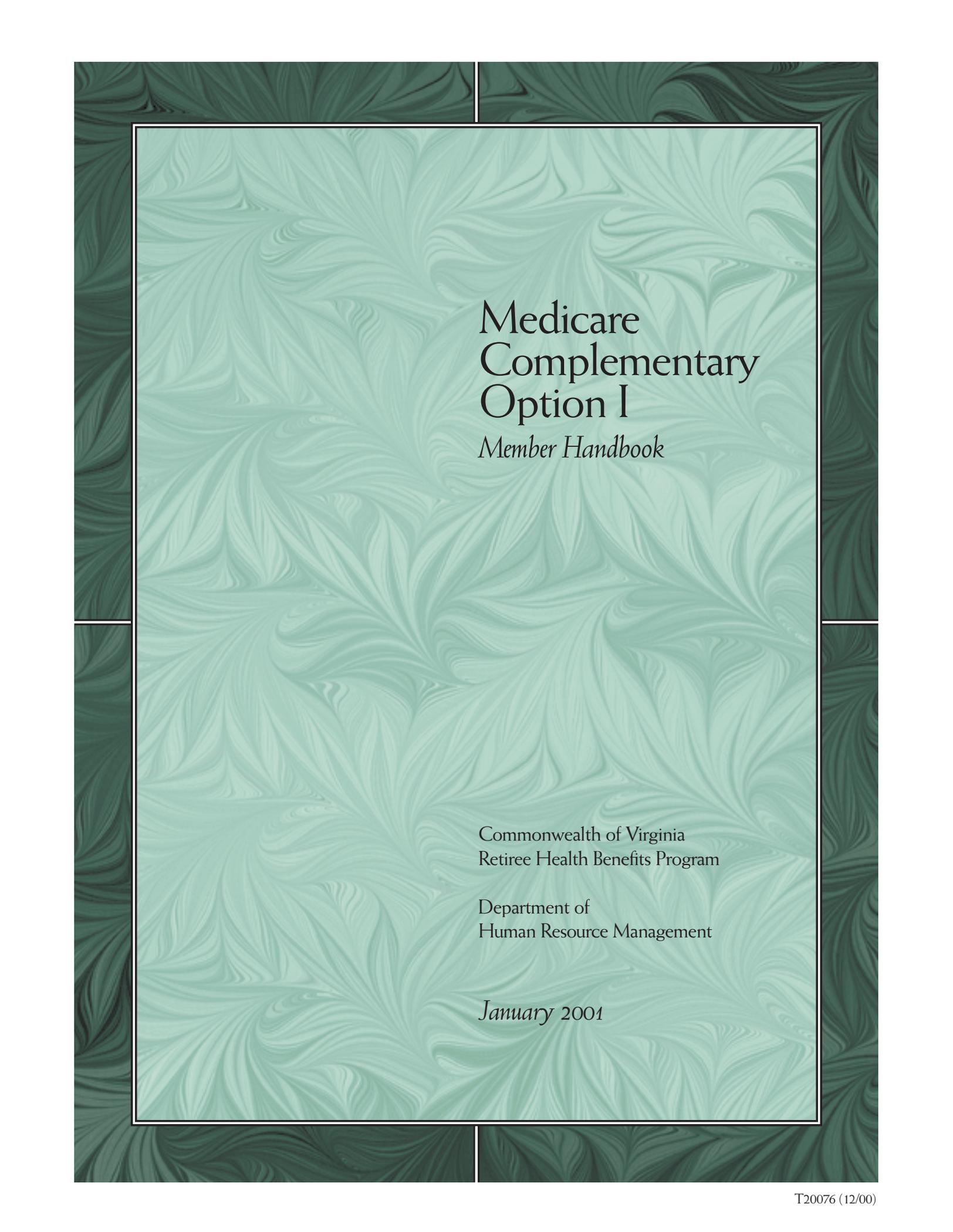
Eligibility for The Local Choice retirees is defined by the Local employer. Contact your Benefits Administrator if you have questions about eligibility.

Page 29 – 11. Notice From The Company To You

For The Local Choice, a notice sent to your former employer by the Company (Trigon Blue Cross Blue Shield) is considered “given”.

References to the State, the Commonwealth of Virginia, and the Department of Human Resource Management (DHRM) throughout this handbook

As a The Local Choice retiree, these references apply equally to The Local Choice Health Benefits Program.



Medicare
Complementary
Option I
Member Handbook

Commonwealth of Virginia
Retiree Health Benefits Program

Department of
Human Resource Management

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INTRODUCTION

Welcome to the Commonwealth of Virginia Retiree Health Benefits Program. Your Medicare Complementary Plan (Option I) is designed to help with some of the health care costs that Medicare doesn't cover.

This booklet is your Member Handbook, and it fully explains your health care benefits and how you can best use them. This handbook includes your copayment and coinsurance schedule as well as detailed descriptions of the benefits, limitations, exclusions, terms and conditions, and your responsibilities as a member of this health care Plan. Please read every part of this booklet carefully.

When the Enrollee's valid enrollment form is accepted, Trigon Blue Cross Blue Shield ("the Company") will administer the health care services explained in this booklet as of the Enrollee's Effective Date. The Commonwealth of Virginia, together with Enrollee contributions, funds the benefits provided under this health care Plan. The Company does not insure these benefits.

Throughout your booklet are words and phrases which are capitalized. These are defined terms. Definitions can be found in Article I, "Definitions", or in the article in which the term is used.

Coverage under this Plan will not duplicate coverage available to you under either Medicare Part A or Part B. This limitation applies even if you are not enrolled in either or both. If enrolled, you must take all the steps necessary to see that your claim is fully reviewed by Medicare. Please see your Medicare handbook for more information about Medicare.

USING YOUR BENEFITS TO BEST ADVANTAGE

Because the Medicare Complementary Plan coordinates its benefits with Medicare, enrollment in Medicare Parts A and B is necessary to receive full benefits.

Medicare Participating Providers

To help save on your medical expenses, use Medicare Participating Providers whenever possible. Hospitals and doctors who participate in Medicare agree to accept Medicare's payment for Covered Services and to file Medicare claims on your behalf. Doctors who do not accept assignment may not charge Medicare beneficiaries any more than 9.5% above the Medicare allowable charge.

Some doctors or facilities may not file claims for your secondary coverage with Trigon, in which case you must file the claim yourself. When you file your claim, the Medicare Explanation of Benefits (EOB) must be sent to Trigon with your claim.

Trigon Blue Cross Blue Shield Contracting Dentists

For dental care, use Trigon Blue Cross Blue Shield contracting dentists. They accept Trigon's Allowable Charge as payment in full and file claims on your behalf. You are responsible for any deductible, copayment, or coinsurance that may apply.

If your dentist is a Non-Contracting Provider, you must pay any billed amounts that are more than the Allowable Charge. This is in addition to your deductible, copayment, or coinsurance amounts. Also, you may have to file your own claims.

PAID Prescriptions Coordinated Care Network Pharmacies

You are covered by a mandatory generic outpatient prescription drug program which uses the PAID Prescriptions Coordinated Care Network. If a generic equivalent exists for a brand name drug, you have two choices. You may request the generic and pay only the copayment. Or you or your doctor may request a brand name drug and you will be responsible for the following:

- At a participating pharmacy you will be responsible for the copayment plus the difference between the Allowable Charge for the generic equivalent and the Allowable Charge for the brand name drug.
- At a non-participating pharmacy you pay the total price for the drug and then file a Prescription Drug Program Direct Reimbursement Claim Form for reimbursement. Reimbursement is limited to the Allowable Charge for the generic drug.

To obtain prescriptions at a participating retail pharmacy simply:

- Present your Medicare Complementary (Option I) health care identification card.
- Pay the copayment. Or, if you request a brand name drug when a generic is available, pay the copayment plus the difference between the generic and the brand name Allowable Charge.

To obtain maintenance prescription drugs prescribed for the treatment of long-term or chronic illnesses, you may use the Mail Service Program. For more information, call Trigon Member Services to request the Mail Service Program brochure/order form.

Note: Some drugs require **Prior Authorization** before they are dispensed. Contact Trigon Member Services for a list of drugs that require prior authorization.

WHO TO CONTACT FOR ASSISTANCE

Medical, Outpatient Prescription Drug, and Dental Benefits

Trigon Blue Cross Blue Shield

Member Services (804) 355-8506 in Richmond
1-800-552-2682 outside Richmond

Web Address <http://state.trigon.com>

Mailing Address Trigon Blue Cross Blue Shield
Member Services - Mail Drop 03K
P. O. Box 27401
Richmond, VA 23279

Department of Human Resource Management

Web Address www.dhrm.state.va.us/hbenefit.htm
Click on "Retirees" at the main menu.

SCHEDULE OF BENEFITS

SCHEDULE OF BENEFITS FOR BASIC SERVICES

This Schedule of Benefits explains the extent to which Basic Services are available to you. This schedule is not a complete explanation of these benefits. To understand them, you must read this schedule, the Basic Hospital and Skilled Nursing Facility Services article, the Basic Provider Services article, and the rest of your booklet.

BASIC HOSPITAL SERVICES

PLAN PAYS

DAYS OF INPATIENT CARE¹

120 days per Medicare Benefit Period, but only to the extent listed below:

Day 1-60

- Medicare Deductible less \$100

Day 61-90

- Medicare Copayment Amount

Day 91-120

- 100% of Allowable Charge for services and supplies listed in Paragraphs **B.1.** and **B.2** of the Basic Hospital and Skilled Nursing Facility Services article

ADDITIONAL DAYS OF INPATIENT CARE

60 days during your lifetime minus any Medicare Lifetime Reserve Days you used before your Effective Date, but only to the extent listed below:

Day 1-60

- Medicare Copayment Amount

¹ Medicare limits to 190 days during your lifetime the number of days of care which Medicare will cover when you are an Inpatient in a Hospital designated by Medicare as a psychiatric hospital. Any Days of Inpatient Care in excess of this 190-day limit will not be covered by Medicare or under the Basic Hospital and Skilled Nursing Facility Services article of this booklet.

BASIC SKILLED NURSING FACILITY SERVICES

DAYS OF INPATIENT CARE

180 days per Medicare Benefit Period, but only to the extent listed below:

Day 1-20

- \$0 (Medicare covers these days in full)

Day 21-100

- Medicare Copayment Amount

Day 101-180

- A daily amount equal to the above daily Medicare Copayment Amount (Medicare does not cover days beyond 100)

BASIC PROVIDER SERVICES

100% of Medicare-Approved Charges, but only to the extent listed below:

- Medicare Deductible, and
- Medicare Copayment Amount (the total of which exceeds \$1,000 per Calendar Year)

SCHEDULE OF BENEFITS FOR BASIC DENTAL SERVICES

This Schedule of Benefits explains the extent to which Basic Dental Services are available to you. This schedule is not a complete explanation of these benefits. To understand them, you must read this schedule, the Basic Dental Services article, and the rest of your booklet.

BASIC DENTAL SERVICES

PLAN PAYS

DIAGNOSTIC AND PREVENTIVE SERVICES

100% of the Allowable Charge

PRIMARY SERVICES

80% of the Allowable Charge

DIAGNOSTIC AND PREVENTIVE SERVICES

Two of each of the following per Benefit Period:

- oral exams
- bitewing x-rays
- prophylaxis
- topical fluoride applications
- pulp vitality tests

One full mouth x-ray every three years

Benefits for fluoride applications are available only to Enrollees under age 19

BENEFIT PERIOD

Calendar Year

MAXIMUM PAYMENT

\$1,200 per Benefit Period

The services listed in this Schedule of Benefits are available from both Contracting and Non-Contracting Dentists. However, special rules apply to services you receive from a Non-Contracting Dentist. Please see the Basic Dental Services article for the definitions of a Contracting and Non-Contracting Dentist and these special rules.

SCHEDULE OF BENEFITS FOR BASIC VISION SERVICES

This Schedule of Benefits explains the extent to which Basic Vision Services are available to you. This schedule is not a complete explanation of these benefits. To understand them, you must read this schedule, the Basic Vision Services article, and the rest of your booklet.

BASIC VISION SERVICES

PLAN PAYS

ROUTINE VISION EXAMINATIONS

Provider's charge up to a maximum of \$40 per routine exam

FRAMES

Provider's charge up to a maximum of \$50 per pair

LENSES

Provider's charge up to the maximum amounts specified below for the type of lenses provided:

Single Eyeglass Lenses, or

\$35 per pair per 24-month period

Bifocal Eyeglass Lenses, or

\$50 per pair per 24-month period

Trifocal Eyeglass Lenses, or

\$70 per pair per 24-month period

Contact Lenses (any type)

\$100 per 24-month period

SPECIAL LIMITATIONS

1. Benefits will not be provided for more than one routine vision examination and one pair of frames in a 24-month period.
2. Benefits will not be provided for more than one pair of eyeglass lenses or contact lenses (regardless of type) in a 24-month period.

SCHEDULE OF BENEFITS FOR RETAIL PHARMACY PRESCRIPTION DRUG SERVICES

This Schedule of Benefits explains the extent to which Retail Pharmacy Prescription Drug Services are available to you. This schedule is **not** a complete explanation of these benefits. To understand them, you must read this schedule, the Retail Pharmacy Prescription Drug Services article, and the rest of your booklet.

COVERED SERVICES

Up to a 34-day supply² at network retail pharmacy

More than a 34-day supply and up to a 90-day supply at network retail pharmacy

COPAYMENT

\$22.00 per Prescription

\$44.00 per Prescription

PLAN PAYS

After the Copayment is met, the Plan pays 100% of the Allowable Charge

SPECIAL EXCEPTION

- A.** If a generic equivalent exists for a brand name prescription drug, the Allowable Charge for that brand name prescription drug will be limited to the Allowable Charge for the generic equivalent. The Company will determine whether a particular generic prescription drug is equivalent to a brand name prescription drug. 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.

² A 34 consecutive day supply of a Prescription Drug (other than insulin) shall not exceed:

- a.** 120 units of the drug; or
- b.** 500 milliliters of the drug.

A 34 consecutive day supply of insulin shall be limited to two 10 milliliter vials.

SCHEDULE OF BENEFITS FOR MAIL ORDER PHARMACY PRESCRIPTION DRUG SERVICES

This Schedule of Benefits explains the extent to which Mail Order Prescription Drug Services are available to you. This schedule is **not** a complete explanation of these benefits. To understand them, you must read this schedule, the Mail Order Prescription Drug Services article, and the rest of your booklet.

COVERED SERVICES

Mail Order Prescription Drugs
(up to a 90-day supply)

COPAYMENT

\$27.00 per Prescription

PLAN PAYS

After the Copayment is met, the Plan Pays 100% of the Allowable Charge

SPECIAL EXCEPTION

A. If a generic equivalent exists for a brand name prescription drug, the Allowable Charge for that brand name prescription drug will be limited to the Allowable Charge for the generic equivalent. The Company will determine whether a particular generic prescription drug is equivalent to a brand name prescription drug. 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.

ARTICLE I. DEFINITIONS

This article gives you the meaning of words you will find in this booklet. If you read this article carefully, you will better understand the Plan.

A.1. ALLOWABLE CHARGE

This term is defined in three ways:

- a. With respect to any Provider's charge for Services rendered in the Company's network,
 - The amount set forth on the network schedule of allowances, or
 - The Provider's charge for that service, whichever is less.
- b. With respect to any Provider's charge for services not rendered in the Company's network,
 - The amount set forth on the network schedule of allowances, or
 - The Provider's charge for that service, whichever is less.
- c. With respect to a facility's charge, if the facility is a Participating Hospital, home health care agency, or skilled nursing facility located in Virginia, or the facility has a claims reimbursement agreement directly with the Company, the term "Allowable Charge" means:
 - The amount of the Company's negotiated compensation to the facility, or the facility's charge for that service, whichever is less.

If the Company's negotiated compensation is incalculable at the time the claim for the service is processed, the Company will use the value of the last known negotiated compensation derived from its most recent settlement with the facility.

- d. With respect to a facility's charge, if the facility is a Participating Hospital, home health care agency, or skilled nursing facility located outside of Virginia and participating in the network of another affiliated plan, the amount of the affiliated plan's allowance for services.
- e. If the facility is a Non-Participating Hospital located in Virginia, the Company's allowance for a specified service or set of services, or the Hospital's charge for that service, whichever is less.
- f. If the facility is a Non-Participating Hospital located outside of Virginia, the amount which the Company determines, in its sole discretion, to be reasonable for the service.
- g. With respect to charges for services supplied by other than covered facilities or Providers, the term means the amount which the Company, in its sole discretion, determines is reasonable for the services provided.

A.2. ANESTHESIA SERVICES

These are services required to induce partial or complete loss of sensation before certain Dental Services are performed.

A.3. BASIC SERVICES

Basic Services are described in Articles IV, V, VI, VII, VIII, and IX of this booklet. Words like “Basic Hospital Service” describe a service covered in a Basic Services article.

A.4. BENEFITS ADMINISTRATOR

This phrase means the individual whom the State has named to administer the details of your State program. Among other duties, your Benefits Administrator will advise the Company about people who are added or removed from enrollment under the Plan.

A.5. BENEFITS SECTION

This means your enrollment form, if any, and this document, which is the part of the Plan that describes your Covered Services.

A.6. CALENDAR YEAR

The period beginning January 1 and ending on the following December 31.

A.7. CLINICAL TRIAL COSTS

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

- a. The treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial;
- b. 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.

- c. With respect to the treatment provided by a clinical trial:
- There is no clearly superior, noninvestigational treatment alternative;
 - The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative; and
 - You and your Physician or health care Provider conclude that your participation in the clinical trial would be appropriate; and
- d. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise.

Patient cost means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to you for purposes of a clinical trial. Patient cost does not include (i) the cost of non-health care services that you 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.

A. 8. COMPANY

This word means Blue Cross and Blue Shield of Virginia, doing business as Trigon Blue Cross Blue Shield.

A.9. CONTRACTING AND NON-CONTRACTING PROVIDERS

A Contracting Provider is a Provider listed as “contracting” by the Company. The Provider must be listed as such at the time you receive the service for which coverage is sought. A Non-Contracting Provider means any other Provider including a Provider who participates or contracts with another Blue Shield plan.

A.10. COVERED FACILITY

This means an institution in which, or through which, you receive Covered Services. Covered Facilities under this Plan are:

- Hospitals
- Skilled Nursing Facilities

A.11. COVERED SERVICES

This means Basic Services.

A.12. DAYS OF INPATIENT CARE

This means the number of days of care for which you are covered as an Inpatient. Days of Inpatient Care you use in a Covered Facility are subtracted from those available in this way:

- The day you are admitted is subtracted.
- Each day, up to the day of discharge, is subtracted.
- The day you are discharged is not subtracted.

You must be discharged by the established discharge hour. If you stay beyond the established discharge hour, the Company will pay for Inpatient services only if your longer stay was Medically Necessary.

A.13. DIAGNOSTIC SERVICES

This phrase means medically accepted tests or procedures used to identify a specific illness, injury, or pregnancy-related condition. Under the Plan, the following are Diagnostic Services:

- a. Diagnostic x-rays, ultrasound, and nuclear medicine;
- b. Laboratory and pathology services; and
- c. EKGs, EEGs, and other electronic diagnostic tests.

Diagnostic Services do not include routine or periodic physical examinations or screening examinations.

A.14. EFFECTIVE DATE

This is the date your coverage begins under the Plan. Your Benefits Administrator can give you further information about when your coverage begins.

A.15. ELIGIBLE ENROLLEE

This phrase means the class of persons enumerated under Paragraph A. of Article II, Eligibility.

A.16. ENROLLEE

This word means the person who applied for coverage under the Plan and in whose name the coverage was obtained.

A.17. EXCLUSIONS

This means services which will not be covered under any circumstances. Exclusions are limitations on Covered Services.

A.18. EXPERIMENTAL/INVESTIGATIVE

This phrase describes any service or supply which is judged to be experimental or investigative at the Company's sole discretion. The Company will apply the following criteria to decide this.

- a.** 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 as defined below. There are 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.

This criterion will be satisfied if the use of the supply or drug is recognized for treatment of the indication or application in any of the following resources:

- (1)** the following standard reference compendia:
 - (a)** the U.S. Pharmacopoeia Dispensing Information;
 - (b)** the American Medical Association Drug Evaluations; or
 - (c)** the American Hospital Formulary Service Drug Information; or
- (2)** 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 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
- (3)** 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 exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is contraindicated for the treatment of the specific indication for which it is prescribed.

- b.** There must be enough information in the peer-reviewed medical and scientific literature to let the Company judge the safety and efficacy;
- c.** The available scientific evidence must show a good effect on health outcomes outside a research setting; and

- d. The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

A service or supply will be experimental or investigative if the Company determines that any one of the four criteria is not met.

A.19. EXPLANATION OF MEDICARE BENEFITS

This is the notice Medicare sends you after a claim for services is processed. If you file your own claim for secondary coverage, the Medicare notice should always be sent to the Company with your claim for benefits.

The Medicare notice shows:

- what services were covered;
- what charges were approved;
- how much was credited toward your Medicare Deductible; and
- the amount Medicare paid.

A.20. HOSPITAL

- a. This word means an institution which meets the American Hospital Association's standards for registration as a "Hospital". It must be mainly involved in providing acute care for sick and injured Inpatients. The institution must be licensed as a "Hospital" by the State in which it operates. It must also have a staff of licensed Physicians and provide 24-hour nursing service by, or under the supervision of, registered graduate professional nurses (R.N.s). Except in unusual cases approved in advance by the Company, an institution will not be considered a Hospital if its average length of stay is more than 30 days.
- b. This word also means a facility providing Inpatients a structured 24-hour per day program of treatment and rehabilitation for alcohol and drug abuse. It must be licensed to provide these services by the State in which it operates. This facility may also be called a "Substance Abuse Treatment Facility".

A.21. INPATIENT

This term refers to a person who:

- is admitted to a Hospital or Skilled Nursing Facility;
- is confined to a bed there; and
- receives meals and other care in that facility.

A.22. MEDICALLY NECESSARY

A Medically Necessary service is one required to identify or treat an illness, injury, or pregnancy-related condition that a Provider has diagnosed or reasonably suspects. To be Medically Necessary, the service must:

- be consistent with the diagnosis of your condition;
- be in accordance with standards of good medical practice;
- not be for the convenience of the patient, the patient's family, or the Provider; and
- be performed in the least costly setting required by your medical condition. A "setting" may be your home, a Provider's office, the Hospital Outpatient department, a Hospital when you are an Inpatient, or another type of facility providing a lesser level of care.

Only your medical condition is considered in deciding which setting is Medically Necessary. Your financial or family situation, the distance you live from a Covered Facility, or any other non-medical factor is not considered. As your medical condition changes, the need for a particular setting may change.

A.23. MEDICARE

Medicare means the program established by Title XVIII of the Social Security Act of 1965, as amended. Medicare covers people age 65 and older and some people under 65 who are disabled.

Medicare has two parts. One part is called Hospital Insurance. This is Part A. The other part is called Medical Insurance. This is Part B. See the Medicare Handbook, published each year by the federal government, for more information about Part A and Part B of Medicare.

A.24. MEDICARE-APPROVED CHARGES

This is the maximum amount Medicare will pay for a Covered Provider Service. Medicare-Approved Charges will not always cover your Provider's entire bill.

A.25. MEDICARE BENEFIT PERIOD

This means a period of time Medicare uses to measure Inpatient benefits. It starts when you are admitted to a Covered Facility and ends when you have not been an Inpatient in any Covered Facility for 60 days in a row.

A.26. MEDICARE COPAYMENT AMOUNT

This term is used in this booklet in two ways. The Medicare Copayment Amount for a Covered Facility's service is a fixed dollar limit set by Medicare. The Medicare Copayment Amount for a Basic Provider Service is the difference between the Medicare-Approved Charge and the amount Medicare pays.

A.27. MEDICARE DEDUCTIBLE

This is the specified dollar amount you must pay for Inpatient Services before Medicare will pay for further Inpatient Services.

A.28. MEDICARE LIFETIME RESERVE DAYS

These are the extra Medicare Part A Hospital days you have left after you have used all of your regular Medicare Part A Hospital days.

A.29. MEMBERSHIP

Membership describes the way in which Enrollees are enrolled for coverage. Please see the Eligibility article.

A.30. OUTPATIENT

This term refers to a person who is not an Inpatient.

A.31. PARTICIPANT

This means the Enrollee or eligible family members while enrolled in a Plan.

A.32. PARTICIPATING AND NON-PARTICIPATING HOSPITALS

- a. A Participating Hospital is a Hospital listed as “participating” or “contracting” by the Company. A Hospital outside Virginia which is listed by any other Blue Cross plan as “participating” or “contracting” is also a Participating Hospital. In either case, the Hospital must be listed as such at the time you receive the service for which coverage is sought. Any other Hospital is a Non-Participating Hospital.
- b. The Company may, at its sole option, name one or more Non-Participating Hospitals as ones in which you will receive Covered Services as if you were in a Participating Hospital. There is one difference. Payment will be made directly to the Enrollee or, at the Company’s sole option, any other person responsible for paying the Non-Participating Hospital’s charge.

A.33. PARTICIPATING AND NON-PARTICIPATING PROVIDERS

A Participating Provider is a Provider who is listed as a “Participating Provider” by the Company. The Provider must be listed as such at the time you receive the service for which coverage is sought. A Non-Participating Provider means any other Provider including one who participates with another Blue Shield plan.

A.34. PLAN

Plan, in this booklet, means the Medicare Complementary (Option I) Plan.

A.35. PHYSICIAN

A Physician is a properly licensed Doctor of Medicine.

A.36. PROVIDER

This means a Physician, as previously defined. It also means a properly licensed:

- Audiologist;
- Certified Nurse Midwife;
- Chiropractor;
- Clinical Nurse;
- Clinical Social Worker;
- Dentist;
- Doctor of Chiropody;
- Doctor of Osteopathy;
- Doctor of Podiatry;
- Licensed Professional Counselor;
- Mental Health Specialist;
- Optician;
- Optometrist;
- Psychologist;
- Registered Physical Therapist; or
- Speech Pathologist.

A.37. PROVIDER'S EMPLOYEE

A Provider's Employee is an allied health professional who works for the Provider. The Provider must withhold Federal and State income and Social Security taxes from the Provider's Employee's salary.

A service which would have been covered if performed by your Provider will be covered if performed by your Provider's Employee, but only when:

- the Provider's Employee is licensed to perform the service,
- the service is performed under the direct supervision of your Provider, and
- the services of the Provider's Employee are billed for by your Provider.

The services of the Provider's Employee are available as a substitute for the services of the Provider. For this reason, the Company will not pay a supervisory or other fee for the same service rendered by both the Provider and the Provider's Employee.

A.38. SCHEDULE OF BENEFITS

This is a summary of Covered Services and is not a complete explanation of Covered Services.

A.39. SEMI-PRIVATE ROOM

This phrase means a room with two, three, or four beds, all of which are used for Inpatient care.

A.40. STATE

This word means the Commonwealth of Virginia.

A.41. THERAPY SERVICES

This phrase means one or more of the following services used to treat or promote your recovery from an illness or injury. The Basic Hospital and Skilled Nursing Facility Services article tells you which Therapy Services are covered. They are covered only to the extent specified in those articles.

a. Radiation Therapy

This is treatment using x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

b. Chemotherapy

This is treatment of malignant disease by using chemical or biological antineoplastic agents.

c. Renal Dialysis

This is treatment of acute kidney failure or chronic irreversible renal insufficiency by removing waste products from the body. Renal Dialysis includes hemodialysis and peritoneal dialysis.

d. Physical Therapy

This is treatment required to relieve pain, restore maximum function, or prevent disability following illness, injury, or loss of limb.

e. Intravenous Therapy

This is treatment by placing therapeutic agents into the vein. This term also means intravenous feeding.

f. Occupational Therapy

This is treatment to restore your ability to perform the ordinary tasks of daily living. These tasks include special skills required by your work.

g. Speech Therapy

This is treatment for the correction of a speech impairment. The impairment must result from disease, surgery, injury, congenital and anatomical anomaly, or previous therapeutic process.

h. Inhalation Therapy

This is treatment of impaired breathing. It may be done by introducing specialized gases into your lungs by mechanical means.

A.42. YOU, YOUR, OR YOURSELF

These words refer to an Enrollee.

ARTICLE II. ELIGIBILITY

This article explains coverage available to eligible retirees and eligible family members who, in both cases, are eligible for Medicare.

A. RETIREES

Classified employees and full-time faculty members who retire and are eligible for a monthly annuity or a periodic benefit and who are not deferring receipt of the retirement benefit are eligible for Membership in this Plan.

Dependents

The following dependents are also eligible for Membership:

- The legally married spouse of an eligible retiree.
- The eligible retiree's unmarried biological or legally adopted child(ren).
- A child placed in an eligible retiree's home under a pre-adoptive agreement which has been approved by the Department of Human Resource Management. Such an agreement must, at a minimum, (1) stipulate that the biological parents have ceded all parental rights, including care, custody, and visitation, and (2) vest responsibility for the welfare of a child in a court or a public agency appointed by a court.
- Unmarried stepchildren living full time with the eligible retiree in a parent-child relationship **and** who are lawfully claimed as a dependent on the eligible retiree's federal income tax return.
- Disabled adult children who are certified as such by the Plan upon application by the eligible retiree filed within 31 days of the child's losing eligibility for Membership due to age.
- Other children, on an exception basis approved by the Department of Human Resource Management, provided that the children are in the permanent custody of the eligible retiree pursuant to an order of a court.

Ineligible Persons

The following persons are never eligible for Membership:

- A child who is married.
- A child who is self-supporting. A child who works full time is self-supporting for the purposes of the health benefits program, regardless of where the child lives and regardless of the child's eligibility for health insurance through the child's employer. The only exception is a child who was a full-time student during the spring semester, works full time only during the summer months, and becomes a full-time student again in the fall.
- A child over the age of 23, unless eligible through disability. (Eligibility may continue through the end of the Calendar Year in which the child turns 23.)*

* There is one exception. Surviving non-annuitant dependent children of an active or retired State employee are eligible for coverage up to the age of twenty-five if the dependent is a full-time college student. Coverage terminates when the dependent reaches age twenty-five or ceases to be a full-time college student.

- Stepchildren who do not live full time with the retiree; stepchildren living with the retiree who are not claimed as a dependent on the eligible retiree's federal income tax return.
- Parents.
- Grandparents.
- Brothers or sisters, unless found eligible by the Department of Human Resource Management as other children described above.
- Grandchildren, unless found eligible by the Department of Human Resource Management as other children described above.
- Ex-spouses. A court order or separation agreement which requires a retiree to provide coverage for an ex-spouse does not make an ex-spouse eligible for coverage through the health benefits program.

Enrollment and Plan or Membership Changes

- **Newly Retired:** Coverage for newly eligible retirees is effective the first of the month following the date active employment ends. Election to participate in the health benefits program must be made within 31 days of retirement.
- **Making Changes:** Membership and Plan changes may be made the first of the month following receipt of an Enrollment/Waiver Form by your Benefits Administrator.
- **Termination of Coverage:** Coverage terminates the last day of the month in which a Participant loses eligibility.

B. RETIRED EMPLOYEES AND SURVIVING DEPENDENTS

- Medicare eligible retirees may continue coverage in the selected plan until a change is made or coverage terminates. Retirees may also continue health care coverage for their spouse and dependent children.
 - A surviving spouse with a survivor benefit may continue health care coverage as long as conditions outlined in the policies and procedures of the Department of Human Resource Management are met.
 - Eligible dependent children of a retiree or deceased retiree may be covered through the end of the year in which the child turns age 23 as long as the child is not self-supporting or married unless eligible through disability.*
- Health benefits for the surviving spouse and/or dependent children of an active or retired State employee who are non-annuitants are also eligible for coverage provided through the Retiree Health Benefits Program.

* There is one exception. Surviving non-annuitant dependent children of an active or retired State employee are eligible for coverage up to the age of twenty-five if the dependent is a full-time college student. Coverage terminates when the dependent reaches age twenty-five or ceases to be a full-time college student.

- ▶ Coverage for the surviving spouse automatically terminates at remarriage; alternate health insurance coverage being obtained; or any applicable condition outlined in the policies and procedures of the Department of Human Resource Management.
 - ▶ Coverage for any surviving dependent children in this category automatically terminates at death; age twenty-one, unless the dependent is:
 - (a) a full-time college student, in which case the coverage shall not terminate until the dependent has either reached the age of twenty-five or ceases to be a full-time college student, whichever occurs first, or
 - (b) under a mental or physical disability, in which event coverage shall not terminate until three months following cessation of the disability; or any applicable condition outlined in the policies and procedures of the Department of Human Resource Management.
- Special rules apply to employees and/or their covered dependents when the employee is disabled or killed in the line of duty.
 - ▶ Coverage for the surviving spouse automatically terminates upon alternate health insurance coverage being obtained or any applicable condition outlined in the policies and procedures of the Department of Human Resource Management.
 - ▶ Coverage for any surviving dependent children in this category automatically terminates at death; age twenty-one, unless the dependent is:
 - (a) a full-time college student, in which case the coverage shall not terminate until the dependent has either reached the age of twenty-five or ceases to be a full-time college student, whichever occurs first, or
 - (b) under a mental or physical disability, in which event coverage shall not terminate until three months following cessation of the disability; or any applicable condition outlined in the policies and procedures of the Department of Human Resource Management.

ARTICLE III. 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 Company 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 is one exception. If you are an Inpatient on the day your enrollment ends, the services to which you would have been entitled under the Basic Hospital and Skilled Nursing Facility Services article will be covered until your date of discharge for that admission. These benefits will be provided only to the extent they would have been provided had your enrollment not ended.

5. DEFINING SERVICES

When classifying a particular service, the Company will use the most recent edition of a book published by the American Medical Association entitled *Current Procedural Terminology* (CPT) and the American Dental Association entitled *Current Dental Terminology* (CDT). The Allowable Charge for a procedure will be based on the most inclusive code in *Current Procedural Terminology* or *Current Dental Terminology*. The Company 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 PARTICIPATING OR CONTRACTING PROVIDERS

The Company pays the Allowable Charge which remains after your Copayment or Coinsurance to the Provider.

When an Enrollee receives services from a Participating or Contracting Provider, the Company will make payment for these services directly to the Provider. But, if the Enrollee has already paid the Provider and the Provider tells the Company to do so, the Company will pay the Enrollee. A Provider who participates in one of the Company's Networks will accept the Company's allowance as payment in full for that

service. Payment by the Company will relieve the Company and the Plan of any further liability for the service.

7. NON-PARTICIPATING OR NON-CONTRACTING PROVIDER PAYMENTS

When a Participant receives services from a Non-Participating or Non-Contracting Provider, the Company may choose to make payment directly to the Enrollee or, at the Company's sole option, to any other person responsible for payment of the Provider's charge. Payment will be made only after the Company has received an itemized bill and the medical information the Company decides is necessary to process the claim. Payment will be made directly to the Enrollee. The Enrollee will also be responsible for the difference between the Plan's allowance and the Provider's charge. Payment by the Company will relieve it and the Plan of any further liability for the Non-Participating or Non-Contracting Provider's services.

8. ORGAN AND TISSUE TRANSPLANTS

When the recipient of a human organ or tissue transplant is a Participant, Inpatient services (as well as Outpatient services rendered in anticipation of Inpatient services) which are rendered to the donor in connection with the transplant procedure will be treated as services which are rendered to the Participant. However, benefits for these services are limited to only 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 Participant, Inpatient services (as well as Outpatient services rendered in anticipation of Inpatient services) which are rendered to the donor in connection with the transplant procedure will not be eligible for reimbursement. This paragraph will not limit services rendered to the donor Participant after the discharge date.

9. APPEALS

You have the right to request the Company to review the denial or payment of any claim. There are strict limits on each stage of appeal. You will be notified of these limits in correspondence which denies your claim. Look for and observe these strict time limits. You must initiate an appeal to the Company within 60 days of the Company's denial of your initial claim.

The Company will have previously reviewed your medical records for any claim requiring a medical determination. If the Company denies a claim for medical reasons, you may request verbally or in writing that the Company review the claim.

If you are not satisfied with the results of the review, you may file a written appeal to the Company. The appeal must be written and include your full name, the Enrollee's identification number (indicated on your Membership card), the date of the service, the name of the Provider for whose services payment was denied, and the reason you think the claim should be paid. You are responsible for providing the Company with all information necessary to review the denial of your claim. The Company will

review your appeal and respond within 60 days of the Company's receipt of all information necessary to make a decision.

If you are not satisfied with the results of the first appeal, you may request a review by the Company's appeals committee. The request must be written and include your full name, the Enrollee's identification number, the date of the service, the name of the Provider for whose services payment was denied, and the reason you think the claim should be paid. You are responsible for providing the Company with all information necessary to review the denial of your claim. The committee will review your appeal and respond within 60 days of the Company's receipt of all information necessary to make a decision. If, after review, the claim remains denied, that denial is final, unless you appeal that determination to the Commonwealth of Virginia, Department of Human Resource Management.

In situations requiring immediate medical care, the Company provides a separate expedited emergency appeals process. You or your Provider may request an expedited review. The Company will provide resolution within one business day of receipt of all information.

To appeal a claim decision made by the Company, you must submit to the director of the Department in writing, within 60 days of the Company's denial, your full name, the Enrollee's identification number, the date of the service, the name of the Provider for whose services payment was denied, and the reason you think the claim should be paid. You are responsible for providing the Department with all information necessary to review the denial of your claim. The Department will ask you to submit any additional information you wish to have considered in its review, and will give you the opportunity to explain, in person or by telephone, why you think the claim should be paid. Claims denied due to such things as contractual or eligibility issues will be reviewed by the director. Claims denied because the treatment provided was considered not Medically Necessary will be referred to an independent medical review organization. If, after review, the claim remains denied, that denial is final, unless you appeal that determination within 30 days as provided under the Administrative Process Act. You may obtain a "State Health Benefits Program Appeal Form" on the Web at www.dhrm.state.va.us/hbenefit.htm.

10. COORDINATION OF BENEFITS

You are required to notify the Company that you are enrolled under another Health Benefit plan. If you are eligible for coverage under two or more Health Benefit plans, the Health Benefit plans involved will share the responsibility for your benefits according to these rules.

- A.** If the other Health Benefit plan contains a coordination of benefits provision establishing the substantially same order of benefit determination rules as the ones in this section, the following will apply in the order of priority listed:

- (1)** The Health Benefit plan which lists the person receiving services as the Enrollee, insured or policyholder, not as a dependent, will provide Primary Coverage.¹
 - (2)** Primary Coverage for an enrolled child will be the Health Benefit plan which lists the parent whose month and day of birth occurs earliest in the Calendar Year as an Enrollee, insured, or policyholder, except in the following circumstances:
 - (a)** When the parents are separated or divorced, Primary Coverage will be the Health Benefit plan which covers the child as a dependent of the parent with custody. The Health Benefit plan of the husband or wife of a remarried parent with custody may provide Primary Coverage if the remarried parent with custody does not have a Health Benefit plan which covers the child.
 - (b)** Despite sub-paragraph (a), if there is a court order which requires one parent to provide Hospital or Medical or Surgical coverage for the child, Primary Coverage will be that parent's Health Benefit Plan. If the specific terms of a court decree state that the parents will share joint custody and the court decree does not state that one of the parents is responsible for health care expenses of the child, then the rule set forth in the first sentence of paragraph a. (2), the birthday rule, will apply.
 - (3)** If paragraphs (1) AND (2) do not apply, Primary Coverage will be the Health Benefit plan which has covered the Participant for the longest uninterrupted period of time. There are two exceptions to this rule:
 - (a)** The benefits of the Health Benefit plan which covers the person as a working employee (or the employee's dependent) will be determined before those of the Health Benefit plan which covers the person as a laid-off or retired employee (or the employee's dependent).
 - (b)** The benefits of the Health Benefit plan which covers the person as an employee (or the employee's dependent) will be determined before those of the Health Benefit plan which covers the person under a right of continuation pursuant to federal or state law.
- B.** If a Health Benefit plan does not have a coordination of benefits provision establishing substantially the same order of benefit determination rules as the ones in this section, that Health Benefit plan will be the Primary Coverage.

¹ There is one exception. If the person is also entitled to Medicare, and as a result of federal law Medicare is (1) secondary to the Health Benefit covering the person as a dependent; and (2) primary to the Health Benefit plan covering the person as other than a Dependent (e.g., a retired employee), then the benefits of the Health Benefit plan covering the person as a Dependent are determined before those of the Health Benefit plan covering the person as other than a Dependent.

- C. If, under the priority rules, this Plan is the Primary Coverage, you will receive unreduced benefits for Covered Services to which you are entitled under this Plan.
- D. If the other Health Benefit plan is the Primary Coverage, your benefits will be reduced so that the total benefit paid under this Plan and the other Health Benefit plan will not exceed the benefits payable for Covered Services under this Plan absent the other Health Benefit Plan. In calculating benefits which would have been paid under this Plan absent the other Health Benefit Plan, any reduction in benefits for failure to receive a Referral will not be considered. Benefits that would have been paid if you had filed a claim under the Primary Coverage will be counted and included as benefits provided. In a Calendar Year, benefits will be coordinated as claims are received.
- E. When a Health Benefit plan provides benefits in the form of services, a reasonable cash value will be assigned to each Covered Service. This cash value will be considered a "benefit payment."
- F. At the option of the Company, payments may be made to anyone who paid for the coordinated services you received. These benefit payments by the Company are ones which normally would have been made to you or on your behalf to a facility or Provider. The benefit payments made by the Company will satisfy the obligation to provide benefits for Covered Services.
- G. If the Company provided Primary Coverage and discovers later that it should have provided Secondary Coverage, the Company has the right to recover the excess payment from you or any other person or organization. If excess benefit payments are made on your behalf, you must cooperate with the Company in exercising its right of recovery.
- H. You are obligated to supply the Company all information needed to administer this section. This must be done before you are entitled to receive benefits under this Plan. Further, you agree that the Company has the right to obtain or release information about Covered Services or benefits you have received. This right will be used only when working with another person or organization to settle payments for coordinated services. Your prior consent is not required.

11. NOTICE FROM THE COMPANY TO YOU

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

12. NOTICE FROM YOU TO THE COMPANY

Notice by you or your Benefits Administrator is considered “given” when delivered to the Company at the address on page 4 of this book. The Company will not be able to provide assistance unless the Enrollee’s name and identification number are in the notice.

ARTICLE IV. BASIC HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Except as limited in this booklet, the Basic Hospital Services and Basic Skilled Nursing Facility listed as covered in this article are covered. But they are covered only to the extent specified in your Schedule of Benefits for Basic Services and this article. These services must also be:

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

A. DAYS OF INPATIENT CARE AS BASIC HOSPITAL SERVICES

A.1. Medicare pays for 90 regular Days of Inpatient Care in a Hospital per Medicare Benefit Period. Under this article, you are entitled to 120 Days of Inpatient Care per Medicare Benefit Period in a Hospital. However, the Company will pay only to the extent listed below:

- a. During the first 60 days, the Company will pay your Part A Medicare Deductible less \$100.
- b. During each of the next 30 days, the Company will pay your Part A Medicare Copayment Amount.
- c. During the last 30 days, the Company will pay 100% of the Allowable Charge for services and supplies listed in Paragraph B. of this article.

A.2. Medicare provides up to 60 additional Days of Inpatient Care in a Hospital during your lifetime. During each of these additional 60 days, the Company will pay your Part A Medicare Copayment Amount.

A.3. Medicare limits to 190 days during your lifetime the number of days of care which Medicare will cover when you are an Inpatient in a Hospital designated by Medicare as a psychiatric hospital. Any Days of Inpatient Care in excess of this 190-day limit will not be covered by Medicare or under this article.

B. BASIC HOSPITAL SERVICES AFTER YOUR MEDICARE BENEFIT PERIOD

If you need Inpatient care beyond the 90-day Medicare Benefit Period, the Company will cover 100% of the Allowable Charge for the Basic Hospital Services described in the following Paragraphs B.1. and B.2. for up to 30 additional Days of Inpatient Care.

B.1. Basic Services for Your Room and Meals in a Hospital

The Company will cover bed and board, any special diets, and general nursing services when you occupy one of the following:

a. A Semi-Private Room

b. A bed in an intensive care unit. An intensive care unit is a Hospital room specially equipped to provide a higher level of care to critically ill Inpatients.

c. A private room. The Company will not pay more for a private room than it would for your Hospital's most common Semi-Private Room. There are two special exceptions:

1. The Company will cover a private room in a Hospital if the Company determines that you need the private room because you have:

- a highly contagious disease, or
- a greater risk of contracting an infectious disease due to your medical condition.

In either case, your Physician must prescribe the private room. Upon request, he must explain why he did so.

2. The Company will also cover your private room if you are admitted to a Hospital where all the rooms are private. But, in an all-private room Hospital, you pay the difference between your daily room charge and the average daily Semi-Private Room charge for other Hospitals in the community. The Company determines the average daily Semi-Private Room charge for other Hospitals in the community. However, regardless of the type of room or bed you occupy, the Company will only cover one room or bed on each Day of Inpatient Care.

B.2. Basic Ancillary Services in a Hospital

The Company will also cover the following Basic ancillary services while you are an Inpatient in a Hospital:

a. Operating, recovery, or treatment rooms.

b. Medications, drugs, solutions, and biological preparations the Hospital furnishes you.

c. Oxygen and oxygen tent.

d. Dressings and plaster casts.

e. Diagnostic Services. Under this paragraph, Diagnostic Services are:

- diagnostic x-rays, ultrasound, and nuclear medicine;
- laboratory and pathology services; and
- EEGs, EKGs, and other electronic diagnostic tests.

Diagnostic Services which are part of routine or periodic physical examinations or screening examinations are not covered.

- f. Anesthesia services and supplies.
- g. Therapy Services. Under this paragraph the term “Therapy Services” means:
 - Radiation Therapy
 - Chemotherapy
 - Renal Dialysis
 - Physical Therapy
 - Intravenous Therapy
 - Occupational Therapy
 - Speech Therapy
 - Inhalation Therapy
- h. Administration of infusions and transfusions. This does not include the cost of blood, blood plasma, blood derivatives, or professional donor fees.
- i. Ambulance services for transportation between local Hospitals when:
 - the Hospital where you are an Inpatient cannot provide the Covered Service you need; and
 - your condition rules out the use of any other less expensive means of transportation.
- j. Use of the delivery room and routine nursery care of the newborn, but only as part of the mother’s Maternity Services stay when her stay is covered under this article.

C. DAYS OF INPATIENT CARE AS BASIC SKILLED NURSING FACILITY SERVICES IN A MEDICARE BENEFIT PERIOD

Medicare pays up to 100 Days of Inpatient Care per Medicare Benefit Period in a Skilled Nursing Facility. The Company will pay only to the extent listed below:

- C.1.** During the first 20 days, the Company will pay nothing. Medicare covers these days in full.
- C.2.** During each of the next 80 days, the Company will pay your Part A Medicare Copayment Amount.
- C.3.** During each of the next 80 days, the Company will pay an amount equal to the daily Part A Medicare Copayment Amount which the Company paid for each of days 21-100. Medicare does not cover more than 100 days of care in a Skilled Nursing Facility.

D. SPECIAL LIMITATIONS

The amounts to which you are entitled under this article will not increase even if:

- D.1.** You were not enrolled in Part A of Medicare; or
- D.2.** The Hospital or Skilled Nursing Facility providing services did not participate with Medicare at the time you received care.

ARTICLE V. BASIC PROVIDER SERVICES

Except as limited in this booklet, the Basic Provider Services listed as covered in this article are covered. But they are covered only to the extent specified in your Schedule of Benefits for Basic Services and this article. These services must also be:

- performed or prescribed by a Provider licensed to do so, and
- Medically Necessary

A. BASIC SERVICES

The Company will pay for the following:

- Medicare Part B Deductible per Calendar Year; plus
- Medicare Part B Copayment Amounts.

The total of which exceed \$1,000 per Calendar Year.

B. SPECIAL LIMITATIONS

The amounts to which you are entitled under this article will not increase even if:

B.1. You were not enrolled in Part B of Medicare; or

B.2. The person or facility which furnished you a service did not participate with Medicare at the time you received care.

ARTICLE VI. BASIC DENTAL SERVICES

Except as limited in this booklet, Basic Dental Services described as covered in Paragraph **C.** of this article are covered. But they are covered only to the extent specified in your Schedule of Benefits for Basic Dental Services. Special restrictions described in Paragraph **D.** apply. Special Exclusions described in Paragraph **E.** also apply. Basic Dental Services must be:

- billed for by a Dentist in private practice; and
- ones which the Dentist is licensed to render.

A. DEFINITIONS

The following definitions are added to this article:

A.1. Basic Dental Services

Basic Dental Services are those services listed in Paragraph **C.** of this article.

A.2. Contracting Dentist and Non-Contracting Dentist

A Contracting Dentist is one listed as “contracting” by the Company. A Contracting Dentist must be listed as such at the time you receive the service for which coverage is sought. A Non-Contracting Dentist is any other Dentist.

A.3. Dentist

This means a person properly licensed to practice dentistry.

B. PAYMENT RULES FOR CONTRACTING AND NON-CONTRACTING DENTISTS

The payment rules for Basic Services listed in the Payment Rules article also apply to Basic Dental Services. In addition, the following special payment rules apply to Basic Dental Services.

B.1. The Company will pay the Contracting Dentist directly for Basic Dental Services. But if you have already paid the Contracting Dentist and the Dentist tells the Company to do so, the Company will pay the Enrollee. A Contracting Dentist will accept the Company’s Allowable Charge for a Basic Dental Service as payment in full for that service. Payment by the Company will relieve the Company of any further liability for the service.

B.2. The Company may choose to make payment directly to the Non-Contracting Dentist, the Enrollee, or any other person responsible for making payment for the Basic Dental Service the Non-Contracting Dentist renders. Non-Contracting Dentists have not agreed to accept the Company’s Allowable Charge as payment in full. They may bill you up to the full amount of their charges.

Payment by the Company will relieve the Company of any further liability for the service.

C. BASIC DENTAL SERVICES

The Company will pay for the following Basic Dental Services you receive from a Dentist. But these services are subject to any age or frequency limitations in your Schedule of Benefits for Basic Dental Services.

C.1. Diagnostic and Preventive Services which consist of:

- a. Oral examinations;
- b. Dental x-rays, except x-rays for orthodontic purposes (cephalometric film);
- c. Direct fluoride application to natural teeth;
- d. Prophylaxis (includes cleaning, scaling, and polishing);
- e. Palliative emergency treatment;
- f. Space maintainers (not made of precious metals);
- g. Biopsies of oral tissue;
- h. Pulp vitality tests;
- i. Dental pit/fissure sealants on first and second permanent molars;
- j. Bite planes or splints to increase the vertical dimension for temporomandibular joint or associated myofacial pain disorders;
- k. Occlusal adjustments for temporomandibular joint disorders; and
- l. Occlusal night guards for demonstrated tooth wear due to bruxism.

C.2. Primary Services

- a. Maintenance Services which consist of:
 1. Fillings made up of amalgam or tooth color synthetics;
 2. Root canal therapy;
 3. Repair of broken removable dentures;
 4. Recementing of crowns, inlays, and bridges; and
 5. Dentist's visits to your home when Medically Necessary to render Basic Dental Services
 6. Stainless steel crowns;
 7. Sedative fillings.
- b. Oral Surgical Services
Dental Services for oral surgery procedures listed in the most recent edition of the "Code of Dental Procedures and Nomenclature of the American Dental Association" are covered. But a procedure listed in Paragraph **C.1.** of this article or performed for orthodontic purposes will not be covered under this Paragraph **C.2.b.** Covered oral surgery procedures include, but are not limited to:
 1. Simple extractions;
 2. Surgical removal of teeth;
 3. Excision, drainage, or removal of cysts, tumors, and abscesses in the mouth;
 4. Apicoectomies;

5. Hemisections;
 6. Treatment of fractures of the jaw; and
 7. Alveoplasties to prepare the gum ridge for dentures.
- c. Periodontic Services which consist of:
1. Gingivectomy and gingivoplasty;
 2. Gingival curettage;
 3. Osseous surgery, including flap entry and closure;
 4. Surgical periodontic examinations;
 5. Mucogingivoplastic surgery; and
 6. Management of acute periodontal infection and oral lesions.
- d. General Anesthesia Services are covered when rendered in connection with Basic Dental Services by a person licensed to do so. If general Anesthesia Services are rendered by the same Dentist who performs the dental treatment, the Allowable Charge for the services will be 50% of the amount it would have been for them if rendered by someone else.

D. SPECIAL RESTRICTIONS

For this article only, there are three changes to the restrictions listed elsewhere in this booklet:

- D.1.** If you transfer from the care of one Dentist to another during a course of treatment, the Company will only pay the amount it would pay to one Dentist for the same treatment.
- D.2.** If more than one Dentist renders services for one procedure, the Company will only pay the amount it would pay to one Dentist for the same treatment.

E. SPECIAL EXCLUSIONS

The Exclusions in this booklet, not inconsistent with the terms of this article, also apply to Basic Dental Services. In addition, the following special Exclusions apply to Basic Dental Services. Payment will not be made under this article for the following Dental Services:

- E.1.** Those rendered by a dental or medical clinic maintained by your employer, a mutual benefit association, labor union, trustee, or like person or group.
- E.2.** Those related to genetic malformation.
- E.3.** Those rendered to an Inpatient in a facility by a Dentist paid by that facility to perform such services.
- E.4.** Gold foil restorations.
- E.5.** Those not listed in this article. For example, dentures, bridges, and orthodontics are not covered.

E.6. Instruction in personal dental hygiene and care. This includes plaque control.

E.7. Those rendered as part of optional plans of treatment, personalized restorations, or special techniques, unless approved by the Company **in advance**. If these procedures are not approved by the Company, the Company will pay only the Allowable Charges for the standard, less expensive procedures.

ARTICLE VII. BASIC VISION SERVICES

Except as limited in this booklet, Basic Vision Services listed as covered in Paragraph **A.** of this article are covered. But they are covered only to the extent specified in your Schedule of Benefits for Basic Vision Services. Basic Vision Services must be:

- billed for by a Provider in private practice; and
- ones which the Provider is licensed to render.

A. BASIC VISION SERVICES

A.1. Routine vision examinations, once every 24 months.

A.2. Frames (one pair every 24 months) and the following prescription lenses to correct refraction error (one pair of eyeglass lenses or any type of contact lenses every 24 months):

- Single Lenses; or
- Bifocal Lenses; or
- Trifocal Lenses; or
- Contact Lenses (any type).

B. SPECIAL EXCLUSIONS

The Exclusions in this booklet, not inconsistent with the terms of this article, also apply to Basic Vision Services. In addition, the following special Exclusions apply to Basic Vision Services. Payment will not be made under this article for the following vision services:

B.1. Services required by your employer as a condition of employment or rendered through a medical department, clinic or other similar service provided or maintained by the employer; and

B.2. Sunglasses, even if by prescription.

ARTICLE VIII. RETAIL PHARMACY PRESCRIPTION DRUG SERVICES

Except as limited in this booklet, the Retail Pharmacy Prescription Drug Services listed as covered in Paragraph **B.** of this article are covered. But they are covered only to the extent specified in your Schedule of Benefits for Retail Pharmacy Prescription Drug Services. Special Exclusions and limitations described in Paragraph **D.** apply. These services must also be:

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

A. DEFINITIONS

1. Allowable Charge

This term, as used in this article and its Schedule of Benefits only, means the Company's allowance for a prescription drug or the pharmacy's charge for that service, whichever is less.

2. Pharmacy

This term means any facility licensed as a pharmacy which prepares and dispenses prescription drugs for Outpatient use.

3. Prescription Drug

This term means:

- a. any medication which, by federal or state law, cannot be dispensed without a prescription order;
- b. insulin, insulin syringes, and lancets; and
- c. oral contraceptives, depo provera, cervical caps, diaphragms and Norplant.

4. Prescription Order

This term means a direction for the preparing and dispensing of a prescription drug by a Provider licensed to do so.

5. Contracting Pharmacies and Non-Contracting Pharmacies

- a. A contracting pharmacy is a pharmacy listed as a “Paid Prescriptions Coordinated Care Network Pharmacy” by the Company at the time the prescription drug is dispensed.
- b. A non-contracting pharmacy is any other pharmacy.

B. COVERED SERVICES

Except as provided in Paragraph **D.** of this article, prescription drugs are covered if they are:

1. approved for general use by the U. S. Food and Drug Administration; and
2. dispensed on or after your Effective Date by a pharmacy for Outpatient use.

C. PAYMENT RULES

1. If the dispensing pharmacy is a contracting pharmacy, the Company will direct benefit payment to that pharmacy. If the dispensing pharmacy is a non-contracting pharmacy, the Company will direct payment to the Enrollee. You may be required by a non-contracting pharmacy to pay not only the Copayment, but also the difference between the pharmacy’s charge for the prescription drug and the Allowable Charge for the prescription drug.
2. The benefits provided for Covered Services under this article are in lieu of any other benefits for the same Covered Services listed in any other article of this Benefit Section. Any Copayment listed on the Schedule of Benefits for Prescription Drug Services shall not be eligible as a Covered Service under any other article.
3. Through its subcontractor for administering claims for Covered Services under this article, the Company receives 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 Company. Credits received by virtue of the benefits provided under this article are retained by the Company as a part of its compensation from the State for administrative services. Payments to Pharmacies are not adjusted as a result of these credits.

D. SPECIAL EXCLUSIONS AND LIMITATIONS

1. The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription order or any refill authorized by prescription order is limited to a 90 consecutive day supply of the drug.

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.

2. The Company requires certain drugs and drug therapies to be approved in advance. Prior authorization will be required for certain medications that could be prescribed for Experimental/Investigative therapies, drugs approved for restricted uses, and for quantities and uses that may not be Medically Necessary.
3. In addition to the Exclusions listed in the Exclusions article of the Benefit Section, no coverage will be provided under this article for the following:
 - a. Over-the-counter drugs;
 - b. Any refill dispensed after one year from the date of the original prescription order;
 - c. Injectable prescription drugs which cannot be self-administered;
 - d. Therapeutic devices or appliances regardless of their intended use.
Examples are:
 - hypodermic needles;
 - syringes (other than for insulin); and
 - support garments.
 - e. Drugs prescribed for weight loss or as stop-smoking aids;
 - f. Drugs prescribed primarily for a cosmetic purpose;
 - g. Drugs which are dispensed in quantities larger than a 90-day supply;
 - h. Drugs prescribed for infertility;
 - i. Blood derivatives; and
 - j. DESI drugs (i.e., drugs which are of questionable therapeutic value as designated by the FDA's Federal Drug Efficacy Study).
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.

ARTICLE IX. MAIL ORDER PHARMACY PRESCRIPTION DRUG SERVICES

Except as limited in this booklet, the Mail Order Pharmacy Prescription Drug Services listed as covered in Paragraph **B.** of this article are covered. But they are covered only to the extent specified in your Schedule of Benefits for Mail Order Pharmacy Prescription Drug Services. Special Exclusions and limitations described in Paragraph **D.** apply. These services must also be:

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

A. DEFINITIONS

1. Allowable Charge

This term, as used in this article and its Schedule of Benefits only, means the Company's allowance for a prescription drug or the pharmacy's charge for that service, whichever is less.

2. Pharmacy

This term means any facility licensed as a pharmacy which prepares and dispenses prescription drugs for Outpatient use.

3. Prescription Drug

This term includes:

- a. any medication which, by federal or state law, cannot be dispensed without a prescription order;
- b. insulin, insulin syringes, and lancets; and
- c. oral contraceptives, depo provera, cervical caps, diaphragms and Norplant.

4. Mail Order Prescription Drug

This term means any prescription drug which is:

- a. dispensed in quantities no larger than a 90-day supply; and
- b. dispensed by a pharmacy in response to a prescription order submitted to it by mail.

5. Prescription Order

This term means a direction for the preparing and dispensing of a prescription drug by a Provider licensed to do so.

6. Contracting and Non-Contracting Pharmacies

- a. a contracting pharmacy is a pharmacy listed as “contracting” by the Company with respect to its Mail Order Prescription Drug Program at the time the Mail Order Prescription Drug is dispensed.
- b. a non-contracting pharmacy is any other pharmacy.

B. COVERED SERVICES

Except as provided in Paragraph of this article, Mail Order Prescription Drugs are covered if they are:

1. approved for general use by the U. S. Food and Drug Administration; and
2. dispensed on or after your Effective Date by a pharmacy for Outpatient use.

C. PAYMENT RULES

1. The Company will direct payment to the contracting pharmacy for the benefits available under this article. If the dispensing pharmacy is a non-contracting pharmacy, the Company will direct payment to the Enrollee. You may be required by a non-contracting pharmacy to pay not only the Copayment, but also the difference between the pharmacy’s charge for the Mail Order Prescription Drug and the Allowable Charge for the Mail Order Prescription Drug.
2. The benefits provided for Covered Services under this article are in lieu of any other benefits for the same Covered Services listed in any other article of this booklet. Any Copayment listed on the Schedule of Benefits for Mail Order Prescription Drug Services shall not be eligible as a Covered Service under any other article.
3. Through its subcontractor for administering claims for Covered Services under this article, the Company receives 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 Company. Credits received by virtue of the benefits provided under this article are retained by the Company as a part of its compensation from the State for administrative services. Payments to Pharmacies are not adjusted as a result of these credits.

D. SPECIAL EXCLUSIONS AND LIMITATIONS

- 1.** The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription order or any refill authorized by prescription order is limited to a 90 consecutive day supply of the drug.

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.

- 2.** The Company requires certain drugs and drug therapies to be approved in advance. Prior authorization will be required for certain medications.
- 3.** In addition to the Exclusions listed in the Exclusions article of this booklet, no coverage will be provided under this article for the following:
 - a.** Over-the-counter drugs;
 - b.** Any refill dispensed after one year from the date of the original prescription order;
 - c.** Injectable prescription drugs which cannot be self-administered;
 - d.** Therapeutic devices or appliances regardless of their intended use.
Examples are:
 - hypodermic needles;
 - syringes (other than for insulin); and
 - support garments.
 - e.** Drugs prescribed for weight loss or as stop-smoking aids;
 - f.** Drugs prescribed primarily for a cosmetic purpose;
 - g.** Drugs which are dispensed in quantities larger than a 90-day supply;
 - h.** Drugs prescribed for infertility;
 - i.** Blood derivatives; and
 - j.** DESI drugs (i.e., drugs which are of questionable therapeutic value as designated by the FDA's Federal Drug Efficacy Study).
- 6.** Only in documented cases of extended foreign travel will a supply of more than 90 days be prior authorized.
- 7.** Replacement drugs for supplies lost, stolen, etc. are not eligible for reimbursement.

ARTICLE X. EXCLUSIONS

BENEFITS FOR THE FOLLOWING WILL NOT BE PROVIDED

This Plan does not provide benefits for services or supplies that are:

1. not listed or described in this booklet as Covered Services.
2. received by you before your Plan Effective Date.
3. for or rendered during an Inpatient admission which began prior to your Plan Effective Date.
4. payable under Medicare.
5. not Medicare Eligible Expenses, except as specifically covered by this Plan.
6. not reasonable and necessary under Medicare program standards for diagnosing or treating a Sickness or Injury or for restoring a bodily function.
7. not usually accompanied with a charge. Also excluded are services for which you would not have been charged if you did not have health care coverage. Charges for self-administered services, self-care, self-help training, biofeedback, and related diagnostic testing are not covered.
8. furnished by a federal Provider or other federal agency.
9. provided or available to you:
 - a. 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 offered to either civilian employees or retired civilian employees of the federal or a state government. These latter Plans are subject to the rules explained in the General Rules Governing Benefits article.
 - b. under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payor after benefits under this booklet have been provided.

This exclusion applies whether or not you waive your rights under these laws, amendments, programs, or terms of employment.

10. for injuries or diseases related in any way to your job when:
 - a. you receive payment from your employer on account of the disease or injury;
 - b. your employer is required by federal, state, or local laws or regulations to provide benefits to you, or;

- c. You could have received benefits for the injury or disease if you had complied with the laws and regulations.

This exclusion applies whether or not you have waived your rights to payment for the services available. It also applies if your employer (or your employer's health benefits Company) reaches any settlement with you for an injury or disease related in any way to your job.

- 11. for diseases contracted or injuries sustained as a result of any act of war (declared or undeclared), voluntary participation in civil disobedience, or other such activities.
- 12. personal comfort items.
- 13. for rest cures, convalescent care, residential care, custodial care, care in a group home, halfway house, or residential setting.
- 14. for hearing aids and exams for their prescription, fitting, or changing.
- 15. for, or related to, cosmetic surgery, including routine complications thereof.
- 16. determined to be not Medically Necessary by the Company, in its sole discretion, for the treatment of an illness, injury, or pregnancy-related condition.
- 17. determined to be Experimental/Investigative by the Company, in its sole discretion. Also excluded are services to treat routine complications of any Experimental/Investigative service.
- 18. for routine foot care, the treatment of subluxation of the foot, the treatment of flat foot conditions, or orthopedic shoes and other supportive devices for the feet.
- 19. provided by a member of your immediate family and services rendered by a Provider or Provider's Employee to a co-worker.
- 20. for surgical sex transformation and follow-up care.
- 21. for radial keratotomy and other surgical procedures to correct myopia.
- 22. for telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, or charges for giving information concerning a claim.
- 23. for abortions, except in the following cases, and only if not otherwise contrary to law:
 - a. when Medically Necessary to save the life of the mother;
 - b. when the pregnancy occurs as a result of rape or incest which has been reported to a law-enforcement or public health agency; and
 - c. when the fetus is believed to have an incapacitating physical deformity or an incapacitating mental deficiency, which is certified by a Physician.

24. therapeutic injections rendered for the treatment of infertility, such as serophene, pergonal, and metrodin. Therapeutic injections of growth hormones are excluded except under Articles VIII, and IX of this Benefits Section.

ARTICLE XI. BASIC PLAN PROVISIONS

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

This Plan is sponsored by the Commonwealth of Virginia and administered by the Department of Human Resource Management. The Department is authorized to, and reserves the right to change or terminate this Plan on behalf of the Commonwealth at any time. These retained rights extend, without limit, to all aspects of the Plan, including, for example, benefits, eligibility for benefits, premiums, copayments and contributions required of Enrollees. The Department is also authorized and empowered to exercise discretion in interpreting the terms of the 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 the Plan you select. These include rules about admission, discharge, and availability of services. Neither the Company nor the State guarantees admission or the availability of any specific type of room or kind of service. Neither the Company nor the State will be responsible for acts or omissions of any facility. Neither the Company nor the State will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a facility. Neither the Company nor the State will be liable for breach of contract because of anything done, or not done, by a facility.

Similarly, the Company is obligated only to pay, in part, for the services of your professional Provider to the extent the services are covered. Neither the Company nor the State guarantees the availability of a Provider's services. Neither the Company nor the State will be responsible for acts or omissions of any Provider. Neither the Company nor the State will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a Provider. Neither the Company nor the State 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 generally disclosed to others only in accordance with the guidelines set forth in the Virginia Insurance Information and Privacy Protection Act. A more detailed explanation of the Company's information practices is available upon request.

When you apply for coverage under the Plan, you agree that the Company may request any medical information or other records from any source when related to claims submitted to the Company for services you receive.

By accepting coverage under the Plan, you authorize any individual, association, or firm which has diagnosed or treated your condition to furnish the Company 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 Company 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, an Enrollee may review copies of medical records which pertain to enrolled dependent children under age 18.

4. The Personal Nature of These 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 Company'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 Company 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 the Plan.

5. Proof of Loss

In many cases, the facility or Provider will submit your claim to the Company. However, the Company 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 Company 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 Company must be in writing.

6. Prompt Filing of Claims

No claim will be paid if the Company receives it more than one year after the date on which the service was rendered. If the State terminates the Plan for any reason, no claim will be paid if the Company receives it later than 6 months following the Effective Date of termination. You are responsible for making sure the individual or facility rendering the service knows you are eligible for Covered Services. You are also responsible for making sure these facilities and individuals submit claims for Covered Services within the time permitted.

7. Payment Errors and Appeals

Every effort is made to process claims promptly and correctly. If payments are made to you, or on your behalf, and the Company finds at a later date the payments were incorrect, the Company will pay any underpayment. Likewise, you must repay any overpayment. A written notice will be sent to the Enrollee if repayment is required. See Appeals under General Rules Governing Benefits article.

8. Benefits Administrator and Other Plan Information

Your Benefits Administrator is the appropriate person 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 the 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 Company.

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

9. Continuation of Coverage

Extended Coverage

Extended Coverage is a term which describes coverage required of government employers under the provisions of the Public Health Service Act. These are the same provisions which apply to private employers under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Under certain circumstances, a Participant who would ordinarily lose coverage because of any of the Qualifying Events described below is a Qualified Beneficiary who may elect to continue coverage under the State Health Benefits Program for a period of up to 36 months at the Participant's own expense.

There is no State contribution toward Extended Coverage. A fee of 2% is added to the total monthly premium for health benefits. Extended Coverage may run concurrent with any other state-provided continuation such as that provided under long-term disability plans.

In the case of the following Qualifying Events, coverage may be continued up to 36 months at the individual's own expense.

- Death of the Participant under whose Membership the affected person was enrolled as a spouse or as a dependent child.
- Divorce, when the affected person was enrolled as a spouse, or dependent child who loses eligibility as a result of the divorce.
- Loss of dependent child status by a person enrolled in health benefits through the State Health Benefits Program.

Eligibility for Extended Coverage ends at the earliest of any of the following:

- Failure to make a premium payment when due. (Partial payment is considered non-payment.)
- The Qualified Beneficiary becomes covered under any other group health plan which does not contain any exclusion or limitation regarding a pre-existing condition of such Qualified Beneficiary. This provision does not apply if the other coverage was in place prior to the Qualifying Event.
- Expiration of the 36-month continuation period.

Reduction or elimination of coverage in anticipation of an Extended Coverage Qualifying Event will not disqualify an otherwise eligible Qualified Beneficiary from receiving Extended Coverage. In the case of a divorce, the Plan will offer Extended Coverage effective on the date of the divorce, but not for any period between when the coverage was lost and the divorce became final.

Your Benefits Administrator will notify your dependents of their continuation of coverage rights in the case of your death. Your dependents must respond within 60 days of the State's notification or actual loss of coverage, whichever is later.

In the case of divorce or a change in dependent status (such as reaching the age limit) that results in a loss of coverage, covered dependents or the Participant are responsible for notifying their agency Benefits Administrator within 60 days of the Qualifying Event. If they do not meet this notification requirement, they will forfeit all of their Extended Coverage rights associated with these events.

Premiums for Extended Coverage are 102% of the premiums for regular coverage. By Extended Coverage rules, the affected person has 45 days from the date of the election to make payment.

10. Company's Continuing Rights

On occasion, the Company or the State may not insist on your strict performance of all terms of this Plan. Failure to apply terms or conditions does not mean the Company or the State waives or gives up any future rights it may have. The Company 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 Company or the State in any matter relating to (1) the Plan, (2) the Company's performance or the State's performance under the Plan; or (3) any statements made by an employee, officer, or director of the Company or the State concerning the 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 Company, the State, or any director, officer, or employee of the Company or the State 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 This Plan

A change in this 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 Participant's coverage can be canceled by the Company or the State if it finds that any information needed to accept the Participant or process a claim was deliberately misrepresented by, or with the knowledge of, the Participant. The Company or the State may also cancel coverage for any other family members enrolled with the Participant. When false or misleading information is discovered, the Company or the State 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 Company has the right to suspend payment of your claims. The Company 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 Company to cancel your coverage.

15. Death of an Enrollee

Coverage will end for a dependent enrolled with the Enrollee if the Enrollee dies unless continuation of coverage is properly elected and maintained pursuant to

Survivor benefits or paragraph 9) of this section. Coverage for the dependent will end on the last day of the month in which the death occurs.

16. Divorce

Coverage will end for the enrolled spouse of an Enrollee on the last day of the month in which the final divorce decree is granted unless continuation of coverage is properly elected and maintained pursuant to paragraph 9) of this section. Conversion privileges for the spouse will be extended if the spouse notifies the Company of the divorce in writing within 31 days after the end of the month in which the divorce is granted.

17. End of Dependent Coverage

When a dependent is no longer eligible for coverage, he/she must notify the Company in writing that he/she wishes to continue coverage under another contract or certificate rather than through the State health benefits program. Conversion privileges for the dependent will be extended if the Company receives notice within 31 days after the end of the month in which the dependent ceased to be eligible for coverage under the State program.

18. Your Responsibility for Conversion

You are responsible for making arrangements for continuous coverage. When you are no longer eligible for coverage under this Plan, you must contact your Benefits Administrator. You must give the Benefits Administrator an address at which you may be reached during the 3 months immediately following termination. The State will notify the Company. Only when the Company receives proper notice from the State can continuous coverage under this Plan or a non-group conversion policy be offered.

19. Conversion Privileges

When the Company is properly notified by the State that you are no longer eligible for coverage, the Company will contact the Enrollee by mail about coverage available under a non-group conversion policy. These conversion privileges are available only if the Company has the Enrollee's current address. You must respond to the Company's offer within 15 days from the date of the Company's offer, or within 31 days from the date your enrollment ends, whichever of the two provides you with the latest date by which to respond. If you accept the enrollment offer within the time allowed by the offer, there will be no lapse in coverage. Although coverage will be continuous, the new benefits will be different. Be sure to read the Company's offer carefully. It will outline the enrollment requirements, the time permitted to accept the offer, the benefits, and the rates for the new program.

ARTICLE XII. STATUTORY BENEFITS

The following must, by statute, be offered to Medicare-eligible retirees in the State retiree health benefits program. This may also be referred to as mandated benefits. The text below has been excerpted from the Code of Virginia, § 2.1-20.1. This information will be updated each July 30. Statutory benefits are believed to have been incorporated into the State retiree health benefits program for plans offered to Medicare-eligible retirees.

The Plan shall:

8. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

H. 1. Any self-insured group health insurance plan established by the Department of Human Resource Management that includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the plan if the formulary is developed, reviewed at least annually, and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are actively practicing licensed (i) pharmacists, (ii) physicians, and (iii) other health care providers.

H. 2. If the plan maintains one or more drug formularies, the plan shall establish a process to allow a person to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the plan, a specific, Medically Necessary nonformulary prescription drug if, after reasonable investigation and consultation with the prescribing physician, the formulary drug is determined to be an inappropriate therapy for the medical condition of the person. The plan shall act on such requests within one business day of receipt of the request.

J. Any plan established by the Department of Human Resource Management shall provide to all covered employees written notice of any benefit reductions during the contract period at least thirty days before such reductions become effective.

L. 1. The Department of Human Resource Management shall appoint an Ombudsman to promote and protect the interests of covered employees under any state employee's health plan.

L. 2. The Ombudsman shall:

a. Assist covered employees in understanding their rights and the processes available to them according to their state health plan.

b. Answer inquiries from covered employees by telephone and electronic mail.

c. Provide to covered employees information concerning the state health plans.

d. Develop information on the types of health plans available, including benefits and complaint procedures and appeals.

e. Make available, either separately or through an existing Internet web site utilized by the Department of Human Resource Management, information as set forth in clause d and such additional information as deemed appropriate.

f. Maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.

g. Upon request, assist covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures. Such assistance may require the review of health care records of a covered employee, which shall be done only with that employee's express written consent. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

h. Ensure that covered employees have access to the services provided by the Ombudsman and that the covered employees receive timely responses from the Ombudsman or his representatives to the inquiries.

i. Report annually on his activities to the standing committees of the General Assembly having jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each year.

M. 1. The plan established by the Department of Human Resource Management shall not refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by a covered employee.

M. 2. For purposes of this subsection, "assignment of benefits" means the transfer of dental care coverage reimbursement benefits or other rights under the plan. The assignment of benefits shall not be effective until the covered employee notifies the plan in writing of the assignment. Any group health insurance plan established by the Department of Human Resource Management that contains a coordination of benefits provision shall provide written notification to any eligible employee as a prominent part of its enrollment materials that if such eligible employee is covered under another group accident and sickness insurance policy, group accident and sickness subscription contract, or group health care plan for health care services, that insurance policy, subscription contract or health care plan may have primary responsibility for the covered expenses of other family members enrolled with the eligible employee. Such written notification shall describe generally the conditions upon which the other coverage would be primary for dependent children enrolled under the eligible employee's coverage and the method by which the eligible enrollee may verify from the plan which coverage would have primary responsibility for the covered expenses of each family member.

§ [38.2-3407.13:1](#). Coordination of benefits; notice of priority of coverage.

Each (i) insurer issuing individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness

subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with any such policy, contract or plan, contains a coordination of benefits provision shall provide written notification to the insured, subscriber or member as a prominent part of its enrollment materials that if such insured, subscriber or member is covered under another group accident and sickness insurance policy, group accident and sickness subscription contract, or group health care plan for health care services, that insurance policy, subscription contract or health care plan may have primary responsibility for the covered expenses of other family members enrolled with the insured, subscriber or member. Such written notification shall describe generally the conditions upon which the other coverage would be primary for dependent children enrolled under the insured's, subscriber's, or member's coverage and the method by which the insured, subscriber or member may verify from the insurer, corporation or health maintenance organization which coverage would have primary responsibility for the covered expenses of each family member. The provisions of this section shall not be construed to abrogate any coordination of benefits provision authorized pursuant to subsection B of § 38.2-340

