

VALUE ALLIANCE *with* DENTAL

M E M B E R H A N D B O O K

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*The Local Choice
Health Benefits Program*

Administered by the Commonwealth of Virginia-Department of Human Resource Management

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Value Alliance With Dental Health Benefits Plan

IMPORTANT NOTICE

Your Plan is administered by two Companies. For Medical, Surgical, Outpatient prescription drug service, and dental services, the Company is Trigon Blue Cross Blue Shield. For Mental Illness and Substance Abuse Services, including Employee Assistance Program (EAP) services, the Company is Magellan Behavioral Health. This booklet describes covered Plan services administered by both Companies. However, there is also a separate Mental Illness and Substance Abuse Member Handbook available from Magellan Behavioral Health or from your Benefits Administrator. You are responsible for reading the separate booklet from Magellan Behavioral Health for an in-depth description of these services.

This Value Alliance With Dental booklet tells You what may be eligible for reimbursement under Your Value Alliance With Dental health benefits Plan. This preface is part of this booklet and contains rules for interpreting this booklet. Throughout this booklet there are words which begin with capital letters. In most cases, these are defined terms. See the Definitions section for the meaning of these words.

Your employer-provided health benefits Plan does not cover everything. Your coverage is limited to the services which are described in this booklet as eligible for reimbursement. There are specific Exclusions for which the program will never pay. Even more important, payment for services is almost always conditional. That is, payment may be reduced or even denied for a service if You received the service without observing all the conditions and limits under which the service is covered. Finally, You almost always have to pay for part of the cost of treatment.

Your health benefits are contractual in nature. This means, in part, that what You or Your employer thinks is covered does not make it a covered service. Likewise, if You or Your employer thinks a service should be covered, that does not make it a covered service. The same is true even when the issue is life or death: a service is not covered simply because You, Your Physician, or Your employer believe You need the service, or because the service is the only remaining treatment which might (or might not) save Your life. This booklet alone describes what services are eligible for reimbursement, the conditions under which the services are covered, the limits of coverage, and the amounts which may be payable under the specified conditions. You, and You alone, are responsible for knowing what is covered and the limits and conditions of coverage. Furthermore, the terms and conditions of Your coverage can be changed without Your consent, if proper notice is given to You. In addition, the most current edition of this booklet may be printed at any time from the following Web sites: www.thelocalchoice.state.va.us or <http://state.trigon.com>.

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

Still there is more You need to know. There are some rules which apply to all benefits. This information starts on page 5. Also, as mentioned earlier, there are some services for which the Company will never pay (see Exclusions section, page 38). Finally, we have included some rules governing the Plan (see Basic Plan Provisions section, page 42). Also refer to the Definitions section beginning on page 49 for an explanation of many of the terms used in this booklet. These sections are important because they will be used to determine exactly what this Plan covers.

**READ THIS BOOKLET BEFORE RECEIVING SERVICES
IF YOU EXPECT PAYMENT UNDER YOUR EMPLOYER HEALTH INSURANCE PLAN.**

SUMMARY OF BENEFITS VALUE ALLIANCE WITH DENTAL

	Covered Services	In-Network You Pay
Plan Year Deductible	Applies to both medical and mental health benefits	Your Plan Year Deductible: \$300 per covered person, not to exceed \$900 per family
Plan Year Out of Pocket Expense Limit	Applies to both medical and mental health benefits. Once you have met your out-of-pocket expense limit for the plan year, the Plan pays 100% of the Allowable Charge (AC)** for in-network services. (Certain expenses do not count toward the limit as defined on page 9.)	Your Plan Year Limit: \$2,500 per covered person, not to exceed \$7,500 per family
Inpatient Hospital	Services and supplies while an Inpatient.	20% Coinsurance after Deductible
Outpatient Hospital	Facility charge for outpatient department of a Hospital or Hospital emergency room including diagnostic tests, x-rays, and laboratory services	20% Coinsurance after Deductible
Skilled Nursing Facility	180 days per plan year in Network Skilled Nursing Facility	20% Coinsurance after Deductible
Home Health Care	Nursing and other services in your home, up to 90 Visits per plan year	20% Coinsurance after Deductible
Professional Services	<ul style="list-style-type: none"> Inpatient physician services 	20% Coinsurance after Deductible
	<ul style="list-style-type: none"> Outpatient physician Visit in office or Hospital 	\$20 per PCP Visit; \$35 per Specialist* Visit
	<ul style="list-style-type: none"> Maternity Services (pre- and post-natal care) 	\$20 per PCP per pregnancy \$35 per Specialist per pregnancy
Physical/Speech/Occupational Therapy	Services rendered by a licensed Physical, Speech, or Occupational therapist; lifetime maximum of up to 90 consecutive days per illness or condition	\$35 per Visit
Diagnostic Tests and Laboratory Services	<ul style="list-style-type: none"> Physician office Clinical reference lab or Outpatient Hospital 	20% Coinsurance after Deductible
Outpatient Prescription Drugs (Mandatory generic)	<ul style="list-style-type: none"> Retail up to 34-day supply (You may purchase up to a 90-day supply at a retail pharmacy by paying multiple Copayments.) 	Tier 1: \$15 Tier 2: \$20 Tier 3: \$35
	<ul style="list-style-type: none"> Home Delivery Pharmacy Service up to a 90-day supply (If You choose the brand when a generic is available, You pay Copayment plus 100% of the difference between the generic drug Allowable Charge and the brand drug Allowable Charge.) 	Tier 1: \$18 Tier 2: \$33 Tier 3: \$63
Dental	Plan pays \$1,200 per member per plan year, except for orthodontic services:	
	<ul style="list-style-type: none"> Diagnostic and preventive services 	\$0
	<ul style="list-style-type: none"> Primary services 	20% Coinsurance, no Deductible
	<ul style="list-style-type: none"> Complex restorative Orthodontic services (Plan pays \$1,200 per member per lifetime) 	50% Coinsurance, no Deductible

	Covered Services	In-Network You Pay
Wellness Services (All ages)	<ul style="list-style-type: none"> Wellness check-up 	\$20 per PCP Visit; \$35 per Specialist Visit
	<ul style="list-style-type: none"> Routine immunizations, preventive screenings, laboratory and x-rays in conjunction with wellness check-up. 	20% Coinsurance after Deductible
Other Adult Wellness Services	<ul style="list-style-type: none"> Routine mammography screening and reading Annual PSA test, digital rectal examination, and colorectal cancer screening (<i>age 40 and over</i>) 	20% Coinsurance after Deductible
	<ul style="list-style-type: none"> Annual routine gynecological Visit <ul style="list-style-type: none"> Pap test 	\$20 per PCP Visit; \$35 per Specialist Visit 20% Coinsurance after Deductible
Emergency Services for Life-Threatening Conditions	<ul style="list-style-type: none"> Hospital emergency room 	20% Coinsurance after Deductible
	<ul style="list-style-type: none"> Physician care 	\$20 per PCP Visit; \$35 per Specialist Visit
Mental Illness and Substance Abuse	<ul style="list-style-type: none"> Outpatient Visit – authorized in advance of care 	\$35 per Visit
	<ul style="list-style-type: none"> Outpatient Hospital Inpatient and partial days of care 	20% Coinsurance after Deductible
	<ul style="list-style-type: none"> Employee Assistance Program (EAP) (four free Visits per incident) 	No Coinsurance, no Deductible

* Specialist: Any provider other than your PCP

** Allowable Charge (AC): See Definitions section.

This is only a summary of the benefits available to you through this health benefits Plan. Complete information on each covered service may be found in the appropriate section of this Member Handbook.

WHO TO CONTACT FOR ASSISTANCE

Medical, and Outpatient Prescription Drug, and Dental Benefits

Trigon Blue Cross Blue Shield

<i>Member Services</i>	(804) 355-8506 in Richmond 1-800-552-2682 outside Richmond
<i>Hospital Admission Review</i>	(804) 359-7277 in Richmond 1-800-242-7277 outside Richmond
<i>Web Address</i>	http://state.trigon.com
<i>Mailing Address</i>	Trigon Blue Cross Blue Shield Member Services - Mail Drop 03K P. O. Box 27401 Richmond, VA 23279

Mental Illness and Substance Abuse Services, including EAP Services

Magellan Behavioral Health

<i>Member Services and Authorization for Care</i>	1-800-775-5138
<i>TDD Service</i>	1-800-828-1120
<i>Web Address</i>	www.dhrm.state.va.us/services/health/magellan.htm
<i>Mailing Address</i>	Magellan Behavioral Health 804 Moorefield Park Drive, Suite 304 Richmond, Virginia 23236

The Local Choice Health Benefits Program

<i>Web Address</i>	www.thelocalchoice.state.va.us
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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.

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). The Allowable Charge for a procedure will be based on the most inclusive code in *Current Procedural 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) Choose a Primary Care Physician

Upon enrollment, You must select a Primary Care Physician. If you do not select a Primary Care Physician no benefits will be available for covered services other than in the case of an Emergency. It is important that You read and understand the definition of Emergency Services which can be found in the Definitions section. You must consult your Primary Care Physician before seeking services from other Providers or Network Hospitals. Your Primary Care Physician must arrange for all referrals to other Network Providers or Network Hospitals. If no Network Provider or Network Hospital is available in the sole judgment of the Company, Your Primary Care Physician may refer to Non-Network Providers or Non-Network Hospitals.

7) Services of a Primary Care Physician

The Company will generally pay the Allowable Charge, minus Your Copayment, for services rendered to You by Your Primary Care Physician, and for Network professional and institutional services ordered by Your Primary Care Physician if these services are otherwise payable (for example, are within the contract limits). The Company will pay no part of the Allowable Charge if You receive services from someone other than the Primary Care Physician or services which the Primary Care Physician has not ordered for You, unless the services are Emergency Services. Even though You may believe You have coverage under the Plan, if You have not chosen a Primary Care Physician or have not secured a Referral for services from Your Primary Care Physician, the Plan will pay no part of the Allowable Charge for services You receive except Emergency Services.

You may select a Primary Care Physician at any time by contacting Trigon Blue Cross Blue Shield Member Services. The first day on which You may receive services or Referrals from that Primary Care Physician is the first of the month *following* the month in which You select the Primary Care Physician.

Outpatient, non-Surgical gynecological services rendered by an obstetrician-gynecologist who is a Network Provider may be covered at the full Allowable Charge if the services are provided to a female Participant in lieu of services rendered by her Primary Care Physician even if she has no Referral from the Primary Care Physician.

8) Payment to Network Providers

The Company pays to the Network Provider the amount of the Allowable Charge which remains after Your Deductible (if applicable), Copayment or Coinsurance.

When a Participant receives services from a Network Provider and has met the applicable Deductible, the Company will make payment for these services directly to the Provider. But, if the Participant 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.

9) Out-of-Network Payments

The Company will not make any payment for services provided by Non-Network Providers under the Plan except for Emergency Services or Urgent Care.

10) Alternative Benefits

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

11) Organ 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.

Covered services for the identification of a suitable donor to a Participant for an allogeneic bone marrow transplant will include a computer search of established bone marrow registries and laboratory testing necessary to establish compatibility of potential donors who are from the patient's immediate family or who have been identified through the computer search. These services must be ordered by a Physician qualified to provide allogeneic transplants. The maximum lifetime benefits will be \$25,000 per Participant.

12) 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.

Reviews for treatment authorizations or medical claims that have been denied will be sent to an impartial health entity. The impartial health entity shall examine the final denial of claims or treatment authorizations to determine whether the decision is objective, clinically valid, and comparable with established principles of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if consistent with law and policy. Medical appeals accepted into the review process must entail a liability of at least \$300 to the appellant or covered family member. 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 “The Local Choice Health Benefits Program Appeal Form” on the Web at www.thelocalchoice.state.va.us

13) 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 Plan 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/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. 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 Plan 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.

14) Out-of-Pocket Expense Limit

When You incur \$2,500 of Out-of-Pocket Expenses in a Plan Year, the Company will pay the Out-of-Pocket Expenses for covered network services You receive during the remainder of that Plan Year. All participants in the same immediate family must satisfy no more than a total of \$7,500 in Out-of-Pocket Expenses in each Plan Year.

If You were enrolled in a prior group contract issued by the Company on the date immediately preceding Your effective date in this Plan, any Deductible, Copayment, and Coinsurance amounts which were included in any Out-of-Pocket expense limit contained in that contract will not apply to Your Out-of-Pocket Expense limit.

The following do not apply to the Out-of-Pocket Expense Limit:

- Copayments and Coinsurance for services listed in the following sections: Dental Services, Outpatient Drugs
- Any amounts in excess of the Allowable Charge for a covered service or any amounts in excess of fixed dollar benefit limits listed in any section

The following will not be paid when the Out-of-Pocket Expense limit has been reached:

- Copayments and Coinsurance for services listed in the following sections: Dental Services, Outpatient Prescription Drugs
- Deductibles, Copayments, and Coinsurance for covered services You receive from a Non-Network Hospital or Non-Network Provider
- Any amounts in excess of the Allowable Charge for a covered service or any amounts in excess of fixed dollar benefit limits listed in any section

15) Cancellation of Coverage by Enrollee

Under the Plan, cancellation of coverage is allowed the first of the month after waiver is received. If You are enrolled in a premium conversion plan, the rules of that plan must also allow the desired change. If cancellation of coverage is permissible under premium conversion, the completed waiver must be received within 31 days of the qualifying mid-year event. Please contact your Benefits Administrator for additional information.

16) Notice from the Company to You

A notice sent to You by the Company is considered “given” when delivered to The Local Choice Group 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.

17) 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.

INSTITUTIONAL SERVICES

HOSPITAL SERVICES

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

Services Which Are Eligible for Reimbursement

- 1) Bed and board in a Semi-Private Room, including general nursing services and special diets. A bed in an intensive care unit is eligible for reimbursement for critically ill patients. The amount charged for a private room above the amount charged for a Semi-Private Room is not eligible for reimbursement unless You have a highly contagious disease or You have a significant risk of contracting an infectious disease. In an all private room Hospital, You pay the difference between Your daily room charge and the average Semi-Private Room Allowable Charge for other Hospitals in the community, as determined solely by the Company. The Company will pay for only one room or bed on each Day of Inpatient Care.
- 2) Customary ancillary services for Inpatient stays, including operating rooms, medications, oxygen and oxygen tents, dressings and casts, anesthesia, Diagnostic and Therapy Services, emergency room services leading directly to admission which are rendered to a patient who dies before being admitted, ambulance services for transportation between local Hospitals when Medically Necessary, and routine nursery care of a newborn as part of a mother's covered maternity service.
- 3) Partial Hospitalization for Mental Illness and Substance Abuse Services. These services are available on the same basis as Inpatient services.
- 4) Outpatient Hospital services including pre-admission testing and other Diagnostic Services, Therapy Services, Therapeutic Injections, Surgical Services, Inpatient ancillary services when unavailable in an Inpatient facility, mammography, Partial Hospitalization for Mental Illness and Substance Abuse Services, and routine colonoscopy screening.
- 5) Routine Mammograms.
- 6) Emergency Services in an emergency room, whether or not leading to a Hospital admission.

Conditions for Reimbursement

- 1) Inpatient and Outpatient Hospital services must be:
 - Prescribed by a Provider licensed to do so;
 - Authorized and arranged by Your Primary Care Physician;
 - Furnished and billed by a Hospital; and
 - Medically Necessary.
- 2) In addition to the applicable Deductible, Coinsurance, or Copayment, You may be financially responsible for the entire Hospital bill if, after Your admission to the Hospital, the Company

finds that the Inpatient stay was not Medically Necessary. In order to avoid this, You must comply with the following Hospital admission review procedure:

- a. You, Your Primary Care Physician, the admitting physician, a family member, or a friend must contact the Company by telephone or by letter prior to a non-emergency Inpatient service and furnish the following information:
 - (i) Primary Care Physician's name, address, and telephone number;
 - (ii) Name and address of the Hospital to which Your admission is planned;
 - (iii) Your name and Enrollee identification number;
 - (iv) Anticipated admission date and length of stay; and
 - (v) Medical justification for Inpatient treatment.

After an emergency admission, You, Your Primary Care Physician, the admitting physician, a family member, or a friend must contact the Company within 48 hours or, if later, the next business day and furnish the above information.

- b. You, Your Primary Care Physician, the admitting physician, a family member, or a friend must receive a response from the Company, either approval or disapproval, prior to the rendering of the non-emergency Inpatient service.

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

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

- c. The Company may not require the admission review procedure to be followed for admissions that arise over the weekend.

3) Mammograms are covered provided that:

- a. The Mammogram is:
 - (1) Ordered by a licensed Network Provider;
 - (2) Performed by a registered technologist;
 - (3) Interpreted by a qualified radiologist;
 - (4) Performed under the direction of a person licensed to practice medicine and surgery, and certified by the American Board of Radiology or an equivalent examining body; and
 - (5) A copy of the Mammogram report is delivered to the Provider who ordered the Mammogram.
- b. The equipment used to perform the Mammogram meets the standards set forth by the Virginia Department of Health in its radiation protection regulations.

- c. The mammography film is retained by the radiology facility performing the examination in accordance with the American College of Radiology guidelines or state law.
- 4) All Mental Illness and Substance Abuse Services must be pre-authorized, unless the rules for emergencies apply. Authorization is required within 48 hours of an emergency.

The following services must be pre-authorized:

- Ambulance
- Cardiac Rehabilitation
- Continuous Passive Motion (CPM) – all services
- Durable Medical Equipment
- Esophageal Ph Monitoring
- Genetic Testing
- Home Health Care
- Hyperbaric Oxygen Pressurization
- MRI (Magnetic Resonance Imaging)
- Non-Routine Dental/Oral
- Organ and Bone Marrow Transplants
- Pallidotomy
- Therapies
- Treatment of Morbid Obesity

The list of services is only a sampling and may change, so always check with Your PCP or Trigon Member Services for the most current and complete list.

Special Limits

One annual colonoscopy screening for members 40 and over.

Reimbursement

After Your Deductible and Coinsurance, the Company pays the remainder of the Allowable Charge for covered services in a Network Hospital during approved admissions.

Your Payments

Inpatient services	20% Coinsurance after Deductible*
Outpatient services	20% Coinsurance after Deductible*

(*Deductible = \$300 per covered person, per Plan Year, not to exceed \$900 per family)

No payment will be made for any service if the service indicated is rendered to a Participant without a Referral, except that:

- Referrals will not be required for Emergency Services in a life-threatening situation. (See description of Emergency Services in Definitions section.)

SKILLED NURSING FACILITY SERVICES

Services Which Are Eligible for Reimbursement

The Company will cover Your Semi-Private Room in a Network Skilled Nursing Facility. The room charge includes Your meals, any special diets, and general nursing services. You are also entitled to receive the same types of ancillary services which are available to a Hospital Inpatient.

Conditions for Reimbursement

- 1) Care which is necessary for a person who does not have a treatable medical illness or injury is not covered. For example, a person is not eligible for covered care in a Skilled Nursing Facility simply because the person is unable to care for himself (that is, the person cannot perform several activities of daily living, such as bathing or feeding).
- 2) Skilled Nursing Facility Services must also be:
 - Medically Skilled Services;
 - Prescribed by Your Provider and listed in the Plan of Treatment;
 - Furnished and billed by the Skilled Nursing Facility; and
 - Medically Necessary.
- 3) You may be financially responsible for the entire bill if, after Your admission, the Company finds that the Inpatient stay was not Medically Necessary. In order to avoid this, You must comply with the following procedure.
 - a. You, Your Primary Care Physician, the admitting physician, family member, or a friend must contact the Company by telephone or by letter prior to a non-emergency Inpatient service and furnish the following information:
 - (i) Primary Care Physician's name, address, and telephone number;
 - (ii) Name and address of the Skilled Nursing Facility to which Your admission is planned;
 - (iii) Your name and Enrollee identification number;
 - (iv) Anticipated admission date and length of stay; and
 - (v) Medical justification for Inpatient treatment.
 - b. You or Your Primary Care Physician must receive a response from the Company, either approval or disapproval, prior to the rendering of the non-emergency Inpatient service.

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

- (i) If, as a part of an admission review procedure the Company determines that a contemplated Inpatient service is not Medically Necessary and the Participant elects to proceed with the Inpatient service despite this determination, the Company will deny this service as not Medically Necessary unless additional information is provided indicating a contrary result is warranted. You are financially responsible for services which are not Medically Necessary.

MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES

Eligible services for Mental Illness and Substance Abuse are covered if pre-authorized. A Referral from Your Primary Care Physician is not necessary to receive these services. Services for alcohol and substance abuse may be reimbursable when rendered in both the Outpatient and Inpatient settings. Residential treatment is not a covered benefit.

Conditions for Reimbursement

Eligible services must be pre-authorized by the Plan. To secure pre-authorization for Mental Illness and Substance Abuse Services, call Magellan Behavioral Health at 1-800-775-5138.

Special Limits

EAP services are limited to four Visits per incident.

Reimbursement

After Your Deductible and Coinsurance, the Company pays the remainder of the Allowable Charge for services in a Network facility during approved admissions.

Your Copayments

Inpatient services, any setting	20% Coinsurance after Deductible*
Partial Hospitalization	20% Coinsurance after Deductible*
Outpatient Hospital	20% Coinsurance After Deductible*
Professional Services, except Employee Assistance	\$35 per Visit
Employee Assistance Program	No Deductible, Copayment or Coinsurance

(*Deductible = \$300 per covered person, per Plan Year, not to exceed \$900 per family)

No payment will be made if the service is rendered to a Participant without pre-authorization.

HOME HEALTH CARE SERVICES

Services Which Are Eligible for Reimbursement

Home health care services include:

- Professional Medical and Surgical Services.
- Periodic nursing care furnished by a licensed registered nurse (R.N.) or licensed practical nurse (L.P.N.) under the supervision of an R.N.
- Therapy Services.
- Medical social services provided by a licensed clinical social worker or social services assistant under the guidance of a licensed clinical social worker.
- Services by a home health aide for personal care provided under the supervision of an R.N.
- Nutritional guidance, but limited to individual consultation by an R.N. or qualified dietician.
- Diagnostic Services, non-covered Therapy Services, and similar services which would be covered if You were an Inpatient in a Hospital. These services are also covered when received in Your Provider's office or the outpatient department of a Hospital, but the services must be arranged through the Network home health care agency.
- Ambulance services if prearranged by Your Primary Care Physician and authorized by the Company if, because of Your medical condition, You cannot ride safely in a car when You go to Your Provider's office or to the outpatient department of the Hospital. Ambulance services will be covered if Your condition suddenly becomes worse and You must go to a local Hospital's emergency room.
- Supplies normally used in a Hospital for an Inpatient, but these supplies must be dispensed by the Network home health care agency.
- Drugs of the type You would have received in the Hospital. These drugs must be ordered by Your Provider. They must also be dispensed by the Network home health care agency.

Conditions for Reimbursement

- 1) Home health care services must be provided in Your home or the outpatient department of a Hospital. Unless otherwise noted, they must be Medically Skilled Services. Home health care services must also be:
 - Prescribed by a Provider licensed to do so;
 - Listed in Your Plan of Treatment filed with the Company;
 - Furnished and billed by a home health care agency;
 - Services the Company approves for payment before services are rendered; and
 - Medically Necessary.
- 2) You must be homebound for medical reasons. You must be physically unable to obtain medical care as an Outpatient. You will still be considered homebound for medical reasons if You must go to the outpatient department of the Hospital because the services You need cannot be furnished in Your home.
- 3) You must be under the active care of a Provider to be eligible for home health care services. Your Provider must certify to the Company that You would be in a Hospital as an Inpatient if home health care services were not available.

- 4) Home health care services will be provided after Your discharge from a Hospital as an Inpatient only when:
 - The Company has received and approved Your Plan of Treatment in advance;
 - Your Provider has certified in writing that You would have to remain in the Hospital as an Inpatient if home health care services were not available; and
 - Home health care services begin within 3 days after Your discharge. The Company may waive the 3-day time limit in unusual situations, such as discharge over a weekend. However, waiver is at the Company's sole option.

- 5) If You are not first confined in a Hospital, home health care services will be provided only when:
 - The Company has received and approved Your Plan of Treatment in advance; and
 - Your Provider has certified in writing that You would have to be admitted to a Hospital as an Inpatient if home health care services were not available.

- 6) Services must follow Your Plan of Treatment. Your Plan of Treatment must be included in Your medical record. Your medical record must be reviewed by Your Provider at regular intervals. A copy of Your Plan of Treatment must be filed with the Company before Home health care services can begin. Any changes to Your Plan of Treatment must be approved for payment in advance by the Company.

- 7) Services must be furnished by trained health care workers employed by the Network home health care agency. A Network home health care agency may make arrangements with another health care organization to provide You with a home health care service, but the Company must approve any such arrangement with another health care organization in writing in advance.

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

- 9) Disapproval of a Plan of Treatment, or any part of a Plan of Treatment, or any arrangement with another health care organization means only that the Company has determined in advance the services are not covered under this section. You may still elect to receive any other services disapproved by the Company, but these will be at Your own expense.

- 10) Therapy Services must be rendered by a therapist qualified to do so.

- 11) Your need for personal care must be determined by the R.N. working for the Network home health care agency. The R.N. must assign duties to the home health aide. Personal care may include non-Medically Skilled Services. The words "personal care" mean:
 - Helping You walk;
 - Helping You take a bath;
 - Helping You dress;
 - Giving You medicine; and
 - Teaching You self-help skills.

Special Limits

Visit maximum

90 Visits per Plan Year

Payment will not be made for:

- Services provided by or through a Non-Network home health care agency
- Housing, food, home-delivered meals, or "Meals on Wheels"
- Services not listed in Your attending Provider's Plan of Treatment, except for ambulance services to a Hospital emergency room
- Counselor's services
- Services which are or are related to diversional, recreational, or social activities
- Prosthetic devices, appliances, and orthopedic braces

Reimbursement

After Your Deductible and Coinsurance, the Company pays 100% of the remainder of the Allowable Charge.

Your Payments

Home health services

20% Coinsurance after Deductible*

(*Deductible = \$300 per covered person, per Plan year, not to exceed \$900 per family)

No payment will be made if the service indicated is rendered to a Participant without a Referral.

INDIVIDUAL CASE MANAGEMENT PROGRAM

Services Which Are Eligible for Reimbursement

In addition to the covered services described in this booklet, the State may elect to offer benefits for an approved, alternative treatment plan for a patient who would otherwise require more expensive services, including, but not limited to, long-term Inpatient care. Inpatient care may be authorized in a variety of settings in order to meet a specific need. The State will provide such alternative benefits at its sole option and only when and for so long as the Company decides the alternative services are Medically Necessary and cost-effective.

Conditions for Reimbursement

The Company must approve in advance the alternative treatment plan.

Reimbursement

The Company pays 100% of the Allowable Charge after applicable Deductible, Coinsurance or Copayment.

The total benefits paid for such services may not exceed the amount that would otherwise be paid under the Plan without alternative benefits. If the State elects to provide alternative benefits for a Participant in one instance, it is not required to provide the same or similar benefits for any Participant in any other instance. Also, this cannot be construed as a waiver of the State's right to administer benefits in the future in strict accordance with its express terms.

Your Payments

There is no special Deductible, Coinsurance, or Copayment for this program. The normal Deductible, Coinsurance and Copayment for covered services will apply.

TRIGON DISEASE MANAGEMENT PROGRAM

This medical and lifestyle management program is designed to help Participants better understand and manage the following conditions:

- asthma,
- congestive heart failure,
- coronary artery disease, and
- diabetes.

The program is confidential, voluntary, and there is no cost to participate. The program gives You:

- Toll-free, 24-hour telephone access to a personal nurse consultant who offers support and helps answer questions or concerns You may have about any of the conditions listed above
- Educational materials geared toward Your age, number of years with the condition, and the seriousness of Your condition
- Help in understanding treatment options available to You
- Coordination of the management of Your care with Your doctor to reinforce and promote compliance with Your doctor's Plan of Treatment
- Help in understanding how Your lifestyle choices such as eating habits and activity levels affect Your health

You may register for this program by calling 1-800-551-6923. Your call is completely confidential.

PROFESSIONAL SERVICES

MEDICAL, SURGICAL, AND MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES

This section explains which Medical, Surgical, and Mental Illness and Substance Abuse Services from health professionals may be eligible for reimbursement. In general, the professional services of authorized Providers are eligible for reimbursement if they are Medically Necessary and rendered within the scope of the Provider's license.

Services Which Are Eligible for Reimbursement

1) Inpatient Medical, Surgical, and Mental Illness and Substance Abuse Services. These services are specifically included:

- Reconstructive surgery to restore a body function, correct congenital or developmental deformity which causes functional impairment, or relieve pain
- Operative procedures for sterilization
- Multiple surgeries
- Assistant surgeon's services
- Maternity Services rendered during an Inpatient stay:
 - Routine delivery services (Cesarean birth is a Surgical Service)
 - Services for complications of pregnancy
 - Services for miscarriage or other interruptions of pregnancy
 - Services for the care of a newborn child if the child is a Participant at the time the services are rendered
- Anesthesia Services rendered by a second Physician
- Medical and Mental Illness and Substance Abuse Visits by a Provider, including:
 - Intensive Medical Services (when Your medical condition requires a Provider's constant attendance and treatment for a prolonged period of time)
 - Concurrent care (treatment You receive from a Provider other than the operating surgeon for a medical condition separate from the condition for which You required surgery)
 - Consultative services from a Provider other than the attending Provider
- Mental Illness and Substance Abuse Services, including services for the treatment of alcohol or substance abuse
- Autologous bone marrow transplants (ABMT) or other forms of stem cell rescue (in which the patient is the donor) and associated high dose Chemotherapy (HDC) or radiation which is rendered for the treatment of breast cancer. The following limitations apply:
 - Benefits for ABMT/HDC services for breast cancer which are rendered in Virginia or the District of Columbia will not be covered services unless they are rendered at one of the Hospitals indicated below:
 - University of Virginia Hospital
 - Medical College of Virginia Hospital
 - Georgetown University Hospital
 - Benefits for ABMT/HDC services for breast cancer which are rendered outside the Commonwealth of Virginia or District of Columbia will not be covered services unless they are rendered at a Hospital which participates in the Blue Cross and Blue Shield Association's national transplant network with respect to these services.

- Reconstructive Breast Surgery. Covered services include reconstructive breast surgery performed on or after July 1, 1998, (i) coincident with a mastectomy performed for breast cancer or (ii) following a mastectomy performed on or after July 1, 1998, for breast cancer to reestablish symmetry between the two breasts. However, reconstructive breast surgery does not include augmentation of the unaffected breast to establish symmetry with a reconstructed breast enlarged from the original breast for cosmetic reasons. For purposes of this paragraph, “mastectomy” means the surgical removal of all or part of the breast as a result of breast cancer.
- The following limited oral surgical procedures are covered services when they have been arranged by Your Primary Care Physician and authorized by the Company. The Company provides coverage only for functional repairs. Services of a cosmetic nature or not deemed to be functional by the Company are not covered services.
 - Oral surgery is provided for non-dental surgical and hospitalization procedures for congenital defects such as cleft lip and cleft palate.
 - Medically Necessary medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses resulting from a broken jaw while a Member are provided if the following conditions are met:
 - The need for these services resulted from an accidental injury that occurred while You were enrolled under The Local Choice Health Benefits Program; and
 - Your Plan Provider submits a Plan of Treatment to the Company within 60 days of the date of Your injury and receives the Company’s approval for the Plan of Treatment.
 - Medically Necessary medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses resulting from the excision of tumors and cysts.
 - All other procedures involving the teeth or areas surrounding the teeth are not covered. These excluded procedures include but are not limited to the following:
 - Shortening of the mandible or maxillae for cosmetic purposes
 - Correction of malocclusion
 - Mandibular retrognathia
 - Any treatment related to temporomandibular joint (TMJ) pain dysfunction syndrome
 - Treatment of natural teeth due to diseases or accidental injury in which the jaw is not broken
 - Restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth
 - Extraction of wisdom teeth (whether impacted or not)

2) Outpatient Medical, Surgical, and Mental Illness and Substance Abuse Services, including:

- Surgical Services
- Maternity Services, including Visits to a Provider for routine pre- and postnatal care, and delivery of a newborn at home by a Provider
- Anesthesia Services
- Medical Services to diagnose or treat Your illness or injury
- Diagnostic Services
- Therapy Services
- Therapeutic Injections
- Mental Illness and Substance Abuse Services, including services for the treatment of alcohol and substance abuse
- Preventive health services, including:

- Services performed by Your Primary Care Physician, including periodic health assessments for adults and children, and immunizations in accordance with accepted medical practices
- A vision screening (assessment of visual acuity through use of the Snelling chart and the detection of color blindness) and a hearing screening (assessment of monaural threshold and the ability to locate the source of pure tones through use of a pure tone, air-only audiometer) are services which may be eligible for reimbursement, when performed by Your Primary Care Physician for members up to age 18.
- Wellness services (all ages), including wellness check-up, routine immunizations, preventive screenings, laboratory and x-rays in conjunction with wellness check-up.
- Mammograms; routine and diagnostic
- One annual routine gynecological examination (breast exam, pelvic exam and Pap smear)
- One annual routine prostate specific antigen (PSA) test and digital rectal examination for members age 40 and over in accordance with American Cancer Society guidelines
- Colorectal cancer screenings for members age 40 and over as outlined:
 - one annual fecal occult blood test, and
 - one annual flexible sigmoidoscopy, or colonoscopy, or double contrast barium enema
- Early Intervention Services are covered. Early Intervention Services are available only to a member from birth up to age three, as described in the Definitions section. Benefits for Early Intervention Services will not be applied to any contractual provision limiting the total amount of coverage paid under the Benefits Section to or on behalf of the Participant during the Participant's lifetime.
- A Medical or Surgical Service if performed by a Provider's Employee who is licensed to perform the service
- Employee Assistance Program

Conditions for Reimbursement

- 1) Medical, Surgical, and Mental Illness and Substance Abuse Services must be:
 - Medically Skilled Services;
 - Billed for by a Provider in private practice;
 - Services which the Provider is licensed to render; and
 - Medically Necessary.
- 2) Your PCP must be contacted within 48 hours of treatment for a life-threatening emergency. The contact may be made by You, the admitting Physician, a family member, or a friend.
- 3) When more than one Surgical Service is performed during a single operation, Your Allowable Charge for the combined services will be calculated as follows:
 - The Allowable Charge for the most costly Surgical Service performed; plus
 - 50% of what Your Allowable Charge would have been for each of the next three Surgical Services if these services had been performed alone.

No more than four Surgical Services performed during a single operation are covered, unless the Company determines that extraordinary circumstances exist.
- 4) Assistant surgeon's services are covered if the operating surgeon explains to the Company, upon request, why this Surgical Service requires the skills of two surgeons. When two or

more surgeons provide a Surgical Service which could reasonably have been performed by one surgeon, the Allowable Charge for this Surgical Service will not exceed the Allowable Charge available to one surgeon.

- 5) Inpatient consultative services are covered provided that the services are requested by Your attending Provider. The Provider rendering the consultative services must examine You and must enter a signed consultation note in Your medical record.
- 6) Mammograms are covered provided that:
 - a. The Mammogram is:
 - Ordered by a Network Provider;
 - Performed by a registered technologist;
 - Interpreted by a qualified radiologist;
 - Performed under the direction of a person licensed to practice medicine and surgery, and certified by the American Board of Radiology or an equivalent examining body; and
 - A copy of the Mammogram report is delivered to the Provider who ordered the Mammogram.
 - b. The equipment used to perform the Mammogram meets the standards set forth by the Virginia Department of Health in its radiation protection regulations.
 - c. The mammography film is retained by the radiology facility performing the examination in accordance with the American College of Radiology guidelines or state law.
- 7) All Mental Illness and Substance Abuse Services must be pre-authorized, unless the rules for emergencies apply. Authorization is required within 48 hours of an emergency.
- 8) Physical, Speech and Occupational Therapy Services must be pre-authorized.

Special Limits

- 1) Inpatient professional services in a Skilled Nursing Facility are limited to 180 days per Plan Year.
- 2) Physical, Speech, and Occupational Therapy Services have a lifetime maximum of up to 90 consecutive days per illness or condition.
- 3) Employee Assistance Program is limited to four Visits per incident.
- 4) Chemotherapy by oral means is excluded.

Reimbursement

- 1) After Your Deductible, Coinsurance, or Copayment , the Company pays the remainder of the Allowable Charge.

- 2) Separate benefits will not be provided for routine pre- and post-operative care. The Company takes these services into account when determining its Allowable Charge for a Surgical Service.
- 3) When the same Physician performs both the Surgical or Maternity Service and the Anesthesia Service, the Allowable Charge for the Anesthesia Service will be 50% of what the Allowable Charge would have been if a second Physician had performed the Anesthesia Service.

Your Payments

Inpatient care	20% Coinsurance after Deductible*
Outpatient Physician Visits	\$20 per PCP Visit \$35 per Visit, all other Providers
Physical, Speech and Occupational Therapy (limited to 90 consecutive days per illness or condition)	\$35 per Visit
Maternity Services ¹	\$35 per delivery
Other Outpatient services	20% Coinsurance after Deductible*
Employee Assistance Program	No Deductible, Copayment or Coinsurance

(*Deductible = \$300 per covered person, per Plan Year, not to exceed \$900 per family)

No payment will be made if the service is rendered to a Participant without a Referral except in the following situations:

- A Referral will not be required for Emergency Services in a life-threatening situation. (See description of Emergency Services in Definitions section.)
- A Referral will not be required for Maternity Services
- A Referral will not be required for Outpatient gynecological services (other than Surgical Services) which are rendered by an obstetrician-gynecologist who is a Network Provider

¹ There is only one “per Visit” Copayment if the Provider bills all the mother’s routine pre- and postnatal care in one lump sum.

OTHER HEALTH SERVICES

Services Which Are Eligible for Reimbursement

The following other Medical Services are eligible for reimbursement.

- 1) The rental of Medically Necessary Durable Medical Equipment if authorized by Your Primary Care Physician (or purchase if such purchase would be less than rental cost as determined by the Company) is a Covered Service up to the limits specified in the Schedule of Benefits. Benefits will be provided for the least expensive item of equipment required by Your medical condition. Durable Medical Equipment must be obtained from the designated Network Provider for this health service. Durable Medical Equipment is listed below:

- Hospital beds
- Bedside commode, shower chair, and tub rails
- Canes, crutches, walkers, slings, splints, cervical collars, and traction apparatus
- Wheelchairs
- Oxygen and oxygen equipment
- Ostomy supplies, including bags, flanges, and belts¹
- Indwelling catheters and catheter bags¹
- Respirators
- Jobst stockings or equivalent when prescribed by a vascular surgeon following vascular surgery
- The first pair of contact lenses or eyeglasses following approved cataract surgery without implant
- Artificial arms and legs, including accessories

Equipment lost or damaged due to Your neglect or abuse will not be repaired or replaced. Ordinary and necessary repairs from normal use will be covered.

- 2) Medically Necessary ambulance services will be covered services if such services are pre-arranged by Your Primary Care Physician and authorized by the Company. In an emergency, Your Primary Care Physician's order is not required. Air ambulance services are also covered when pre-authorized or in cases of threatened loss of life. In cases of threatened loss of life, only such air ambulance services required to take such Member to the closest Hospital with the capability of treating that Member's condition will be covered.
- 3) Intrauterine devices (IUD)
- 4) Inpatient services (as well as Outpatient services rendered in anticipation of Inpatient services) which are rendered to the donor in connection with human organ or tissue transplants when the transplant recipient is a Participant. Also, covered services for the identification of a suitable donor to a Participant for an allogeneic bone marrow transplant will include a computer search of established bone marrow registries and laboratory testing necessary to establish compatibility of potential donors who are from the patient's immediate family or who have been identified through the computer search.
- 5) Diabetes education. Member must be enrolled in the Trigon Disease Management Program and the education services must be authorized through this program.

¹ Supplies to be purchased in quantities or units equivalent to a 30-day supply.

Conditions for Reimbursement

- 1) For Durable Medical Equipment, Your Provider must, upon request, explain why the equipment is needed and how long it will be used.
- 2) Ambulance services (which must be pre-authorized) are eligible for reimbursement when used locally to or from a covered facility or Provider's office.

Special Limits

- 1) The services discussed in this section are not eligible for reimbursement if the same service is available under some other section. The Company will pay only once for a service and will not increase or extend benefits available under other sections.
- 2) Rental and purchase of Durable Medical Equipment only from a Network Provider is covered, and that is limited to a total of \$1,000 per Plan Year.
- 3) The following and similar items are not eligible for reimbursement as Durable Medical Equipment:
 - Exercise equipment
 - Air conditioners
 - Dehumidifiers and humidifiers
 - Whirlpool baths
 - Handrails
 - Ramps
 - Elevators
 - Telephones
 - Adjustments made to a vehicle
 - Leg braces, including attached shoes
 - Arm braces
 - Back braces and neck braces
 - Surgical supporters
 - Head halters
- 4) Corrective shoes and shoe inserts are not eligible for reimbursement.
- 5) Furthermore, the Company will not pay for any other equipment which has both a non-therapeutic and therapeutic use. The Company will pay for the least expensive item of equipment required by Your medical condition. If the Company determines that purchase of the Durable Medical Equipment is less expensive than rental, or if the equipment cannot be rented, the Company may approve the purchase as a covered service.
- 6) Benefits for human organ or tissue transplant 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, 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.

Covered services for the identification of a suitable donor to a Participant for an allogeneic bone marrow transplant must be ordered by a Physician qualified to provide allogeneic transplants. The maximum lifetime benefits will be \$25,000 per Participant.

Reimbursement

After Your Deductible and Coinsurance, the Company pays the remainder of the Allowable Charge.

Your Payments

After Your Deductible*, You pay 20% Coinsurance to Network Providers.

(*Deductible = \$300 per covered person, per Plan Year, not to exceed \$900 per family)

No payment will be made if the service is otherwise covered but rendered to a Participant without a Referral. There is one exception:

- A Referral will not be required for Emergency Services in a life-threatening situation. (See description of Emergency Services in Definitions section.)

HOSPICE CARE SERVICES

Services Which Are Eligible for Reimbursement

- Hospice care services include a program of home and Inpatient care provided directly by or under the direction of a licensed hospice.
- Hospice care programs include palliative and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team.

Conditions for Reimbursement

Hospice care services must be:

- Prescribed by a Provider licensed to do so;
- Furnished and billed by a licensed hospice; and
- Medically Necessary.

Special Limits

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

Reimbursement

After Your Copayment, the Company pays 100% of the Allowable Charge.

No payment will be made if the service indicated is rendered to a Participant without a Referral.

Your Payments

Hospice care services	\$20 per PCP Visit \$35 per Visit, all other Providers
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OUTPATIENT PRESCRIPTION DRUGS (Mandatory Generic Program)

Services Which Are Eligible for Reimbursement

Outpatient prescription drugs plus insulin, insulin syringes, and lancets are eligible for reimbursement. Contraceptive drugs and devices eligible for reimbursement include oral contraceptives, Depo Provera, cervical caps, diaphragms, Norplant, and Lunelle.

Conditions for Reimbursement

The drugs must:

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

Special Limits

- 1) A 34-day supply will be eligible for reimbursement from a retail pharmacy.
- 2) A 35- to 90-day supply is eligible for reimbursement from a retail pharmacy.
- 3) A supply of up to 90 days may be obtained from the home delivery pharmacy.
- 4) Only in documented cases of extended foreign travel will a supply of more than 90 days be prior authorized.
- 5) Replacement drugs for supplies lost, stolen, etc. are not eligible for reimbursement.
- 6) Benefits for any refill of a prescription drug will not be provided until the amount of time has elapsed from the previous dispensing of the prescription drug which would result in at least 75% of the drug being used if taken consistently with the prescribing Provider's directions.
- 7) Prior authorization is required for certain medications. You will be notified in writing when a prescription is denied for coverage. Your physician will be notified of both approval and denial decisions. A list of drugs requiring prior authorization is available at <http://state.trigon.com>.
- 8) In addition to the Exclusions listed in the Exclusions section, no coverage will be provided under this section 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 the intended use. Examples are:
 - Hypodermic needles;
 - Syringes (other than for insulin); and
 - Support garments.
 - e. Prescription drugs prescribed for weight loss or as stop-smoking aids; except for weight loss drugs prescribed in conjunction with the treatment of Morbid Obesity when the patient meets the definition of Morbid Obesity.
 - f. Prescription drugs prescribed primarily for a cosmetic purpose;
 - g. Prescription drugs prescribed for infertility
 - h. Blood derivatives; and
 - i. Growth hormones

Reimbursement

- 1) After the Copayment, the Company pays 100% of the Allowable Charge. The Company will determine whether a particular generic prescription drug is equivalent to a brand name prescription drug. If You or Your Provider determine to fill the prescription with a brand name drug when a generic equivalent is available, You will be responsible not only for the Copayment, but also the difference between the Allowable Charge for the brand name drug and the Allowable Charge of its generic equivalent.
- 2) If the dispensing pharmacy is a Network pharmacy, the Company will direct benefit payment to that pharmacy. If the dispensing pharmacy is a Non-Network pharmacy, the Company will direct payment to the Enrollee.
 - A Network pharmacy is a pharmacy listed as a Network pharmacy by the Company at the time the prescription drug is dispensed.
 - A Non-Network pharmacy is any other pharmacy. You may be required by a Non-Network pharmacy to pay not only the Copayment, but also the difference between the pharmacy's charge for the prescription drug and the Allowable Charge for the prescription drug.
- 3) The benefits provided for services under this section will not be paid as a covered service under any other section of this booklet.
- 4) The Company may receive, directly or indirectly, financial credits from drug manufacturers whose products are included on formulary lists. Credits are received based on the utilization of the manufacturer's products by persons enrolled under contracts insured by or administered by the Company. Credits received by virtue of the benefits provided under this section 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.

Your Payments

This is a three-tier mandatory drug program. Tier 1 is typically generic drugs. Tier 2 is lower cost brand name drugs and some generic drugs. Tier 3 is typically higher cost brand name drugs.

Network Retail Pharmacies up to a 34-day supply	Tier 1: \$15
<i>(You may purchase a 35-68 day supply for two times</i>	Tier 2: \$20
<i>the appropriate tier Copayment, and a 69-90 day supply</i>	Tier 3: \$35
<i>for three times the appropriate tier Copayment.)</i>	

Home Delivery (Mail Order) up to a 90-day supply	Tier 1: \$18
	Tier 2: \$33
	Tier 3: \$63

To determine in which tier Your Prescription drug falls, go to <http://state.trigon.com> and click on Three-Tier Drug Listing.

(If the cost of the drug is less than the Copayment, You pay only the cost of the drug.)

How To Obtain Your Prescriptions

Network Retail Pharmacy

Your outpatient prescription drug program is a mandatory generic program which uses the Medco Health pharmacy network. Present your identification card at the pharmacy and pay the applicable Copayment. If a generic equivalent exists for a brand name drug, you may do one of the following at a Medco Health pharmacy:

- Request the generic and pay only the applicable Copayment, or
- Request the brand name drug and pay the applicable Copayment plus the difference between the generic and brand name drug Allowable Charge.

If you go to a non-network pharmacy, you pay the total price for the drug and then file a Prescription Drug Program Direct Reimbursement Claim Form for reimbursement. The form is available on the Web at <http://state.trigon.com> under Forms, or from Trigon Member Services at (804) 355-8506 in Richmond, or 1-800-552-2682 outside Richmond, or from your Benefits Administrator. Reimbursement is limited to the Allowable Charge for the generic drug minus your Copayment.

Home Delivery Pharmacy Service

This is a convenient, cost-effective way to obtain up to a 90-day supply of medications you take routinely (such as medications for high blood pressure or high cholesterol). Your medications are delivered directly to your home. To use this service, complete the Medco Health Home Delivery Pharmacy Service Order Form. If you are ordering for the first time, also complete the Health, Allergy and Medication Questionnaire. These forms are available on the Web at <http://state.trigon.com> under Forms or from your Benefits Administrator.

Follow the ordering and payment instructions shown on the order form. Prescriptions are typically processed within 48 hours and will be sent to you via first class mail or UPS.

DENTAL BENEFITS

DENTAL SERVICES

Services Which Are Eligible for Reimbursement

- 1) The following diagnostic and preventive dental services are eligible for reimbursement.
 - a. Oral examinations
 - b. Dental x-rays, but not x-rays for orthodontic purposes (cephalometric film)
 - c. Direct fluoride application to natural teeth
 - d. Prophylaxis (includes minor 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
 - l. Occlusal night guards for demonstrated tooth wear due to bruxism

- 2) The following primary services are also eligible for reimbursement.
 - a. Maintenance services which are defined here to mean:
 - i. Fillings made up of amalgam or tooth color synthetics
 - ii. Root canal therapy
 - iii. Repair of broken removable dentures
 - iv. Recementing of existing crowns, inlays, and bridges
 - v. Dentist's Visits to Your home when Medically Necessary to render dental services which are eligible for reimbursement and, in fact, reimbursed
 - vi. Stainless steel crowns
 - vii. Sedative fillings

 - b. Oral surgical procedures listed in the most recent edition of the *Code of Dental Procedures and Nomenclature of the American Dental Association* are covered except that any and all procedures performed for orthodontic purposes are not eligible for reimbursement. Covered oral surgical procedures consist of:
 - i. Simple extractions
 - ii. Surgical removal of teeth
 - iii. Excision, drainage, or removal of cysts, tumors, and abscesses in the mouth
 - iv. Apicoectomies
 - v. Hemisections or root amputations
 - vi. Treatment of fractures of the jaw
 - vii. Alveoloplasties to prepare the gum ridge for dentures
 - viii. Frenectomies

- c. Periodontic services which consist of:
 - i. Gingivectomy and gingivoplasty
 - ii. Scaling and root planing
 - iii. Osseous surgery and grafts, including flap entry and closure
 - iv. Surgical periodontic examinations
 - v. Mucogingivoplastic surgery
 - vi. Management of acute periodontal infection and oral lesions
 - vii. Soft tissue grafts
 - viii. Guided tissue regeneration
 - ix. Supportive periodontal therapy
 - x. Crown lengthening

- d. General anesthesia services

3) The following prosthetic and complex restorative services are also eligible for reimbursement.

- a. Complex Restorative Services, which consist of:

- i. Inlays (not part of bridge)
- ii. Onlays (not part of bridge)
- iii. Crown (not part of bridge)
- iv. Labial veneers involving the incisal edge of anterior teeth, porcelain laminate (laboratory)

- b. Dentures (full and partial), fixed bridges, and implant connecting bars
- c. Denture adjustments and relining
- d. Fixed bridge repairs
- e. Dental implant devices and their surgical placement
- f. Post/core build-up for crowns
- g. Crown repair

4) The following orthodontic services are also eligible for reimbursement:

- a. Orthodontic services to correct a handicapping malocclusion (defined as a severe deviation from the normal range of positioning of teeth) subject to the following:
 - i. The malocclusion must be abnormal and correctable
 - ii. No benefits will be provided for replacement or repair of any appliance used during the course of treatment
- b. Tooth guidance and harmful habit appliances
- c. Interceptive treatment
- d. Surgical exposure of unerupted teeth when performed for orthodontic purposes
- e. Orthodontic evaluations when no treatment is initiated

Conditions for Reimbursement

Dental services must be:

- Billed for by a Provider in private practice;
- Services which the Provider is licensed to render; and
- Necessary for the restoration of function or maintenance of dental health.

The Company must pre-authorize permanent crowns for Participants under age 16.

Special Limits

- 1) Benefits are limited to \$1,200 per Plan Year for all services excluding orthodontics. Benefits for orthodontics are separately limited to \$1,200 per lifetime. If you transfer to another self-insured plan under The Local Choice Health Benefits Program during the Plan Year, the combined benefit limit is \$1,200.
- 2) Benefits for orthodontics are not available during the first 12 months of Your coverage under this Plan unless:
 - a. You had orthodontic coverage under Your previous coverage, and
 - b. That coverage ended the day before this coverage became effective.

If You had orthodontic coverage, the number of months You had that coverage will count toward the 12-month waiting period, and the benefits paid will count against the \$1,200 lifetime limit.

- 3) Replacement of prosthetic appliances, dentures, crowns, cast or preformed post/core to support crowns, implants, inlays and bridges are limited to once every 5 years.
- 4) Diagnostic and preventive services are limited to two (2) each of the following per Plan Year:
 - Oral exams
 - Bitewing x-rays
 - Prophylaxis
 - Topical fluoride applications
 - Pulp vitality tests

In addition, one full mouth x-ray or panorex is covered every 36 months.

- 5) Benefits for fluoride applications and sealants are available only to Participants under age 19.
- 6) 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.
- 7) 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.
- 8) 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.

Special Exclusions

The following dental services are not covered:

- 1) Services rendered by a dental or medical clinic maintained by Your employer, a mutual benefit association, labor union, trustee, or like person or group
- 2) Services related to genetic malformation
- 3) Services rendered to an Inpatient in a facility by a Dentist paid by that facility to perform such services
- 4) Gold foil restorations
- 5) Instruction in personal dental hygiene and care, including plaque control
- 6) Services 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

Reimbursement

The Company pays the remaining Allowable Charge after Your Coinsurance.

Coinsurance

Diagnostic and preventive services	None
Primary services	20% of Allowable Charge
Prosthetic, complex restorative, and orthodontic services	50% of Allowable Charge

EXCLUSIONS

This is a list of services which are not, under any circumstances, eligible for reimbursement. Although these excluded services are not mentioned as limits in previous sections of this booklet, they in fact are limits on the services described earlier. Unless another type of service is specified, the word "services" means both services and supplies.

- 1) Services not listed or described in this handbook as eligible for reimbursement.
- 2) Services of Non-Network Providers and Non-Network Hospitals, except for Emergencies or when authorized, in writing, in advance by the Company. Services received that are not prearranged by Your Primary Care Physician and authorized in advance by the Company.
- 3) Services for rest cures, convalescent care, residential care, custodial care, care in a group home, halfway house, or residential setting.
- 4) Services for injuries or diseases related in any way to Your employment, when:
 - You receive payment from the employer on account of the disease or injury;
 - The employer is required by federal, state, or local laws or regulations to provide benefits to You; or,
 - You could have received benefits for the injury or disease if You had complied with applicable laws and regulations.

This Exclusion applies whether or not You have waived Your rights to payment for the services available or have failed to comply with procedures set out by the employer to receive these benefits. It also applies if the employer (or the employer's insurance Company or group self-insurance association) reaches any settlement with You for an injury or disease related in any way to Your employment.

- 5) Routine vision and hearing care, except as provided herein for children up to age 18. Services for radial keratotomy (RK), a surgical procedure to correct myopia.
- 6) Services for, or related to, Cosmetic Surgery including complications thereof. Cosmetic Surgery is a Surgical Service performed mainly to improve a person's appearance. However, Cosmetic Surgery does not include Surgical Services to correct deformity resulting from disease, trauma, congenital abnormalities that cause functional impairment, or a previous therapeutic process. To determine if a Surgical Service is cosmetic or not, the Company will not take into account the patient's mental state.
- 7) Corrective appliances, artificial aids, devices or equipment not specified herein.
- 8) Whole blood or blood products and the cost of securing the services of blood donors. Charges associated with donating and storing Your own blood.
- 9) Growth hormones and methadone maintenance at any level of care.
- 10) Supplies and devices which are for comfort or convenience only (such as radio, television, telephone, and guest meals); private rooms, unless a private room is Medically Necessary and approved by the Company during Inpatient hospitalization.
- 11) Private duty nursing, and services for rest cures, custodial, domiciliary, residential, or convalescent care.
- 12) Examinations required specifically for insurance, employment, school, sports, or camp, and immunizations required for travel and work. Court ordered examinations or care.
- 13) Reversal of voluntarily induced sterility and complications incidental to such procedures. Procedures, services, and supplies related to sex transformations. Penile implants and related services. Services for the diagnosis and treatment of infertility. Services for artificial insemination, in vitro fertilization, or any other type of artificial or surgical means of conception.

- 14)** Except as provided by federal law, the cost of care for conditions that federal, state, or local law require be treated in a public facility or services or supplies provided or arranged by a governmental facility for which no charge would be made if You had no health benefits insurance.
- Care for military service-connected disabilities and conditions for which You are legally entitled to health services and for which facilities are reasonably accessible to You.
 - The cost of health services covered under the Medicare or Medicaid programs.
- 15)** Routine foot care, such as the removal of corns or calluses and the trimming of nails.
- 16)** Spinal manipulation, acupuncture therapy, and related services.
- 17)** Services for sleep disorders, biofeedback therapy, smoking or nicotine addiction, weight control and related services, remedial or special education services.
- 18)** Education or teacher's service.
- 19)** Services for Occupational Therapy or rehabilitative therapy if the primary purpose is to train the patient for a new job.
- 20)** Physical Therapy Services to maintain motor functions, except when the Company determines there is a reasonable chance that the patient's motor functions will improve as a result of the therapy.
- 21)** Services for the treatment of temporomandibular joint dysfunction, except as shown under the Dental Benefits section of this booklet.
- 22)** Any service determined to be Experimental/Investigative by the Company, in its sole discretion, except for services associated with Clinical Trial Costs. Also excluded are services to treat routine complications of any Experimental/Investigative service, and services related to the Experimental/Investigative service.

23) Organ transplants and tissue transplants are not covered, except for the following:

- Kidney transplants
- Liver transplants
- Bone-marrow transplants (except as provided in Exclusions 24 and 25)
- Corneal transplants

All other organ or tissue transplants are not covered. These include but are not limited to the following:

- Heart transplants (including artificial heart transplants)
- Heart-lung transplants
- Single lung transplants
- Double lung transplants
- Islet Cell transplants
- Pancreas transplants
- Intestinal transplants
- Adrenal to brain transplants

Charges related to the removal of a living organ from a donor will be covered. See the General Rules Governing Benefits section, item 11, page 6.

- 24)** High dose Chemotherapy and/or high dose radiation, any resulting medical complications, and any supporting allogeneic or syngeneic bone marrow transplants or other forms of allogeneic or syngeneic stem cell rescue (those with a donor other than the patient) are not covered. The term "high dose," when used to describe Chemotherapy or radiation, means a dose so high as to predictably require stem cell rescue. This exclusion will not apply to these services when they are used to treat the following:
- Aplastic anemia;
 - Acute leukemia;
 - Lymphoma with bone marrow involvement;
 - Severe combined immunodeficiency;
 - Wiskott-Aldrich syndrome;
 - Infantile malignant osteopetrosis;
 - Chronic myelogenous leukemia;

- Stage III or IV neuroblastoma in children over 1 year of age;
- Thalassemia Major;
- Lysosomal Storage Disorders;
- Myelodysplastic Syndrome;
- Homozygous Sickle Cell Anemia in children or young adults with history or prior stroke and who have an HLA-identical, related donor; and
- Homozygous Sickle Cell Anemia in children or young adults with severe symptoms that increase the risk of stroke or end-organ damage (e.g., recurrent chest syndrome, recurrent vaso-occlusive crises; red blood cell alloimmunization on chronic transfusion therapy) and who have an HLA-identical, related donor.

The following are examples of cases for which this exclusion applies:

- Polycythemia Vera;
- Lymphoma without bone marrow involvement;
- Multiple myeloma; and
- Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus infection.

25) High dose Chemotherapy and/or high dose radiation, any resulting medical complications, and any supporting autologous bone marrow transplants or other forms of autologous stem cell rescue (those in which the patient is the donor) are not covered. The term “high dose,” when used to describe Chemotherapy or radiation, means a dose so high as to predictably require stem cell rescue. This exclusion will not apply to these services when they are used to treat the following:

- Hodgkin’s disease which has come back after an initial complete remission or is in first remission with poor prognostic factors, with no bone marrow involvement;
- Non-Hodgkin’s lymphoma which has come back after an initial complete remission or is in first remission with poor prognostic factors, with no bone marrow involvement;
- Advanced neuroblastoma or other primitive neuroectodermal tumor without bone marrow involvement;
- Multiple myeloma;
- Acute lymphocytic or non-lymphocytic leukemia which has come back after an initial complete remission or is in first remission with poor prognostic factors;
- Germ cell tumors with no prospect for complete remission with standard dose therapy.

The following are examples of cases for which this exclusion applies:

- Acute leukemia in first remission if poor prognostic factors are absent;
- Hodgkin’s or non-Hodgkin’s lymphoma in first remission if poor prognostic factors are absent;
- Intrinsic brain tumors other than primitive neuroectodermal tumors;
- Breast cancer (except to the extent covered under the ABMT and High Dose Chemotherapy for breast cancer services described in the Professional Services section, item 1, page 22);
- Ovarian cancer other than germ cell tumors;
- Lung cancer;
- Testicular cancer other than germ cell tumors;
- Colon cancer;
- Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus infection;
- Melanoma;
- Genitourinary system tumors;
- Soft tissue sarcomas;
- Thyroid tumors; and
- Thymus tumors.

- 26)** Any service determined to be not Medically Necessary by the Company, in its sole discretion for the treatment of an illness, injury or pregnancy related condition. Effective October 1, 2002 and thereafter Your coverage does not include benefits for services or supplies if they are deemed not Medically Necessary as determined by Trigon in its sole discretion. However, if you receive inpatient or outpatient services that are denied as not Medically Necessary, or are denied for failure to obtain the required pre-authorization or primary care physician referral, the following professional provider services that you receive during Your inpatient stay or as part of your outpatient services will not be denied under this exclusion in spite of the Medical Necessity denial of the overall services:
- For Inpatients** – 1) Services that are rendered by professional providers who do not control whether You are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians. 2) Services rendered by your attending Provider other than inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine Visits by your attending Provider for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management Visits do not include surgical, diagnostic, or therapeutic services performed by your attending Provider.
- For Outpatients** - Services of pathologists, radiologists and anesthesiologists.
- 27)** Services for abortions, except in the following cases, and if and only if not otherwise contrary to law:
- When Medically Necessary to save the life of the mother;
 - When the pregnancy occurs as a result of rape or incest which has been reported to a law enforcement or public health agency; and
 - When the fetus is believed to have an incapacitating physical deformity or an incapacitating mental deficiency, which is certified by a Physician.
- 28)** Services provided by a member of Your immediate family and services rendered by a Provider or a Provider's employee to another Provider in the same practice.
- 29)** Providers' charges for missed appointments, telephone calls, form completion, copying and/or transfer of medical records, returned checks, stop-payment on checks, and other such clerical charges.

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, but not limited to, benefits, eligibility for benefits, Provider Networks, premiums, Copayments and contributions required of employees. The Department is also authorized and empowered to exercise discretion in interpreting the terms of 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, the State, nor The Local Choice Group guarantees admission or the availability of any specific type of room or kind of service. Neither the Company, the State, nor The Local Choice Group will be responsible for acts or omissions of any facility. Neither the Company, the State, nor The Local Choice Group will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a facility. Neither the Company, the State, nor The Local Choice Group 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, the State, nor The Local Choice Group guarantees the availability of a Provider's services. Neither the Company, the State, nor The Local Choice Group will be responsible for acts or omissions of any Provider. Neither the Company, the State, nor The Local Choice Group will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a Provider. Neither the Company, the State, nor The Local Choice Group 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 Local Choice Health Benefits Program, 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 Local Choice Health Benefits Program, 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, to appeal the denial or payment of a claim.

8) Benefits Administrator and Other Plan Information

Your Benefits Administrator is the person appointed by Your employer to assist You with Your health care benefits. Your Benefits Administrator may also provide You information about Your benefits. If there is a conflict between what Your Benefits Administrator tells You and 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, employee communication, 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 Local Choice Health Benefits Program for a period of up to 36 months at the Participant's own expense. The length of time depends on the Qualifying Event.

There is no The Local Choice Group contribution toward Extended Coverage. A fee of 2% is added to the total monthly premium for health benefits (except when there is a fee of 50% added for the last 11 months of the 29-month continuation period of Extended Coverage for a disabled individual). 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 employee 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 Local Choice Health Benefits Program.

Also, covered employees who go on active military duty, or their covered dependents, may enroll in Extended Coverage until the employee returns from active duty or 18 months, whichever occurs first. In addition, an employee or their covered dependents who would ordinarily lose coverage due to any of the following Qualifying Events may elect to extend coverage under the program for a period of up to 18 months at the employee's own expense.

- Voluntary or involuntary (except for gross misconduct) termination. A Qualifying Event occurs when the employee terminates while under coverage on leave without pay.
- Notification that You are not returning from a Family Medical Leave Act absence, or failing to return from a Family Medical leave of absence period once You have used up Your leave entitlement.

- Reduction in work hours to less than full time. Also, reduction of hours by reason of leave without pay is a Qualifying Event.

Special rule for disabled individuals: A Qualified Beneficiary who is disabled, as defined by the Social Security Administration (SSA) within the first 60 days of Extended Coverage, may elect Extended Coverage for up to 29 months. The non-disabled Qualified Beneficiary family members are entitled to the extension if the Qualified Beneficiary has effected the extension based on disability. After the initial 18 months, the fee added to the monthly premium increases from 2% of total premium to 50%.

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.
- Entitlement to Medicare if entitlement occurs after the date of the Extended Coverage election. Dependents may be entitled to continue coverage for at least 36 months from the date of the Qualifying Event.
- Expiration of the 18-, 29- or 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 You or Your dependents of Your continuation of coverage rights in the case of termination of employment, reduction of hours, or death. You or Your dependents must respond within 60 days of The Local Choice Group'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 employee are responsible for notifying their 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, except in the case of disabled individuals, as addressed above. By Extended Coverage rules, the affected person has 45 days from the date of the election to make payment. If eligibility for Extended Coverage ends because of the expiration of the 18-, 29- or 36-month term, the affected person may convert to a non-group coverage, just like any other member of The Local Choice Health Benefits Program, by applying for coverage within 31 days of the loss of Extended Coverage.

Non-Group Coverage

If Your group coverage terminates under this Plan, You may apply for an individual medical policy available from the Company. You must make application within 31 days following the termination of the group coverage. You will not be required to show proof of insurability.

Typically, this coverage is not as comprehensive and is usually more expensive. You may also have some additional options to consider.

It is possible to convert to non-group coverage once Extended Coverage is no longer available. You must contact the health benefits plans to enroll in non-group coverage. Application to the plan for conversion to non-group coverage should be made within 31 days of losing coverage. Furthermore, if You have at least 18 months of creditable service as defined by HIPAA, You may have certain additional rights which may be exercised when securing individual coverage. You should be advised that insurers that offer individual health plans in the Commonwealth must recognize creditable coverage so long as the employee has at least 18 months of creditable coverage and received their most recent health coverage under an employer-related plan.

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

Creditable Coverage

The concept of creditable coverage is that individuals should be given credit for previous health coverage when moving from one employer group health plan to another, from an employer group health plan to an individual policy, or from certain kinds of individual coverage to an employer health plan. If the individual moves to a policy or plan that limits or excludes coverage of pre-existing conditions for a period of time, the new plan's limitation period must be reduced by this credit for prior coverage.

In order to take advantage of creditable coverage, you must enroll in the new group or individual plan within 62 days of losing coverage.

Certificate of Creditable Coverage

The certificate of creditable coverage is intended to establish an individual's prior creditable coverage so that any pre-existing condition limitations period under the individual's new group health plan can be reduced appropriately. The certificate of creditable coverage is a written document which reflects certain details about an individual's creditable health benefits coverage. See Attachment A for an example of a certificate of creditable coverage.

The Local Choice Group must furnish a Certificate of Creditable Coverage:

- When coverage is lost;
- When Extended Coverage ends; or
- Upon request within 24 months of either of the above events.

You will find a form in the back of this booklet that outlines Your rights and can be used to request a certificate of coverage (see Attachment B). This request should be sent to the Benefits Administrator of The Local Choice Group for which You worked.

Important Notice of Your Right to Documentation of Health Coverage

Recent changes in Federal law may affect Your health coverage if You are enrolled or become eligible to enroll in health coverage other than coverage under The Local Choice Health Benefits Program that excludes coverage for pre-existing medical conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before You enroll. Under the law, pre-existing condition Exclusions generally may not be imposed for more than 12 months (18 months for a late Enrollee). The 12-month (or 18-month) exclusion

period is reduced by the length of Your enrollment in Your prior health plan. You are entitled to a certificate that will show evidence of Your prior health coverage. If You purchase health benefits other than through an employer group health plan, a certificate of prior coverage may help You obtain coverage without a pre-existing condition exclusion.

Check with Your new employer's group health plan to see if Your new plan excludes coverage for pre-existing conditions and if You need to provide a certificate or other documentation of Your previous coverage.

To obtain a certificate, complete Attachment B and return it to the Benefits Administrator at Your former employer.

The certificate must be provided to You promptly. Keep a copy of this completed form. You may also request certificates for any of Your dependents (including Your spouse) who were enrolled under Your health coverage.

11) 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.

12) Time Limits on Legal Actions and Limitation on Damages

No action at law or suit in equity may be brought against the Company, the State, or The Local Choice Group 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, the State, or The Local Choice Group 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, The Local Choice Group, or any director, officer, or employee of the Company, the State, or The Local Choice Group 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.

13) 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.

14) Misrepresentation

A Participant's coverage can be canceled by the Company, the State, or The Local Choice Group 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, the State, or The Local Choice Group may also cancel coverage for any other family members enrolled with the Participant. When false or misleading information is discovered, the Company, the State, or The Local Choice Group may cancel coverage retroactive to the date of misrepresentation.

15) 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, or The Local Choice Group may instruct the Company to cancel Your coverage.

16) 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 paragraph **9)** of this section. Coverage for the dependent will end on the last day of the month in which the Enrollee's death occurs. The Local Choice Group will notify the Company so that conversion privileges may be extended to the dependent.

17) 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.

18) 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 Local Choice 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 Local Choice Health Benefits Program.

19) 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 Local Choice Group will notify the Company. Only when the Company receives proper notice from The Local Choice Group can continuous coverage under this Plan or a non-group conversion policy be offered.

20) Conversion Privileges

When the Company is properly notified by The Local Choice Group 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.

DEFINITIONS

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

1) Allowable Charge

This term is defined in several 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 Network Hospital, Network home health care agency, or Network 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 Network Hospital, Network home health care agency, or Network 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-Network 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-Network 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.

2) Anesthesia Services

These are services to induce partial or complete loss of sensation before a Surgical Service or Maternity Service is performed.

3) 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.

4) Coinsurance

This means the percentage of the Allowable Charge which You must pay for a covered service. Some services are listed as paid at less than 100%. Your Coinsurance for a service which is listed as paid at less than 100% of the Allowable Charge is the difference between 100% of the Allowable Charge and the percentage listed. In some cases, You will be required to pay amounts in excess of 100% of the Allowable Charge. These amounts are not part of your Coinsurance. The following example will explain. Your Plan pays 80% of the Allowable Charge for some services. Facilities and health care professionals that do not participate in the Network or contract with the Company may bill You for more than 100% of the Allowable Charge. Your Coinsurance does not include the amounts these facilities or professionals may charge in excess of 100% of the Allowable Charge.

5) Company

This word means the third party administrator under contract with the Department of Human Resource Management to develop and administer provider networks, process claims, provide customer service, and such other functions as are necessary to make health benefits available to employees. For Medical, Surgical, Outpatient prescription drug, and dental services, the Company is Trigon Blue Cross Blue Shield. For Mental Illness and Substance Abuse Services, the Company is Magellan Behavioral Health.

6) Copayment

This is a specified dollar amount for a specific service which You must incur and pay before benefits will be provided for any additional amount for the service.

7) Cosmetic Surgery

Cosmetic Surgery is a Surgical Service performed mainly to improve a person's appearance. However, Cosmetic Surgery does not include Surgical Services to correct deformity resulting from disease, trauma, congenital abnormalities which cause functional impairment, or a previous therapeutic process. To determine if a Surgical Service is cosmetic or not, the Company will not take into account the patient's mental state.

8) Custodial/Residential Care

a. Custodial Care is care provided mainly for maintenance of the patient. It also means care which is designed to assist the patient in meeting activities of daily living. Custodial Care is care not primarily provided for its therapeutic value in the treatment of an illness or injury. Custodial Care includes but is not limited to:

- i. Helping to walk, bathe, dress or eat;
- ii. Preparing special diets; and
- iii. Supervising when the patient takes medicine and it does not require the help of trained medical personnel.

b. Care is "residential" when received in a facility or a part of one where:

- i. The average length of stay is 30 days or more, and
- ii. The patient routinely receives less than an average of 2 Visits per week by or with a Provider for the treatment or diagnosis of the condition for which the patient was hospitalized.

c. The determination of whether a service is custodial care will be made by the Company in its sole discretion.

9) Day of Inpatient Care

This term means one day of care for which You are covered as an Inpatient. The number of Days of Inpatient Care of Your Hospital admission is counted as follows:

- The day You are admitted is a Day of Inpatient Care
- Each day up to the day of discharge is a Day of Inpatient Care
- The day You are discharged is not a Day of Inpatient Care.

You must be discharged by the established discharge hour. If You stay beyond the established discharge hour, the benefits will be provided for these additional Inpatient services only if Your longer stay was Medically Necessary and authorized by the Company.

10) Deductible

This means a specified dollar amount in a Plan Year that You must incur before certain benefits will be provided. The Deductible applies to both Medical and Mental Illness and Substance Abuse Services.

11) Department

The Department denotes the Department of Human Resource Management (DHRM) and is the Commonwealth of Virginia's central source for information regarding its employee work force and employment opportunities.

12) Diagnostic Services

a. This phrase means medically accepted tests or procedures used to identify a specific illness, injury, or pregnancy-related condition. The following Diagnostic Services are covered to the extent specified in this booklet:

- i. Diagnostic x-rays, ultrasound, and nuclear medicine;
- ii. Laboratory and pathology services; and
- iii. EKGs, EEGs, and other electronic diagnostic tests.

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

13) Durable Medical Equipment

This term means those covered services which are listed in the Other Health Services section.

14) Early Intervention Services

This phrase means Medically Necessary Speech and language therapy, Occupational Therapy, Physical Therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically Necessary Early Intervention Services for the population certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services means those services designed to help an individual attain or retain the capability to function age-appropriately within the individual's environment, and will include services which enhance functional ability without effecting a cure.

15) Effective Date

This is the date Your coverage begins under the Plan.

16) Emergency Services

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

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

17) Employee Assistance Program

The Employee Assistance Program is a confidential assessment, Referral, and short-term problem-solving service available to all Participants.

18) Enrollee

This word means the person who applies for coverage in the employee health benefits program and in whose name Your coverage is obtained.

19) Exclusions

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

20) 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.

21) Health Benefit Plan

A Plan or program offering benefits for any type of health care service is considered a Health Benefit Plan when it is group or blanket insurance or a Blue Cross, Blue Shield, group practice, individual practice, or any other pre-payment arrangement (including this

Plan) when an employer contributes any portion of the premium or an employer, association, or other group contracts for the coverage on Your behalf. A Plan or program offering benefits for any type of health care service is considered a Health Benefit Plan if it is provided in whole or in part by any labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan or by any governmental program or any coverage required or provided by law or statute.

The term Health Benefit Plan refers to each Plan or program separately. It also refers to any portion of a Plan or program which reserves the right to take into account benefits of other Health Benefit Plans when determining its own benefits. If a Health Benefit Plan has a coordination of benefits provision which applies to only part of its services, the terms of this section will be applied separately to that part and to any other part.

The term Health Benefit Plan as defined here does not include a prepaid health care services contract or accident and sickness policy which is individually underwritten, and individually issued, and provides only for accident and sickness benefits, and is paid for entirely by the Enrollee.

22) 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 Surgical Services to Outpatients. The facility must be licensed as an Outpatient Hospital by the state in which it operates. Inpatient services received from a facility of this type are not covered. Services provided by an Outpatient Hospital which is a Non-Network Hospital are not covered.

23) 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.

24) Mammogram

A Mammogram is an x-ray examination of the breast using equipment dedicated specifically for mammography. The examination must have an average radiation exposure of less than one rad mid-breast and two views of each breast.

25) Maternity Services

These are services for pregnancy or a pregnancy-related condition.

26) Medical Services

These are services for the treatment of a medical condition. The term Medical Services does not include Surgical Services, Maternity Services, Anesthesia Services, Mental Illness and Substance Abuse Services, Diagnostic Services, or Therapy Services.

27) Medically Necessary

A Medically Necessary service is one required to identify or treat an illness, injury, or pregnancy-related condition which 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 generally accepted medical practice;
- Not be for the convenience of the patient, the patient's family, or the Provider; and
- Be the most suitable, cost-effective supply or level of service which can be safely provided to You.

It further means that the service is 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 Network facility, or any other non-medical factor is not considered. As Your medical condition changes, the need for a particular setting may change.

Medically Necessary is an especially important phrase because payment will be denied unless a service is Medically Necessary. Effective October 1, 2002 and thereafter Your coverage does not include benefits for services or supplies if they are deemed not Medically Necessary as determined by Trigon in its sole discretion. However, if you receive inpatient or outpatient services that are denied as not Medically Necessary, or are denied for failure to obtain the required pre-authorization or primary care physician referral, the following professional provider services that you receive during Your inpatient stay or as part of your outpatient services will not be denied under this exclusion in spite of the Medical Necessity denial of the overall services:

For Inpatients – 1) Services that are rendered by professional provider who do not control whether You are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians. 2) Services rendered by Your attending Provider other than inpatient evaluation and management services provided to You. Inpatient evaluation and management services include routine Visits by your attending Provider for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management Visits do not include surgical, diagnostic, or therapeutic services performed by Your attending Provider.

For Outpatients – Services of pathologists, radiologists and anesthesiologists.

A service is not automatically classified as Medically Necessary because a Provider prescribes it. In an effort to make treatment convenient or to follow the wishes of the patient or the patient's family, a Provider may suggest or permit a method of providing care which is not Medically Necessary.

The Company's Hospital admission review procedure is available to tell You or Your Provider *in advance* if non-emergency Inpatient services are Medically Necessary.

The Company's pre-authorization procedure is available to tell You or Your Provider *in advance* if non-emergency Outpatient services are Medically Necessary.

The Company, upon request, will give You more information about its Hospital admission review and pre-authorization procedures.

28) Medically Skilled Service

This is a service requiring the training and skills of a licensed medical professional. A service is not medically skilled simply because it is performed by medical professionals. If someone else can safely and adequately perform the service without direct supervision of a nurse or Provider, it will be classified as a non-Medically Skilled Service and will not be eligible for reimbursement.

29) Medicare

Medicare means the health insurance program established by Title XVIII of the Social Security Act of 1965, as amended.

30) Mental Illness and Substance Abuse Conditions

This means nervous, mental, and emotional disorders, including alcohol and drug abuse.

31) Mental Illness and Substance Abuse Services

These are services for the diagnosis and treatment of a Mental Illness and Substance Abuse Condition.

32) Morbid Obesity

For the purposes of this Plan, Morbid Obesity means a patient who:

- Weighs at least 100 pounds over or twice the ideal body weight;
- Has a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- Has a body mass index of 40 kilograms per meter squared, without such comorbidity.

The Company determines normal body weight using generally accepted weight tables for a person of Your age, sex, height, and frame.

33) Network and Non-Network Hospitals and Providers

A Network Hospital is a Hospital listed as a Network Hospital by the Company. A Network Provider is a Provider listed as a Network Provider by the Company. A Network Hospital or Network Provider must be listed as such at the time You receive the service for which coverage is sought. Any other Hospital or Provider is a Non-Network Hospital or Non-Network Provider.

The Company may, at its sole option, name one or more Non-Network Hospitals as ones in which You will receive Services as if You were in a Network 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-Network Hospital's charge.

These same definitions apply to all facility and professional Providers.

34) Network Schedule of Allowances

This term means the maximum allowances for Services which are performed by Network Providers.

35) Out-of-Pocket Expenses

This means the Deductibles, Copayments, and Coinsurance You incur for covered services. There are limits as to which Deductibles, Copayments, and Coinsurance are included in Out-of-Pocket Expenses.

36) Outpatient

This term refers to a person who is not an Inpatient. An Outpatient is a person who receives care in a professional provider's office, hospital outpatient department, emergency room, or the home, for example.

37) Partial Hospitalization

Partial hospitalization combines intensive treatment in a medically supervised setting, with the opportunity for the patient to return home or to another residential setting at night. Care includes individual, group, family, educational, and rehabilitation services. These programs usually offer services three to five times per week for more than several hours per day.

38) Participant

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

39) Physician

A Physician is a properly licensed Doctor of Medicine.

40) Plan

Plan, in this booklet, means the Value Alliance with Dental Plan.

41) Plan Year

This means a Plan Year of July 1 through June 30 (or October 1 through September 30 for certain school groups). It can also mean a part of a Plan Year if Your Effective Date is other than July 1 (or October 1 for certain school groups) or if Your enrollment ends other than on June 30 (or September 30). When You first enroll, the Plan Year extends from your effective date to the next June 30 (or September 30). If your coverage is terminated for any reason, your Plan Year will end on the same day your enrollment under this benefits section ends.

42) Plan of Treatment

A Plan of Treatment is a program written by Your Provider. It describes Your condition and the services You need.

43) Primary Care Physician (PCP)

This term means a Physician whom You select as Your "Primary Care Physician" from the Primary Care Physician Network established by the Company. Your Primary Care Physician provides primary health care and coordinates the other covered services that You may require.

44) Primary Coverage

This means the Health Benefit Plan which will provide benefits first. It does not matter whether or not You have filed a claim for benefits with the primary Health Benefit Plan. If You are eligible for coverage under two Health Benefit Plans, the Primary Coverage will be used to decide what Secondary Coverage benefits are available.

45) Provider

This means a properly licensed Audiologist, Certified Nurse Midwife, Chiropractor, Clinical Nurse, Clinical Social Worker, Dentist, Doctor of Chiropractic, Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Independent Clinical Reference Laboratory, Licensed Professional Counselor, Mental Health Specialist, Optician, Optometrist, Psychologist, Registered Physical Therapist, or Speech Pathologist.

46) 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 Medical or Surgical 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 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.

47) Referral

This term means an arrangement made by Your Primary Care Physician for You to obtain Services from another Provider or a facility. A Referral may be for:

- One or more Visits to a Provider to be rendered within a defined period of the date of the Referral; or
- One admission for Inpatient care at a Hospital or Skilled Nursing Facility; or
- One Plan of Treatment for Services from a Network home health care agency.

However, an arrangement made by Your Primary Care Physician for You to obtain services from a Non-Network Provider will not be considered a Referral unless the services are not reasonably available from a Network Provider, in the sole discretion of the Company. You or Your Primary Care Physician may contact the Company, through its pre-authorization program, in advance of receiving services from a Non-Network Provider to determine if the services are reasonably available from a Network Provider.

48) Secondary Coverage

This is the Health Benefit Plan under which the benefits may be reduced to prevent duplicate or overlapping coverage.

49) Semi-Private Room

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

50) Skilled Nursing Facility

A Skilled Nursing Facility is an institution licensed as a Skilled Nursing Facility by the state in which it operates. A Skilled Nursing Facility provides Medically Skilled Services to Inpatients. In most cases, the Inpatients require a lesser level of care than would be provided in a Hospital.

51) Specialist

A Specialist is any provider other than Your Primary Care Physician (PCP).

52) State

This word means the Commonwealth of Virginia.

53) Surgical Services

Surgical Services are:

- Operative or cutting procedures for the treatment of an illness, injury, or pregnancy-related condition;
- The treatment of fractures and dislocations; or
- Endoscopic or diagnostic procedures such as cystoscopy, bronchoscopy, and angiocardiology.

54) The Local Choice Group

This means a local employer participating in The Local Choice Health Benefits Program.

55) The Local Choice Health Benefits Program

This means the health benefits program administered by the Department of Human Resource Management for the benefit of local governments, local officers, teachers, commissions, public authorities and other organizations created by or under an act of the General Assembly.

56) Therapeutic Injections

These are injections a Provider gives to treat an illness, injury, or pregnancy-related condition. For the purposes of this booklet, Therapeutic Injections include allergy shots, but they do not include immunizations.

57) Therapy Services

This phrase means one or more of the following services used to treat or promote Your recovery from an illness or injury.

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 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 may include special skills required by the job You had at the time of Your illness or injury.

g. Speech Therapy

This is treatment for the correction of a speech impairment. The impairment must result from disease, surgery, injury, congenital 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.

58) Urgent Care

This term means care for a health problem usually marked by rapid onset of persistent or unusual discomfort associated with an illness or injury. These problems may include high fever, vomiting, sprains, and minor cuts. An Urgent Care situation must be handled through your Primary Care Physician regardless of the time of day or the day of the week.

59) Visit

This means a brief period during which You meet with a Physician or another person whose services are eligible for reimbursement.

60) You, Your, or Yourself

These words refer to a Participant.

ELIGIBILITY

ACTIVE EMPLOYEES

Full-time, part-time, and other classifications of employees may be eligible to participate. The local employer defines the categories of employees eligible to enroll when they complete the employer application which is forwarded to the Department of Human Resource Management. If part-time employees are covered, all part-time employees in the same classification must be treated similarly.

Dependents

The following dependents are also eligible for membership:

- The legally married spouse of an eligible employee.
- The eligible employee's unmarried biological or legally adopted child(ren).
- A child placed in an eligible employee'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 employee in a parent-child relationship **and** who are lawfully claimed as a dependent on the eligible employee's federal income tax return.
- Disabled adult children who are certified as such by the Plan upon application by the eligible employee 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 employee 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 employee 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 Plan Year in which the child turns 23.)
- Stepchildren who do not live full time with the employee; stepchildren living with the employee who are not claimed as a dependent on the eligible employee'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 an employee to provide coverage for an ex-spouse does not make an ex-spouse eligible for coverage through the employee health benefits program.

Enrollment and Plan or Membership Changes

Procedures for enrollment, plan or membership changes and effective dates for coverage may be obtained from Your employer.

RETIRED EMPLOYEES AND SURVIVING DEPENDENTS (The Local Choice Group Option)

- If The Local Choice Group allows, retirees may remain in the selected plan until reaching age 65 or eligibility for Medicare, whichever comes first. A Medicare supplement is available to retirees upon enrollment in Medicare Parts A and B.
 - Retirees may 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.
- Health benefits for a covered surviving spouse and/or covered dependent children of a retired The Local Choice Group employee may be available through the Group's Retiree Health Benefits Program.
 - 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; at the end of the year in which the child turns age twenty-three (unless eligible through disability); or if the child marries or becomes self-supporting. Loss of eligibility for a surviving spouse will result in the loss of eligibility for dependent children covered under the surviving spouse's membership.
- Special rules apply for dependents of employees who are disabled or killed in the line of duty. See Your Benefits Administrator for more information.

STATUTORY BENEFITS

Following is a list of benefits which must, by statute, be offered in The Local Choice Health Benefits Program. These may also be referred to as mandated benefits. The text below has been excerpted from the Code of Virginia, §2.2-2818. This list will be updated each July 30. All of the statutory benefits are believed to have been incorporated into The Local Choice Health Benefits Program. Note: Where reference is made to State employees, this also refers to The Local Choice covered employees. The Local Choice Health Benefits Program and the State Health Benefits Program are governed by the same regulations.

A. The Department of Human Resource Management shall establish a plan, subject to the approval of the Governor, for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Human Resource Management shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally.

The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

In order to be considered a screening mammogram for which coverage shall be made available under this section:

a. The mammogram shall be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization physician, (ii) performed by a registered technologist, (iii) interpreted by a qualified radiologist, and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report shall be sent or delivered to the health care practitioner who ordered it;

b. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

c. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

2. Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

3. Include coverage for postpartum services providing inpatient care and a home visit or visits that shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

4. Include an appeals process for resolution of written complaints concerning denials or partial denials of claims that shall provide reasonable procedures for resolution of such written complaints and shall be published and disseminated to all covered state employees. The appeals process shall include a separate expedited emergency appeals procedure that shall provide resolution within one business day of receipt of a complaint concerning situations requiring immediate medical care. For appeals involving adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more impartial health entities to review such decisions. Impartial health entities may include medical peer review organizations and independent utilization review companies. The Department shall adopt regulations to assure that the impartial health entity conducting the reviews has adequate standards, credentials and experience for such review. The impartial health entity shall examine the final denial of claims to determine whether the decision is objective, clinically valid, and compatible with established principles of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if consistent with law and policy.

Prior to assigning an appeal to an impartial health entity, the Department shall verify that the impartial health entity conducting the review of a denial of claims has no relationship or association with (i) the covered employee, (ii) the treating health care provider, or any of its employees or affiliates, (iii) the medical care facility at which the covered service would be provided, or any of its employees or affiliates, or (iv) the development or manufacture of the drug, device, procedure or other therapy that is the subject of the final denial of a claim. The impartial health entity shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers. There shall be no liability on the part of and no cause of action shall arise against any officer or employee of an impartial health entity for any actions taken or not taken or statements made by such officer or employee in good faith in the performance of his powers and duties.

5. Include coverage for early intervention services. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation and

Substance Abuse Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime.

6. Include coverage for prescription drugs and devices approved by the United States Food and Drug Administration for use as contraceptives.

7. Not deny coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in one of the standard reference compendia.

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.

9. Include coverage for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

10. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive breast surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the two breasts. For persons previously covered under the plan, there shall be no denial of coverage due to preexisting conditions.

11. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for annual testing performed by any FDA-approved gynecologic cytology screening technologies.

12. Include coverage providing a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

13. Include coverage (i) to persons age fifty and over and (ii) to persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

14. Permit any individual covered under the plan direct access to the health care services of a participating specialist (i) authorized to provide services under the plan and (ii) selected by the covered individual. The plan shall have a procedure by which an individual who has an ongoing special condition may, after consultation with the primary care physician, receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care related to the initial specialty care referral. If such an individual's care would most appropriately be coordinated by such a specialist, the plan shall refer the individual to a specialist. For the purposes of this subdivision, "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) requires specialized medical care over a prolonged period of time. Within the treatment period authorized by the referral, such specialist shall be permitted to treat the individual without a further referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services related to the initial referral as the individual's primary care provider would otherwise be permitted to provide or authorize. The plan shall have a procedure by which an individual who has an ongoing special condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the treatment of the special condition. If the primary care provider, in consultation with the plan and the specialist, if any, determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to a specialist. Nothing contained herein shall prohibit the plan from requiring a participating specialist to provide written notification to the covered individual's primary care physician of any visit to such specialist. Such notification may include a description of the health care services rendered at the time of the visit.

15. Include provisions allowing employees to continue receiving health care services for a period of up to ninety days from the date of the primary care physicians notice of termination from any of the plan's provider panels. The plan shall notify any provider at least ninety days prior to the date of termination of the provider, except when the provider is terminated for cause.

For a period of at least ninety days from the date of the notice of a provider's termination from any of the plan's provider panels, except when a provider is terminated for cause, a provider shall be permitted by the plan to render health care services to any of the covered employees who (i) were in an active course of treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care services from the provider.

Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the plan to continue rendering health services to any covered employee who has entered the second trimester of pregnancy at the time of the provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue through the provision of postpartum care directly related to the delivery.

Notwithstanding the provisions of subdivision 1, any provider shall be permitted to continue rendering health services to any covered employee who is determined to be terminally ill (as defined under § 1861 (dd) (3) (A) of the Social Security Act) at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue for the remainder of the employee's life for care directly related to the treatment of the terminal illness.

A provider who continues to render health care services pursuant to this subdivision shall be reimbursed in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

16. Include coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials.

The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally.

For purposes of this subdivision:

"Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group.

"Cooperative group" includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute Community Clinical Oncology Program.

"FDA" means the Federal Food and Drug Administration.

"Multiple project assurance contract" means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

"Patient" means a person covered under the plan established pursuant to this section.

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

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

The treatment described in the previous paragraph shall be provided by a clinical trial approved by:

- a. The National Cancer Institute;
- b. An NCI cooperative group or an NCI center;
- c. The FDA in the form of an investigational new drug application;
- d. The federal Department of Veterans Affairs; or
- e. 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. The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

Coverage under this section shall apply only if:

- (1) There is no clearly superior, noninvestigational treatment alternative;
- (2) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative; and
- (3) The patient and the physician or health care provider who provides services to the patient under the plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to procedures established by the plan.

17. Include coverage providing a minimum stay in the hospital of not less than twenty-three hours for a covered employee following a laparoscopy-assisted vaginal hysterectomy and forty-eight hours for a covered employee following a vaginal hysterectomy, as outlined in Milliman & Robertson's nationally recognized guidelines. Nothing in this subdivision shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the covered employee, determines that a shorter hospital stay is appropriate.

18. (Effective until July 1, 2004) Include coverage for biologically based mental illness. For purposes of this subdivision, a "biologically based mental illness" is any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

Coverage for biologically based mental illnesses shall neither be different nor separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

Nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this option, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations made for the treatment of any other illness, condition or disorder covered by such policy or contract.

In no case, however, shall coverage for mental disorders provided pursuant to this section be diminished or reduced below the coverage in effect for such disorders on January 1, 1999.

19. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as

hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, "BMI" equals weight in kilograms divided by height in meters squared.

20. Include coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. The coverage for colorectal cancer screening shall not be more restrictive than or separate from coverage provided for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

21. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each employee provided coverage pursuant to this section, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide employees covered under the plan such corrective information as may be required to electronically process a prescription claim.

22. Include coverage for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such coverage shall include follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund shall be deemed separate and independent trust funds, shall be segregated from all other funds of the Commonwealth, and shall be invested and administered solely in the interests of the employees and their beneficiaries. Neither the General Assembly nor any public officer, employee, or agency shall use or authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and administrative expenses, including but not limited to legislative oversight of the health insurance fund.

D. For the purposes of this section:

"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.

"Standard reference compendia" means the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information.

"State employee" means state employee as defined in § 51.1-124.3, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

E. Provisions shall be made for retired employees to obtain coverage under the above plan, including, as an option, coverage for vision and dental care. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Human Resource Management that utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

G. The plan shall include, in each planning district, at least two health coverage options, each sponsored by unrelated entities. In each planning district that does not have an available health coverage alternative, the Department shall voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide coverage under the plan. This section shall not apply to any state agency authorized by the Department to establish and administer its own health insurance coverage plan separate from the plan established by the Department.

H. Any self-insured group health insurance plan established by the Department of Personnel 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.

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.

I. Any plan established in accordance with this section requiring preauthorization prior to rendering medical treatment shall have personnel available to provide authorization at all times when such preauthorization is required.

J. Any plan established in accordance with this section 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.

K. No contract between a provider and any plan established in accordance with this section shall include provisions that require a health care provider or health care provider group to deny

covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a covered employee with similar medical conditions.

L. 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.

The Ombudsman shall:

1. Assist covered employees in understanding their rights and the processes available to them according to their state health plan.
2. Answer inquiries from covered employees by telephone and electronic mail.
3. Provide to covered employees information concerning the state health plans.
4. Develop information on the types of health plans available, including benefits and complaint procedures and appeals.
5. Make available, either separately or through an existing Internet web site utilized by the Department of Human Resource Management, information as set forth in subdivision 4 and such additional information as he deems appropriate.
6. Maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.
7. 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.
8. 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.
9. 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. The plan established in accordance with this section 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.

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.

N. 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 that coverage would have primary responsibility for the covered expenses of each family member.

O. Any plan established by the Department of Human Resource Management pursuant to this section shall provide that coverage under such plan for family members enrolled under a participating state employee's coverage shall continue for a period of at least thirty days following the death of such state employee.

SAMPLE

The Local Choice (TLC) – Certificate of Creditable Health Coverage

This certificate provides evidence of your prior creditable health coverage. You may need to furnish this certificate if you become eligible under a health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is furnished to everyone leaving a TLC Health Benefits Program (except for Medicare Supplement Plans). If you become covered under another health plan, check with the plan administrator to see if you need to provide this certificate. It would apply if your new plan has a pre-existing conditions provision and medical advice, diagnosis, care or treatment for such a medical condition was received or recommended for you or a covered family member within the six-month period before enrollment in the new plan. If you have at least 18 months of creditable service as defined by HIPAA, you may have certain additional rights which may be exercised when securing individual coverage. Please be advised that insurers that offer individual health plans in the Commonwealth of Virginia must recognize creditable coverage so long as the employee has at least 18 months of creditable coverage and received their most recent health coverage under an employment-related group health plan. Please note that periods of creditable coverage prior to a 63-day break in coverage may be disregarded by the new health plan. You may obtain additional certificates for you or your covered family members from your Benefits Administrator/Employer Representative should you need them during the 24 months following your termination from the plan.

Date of this Certificate: _____

Name of Participant: _____

Name of Health Care Plan: _____

Participant’s Identification Number: _____

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

Names of Dependents for Whom this Certificate also Applies: _____

Was the Period of Creditable Coverage More than 18 Months? (Yes/No) _____
(Disregarding periods of coverage before a 63-day break)

If Less than 18 Months, Date Coverage Began: _____

Date Coverage Ended: _____

Date Waiting Period Began: Not Applicable _____

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

Name: _____

Address: _____

Employer: _____ Telephone Number: _____

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

Use this form to request a Certificate of Group Health Coverage from your Benefits Administrator.

Date: _____

Name of Participant:	
Participant's ID Number:	
Address:	
Telephone Number:	
Name and relationship of any dependents for whom certificates are requested (and their address if different from above).	

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