The Local Choice Health Benefits

Medicare–Coordinating Plans Member Handbook

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www.thelocalchoice.virginia.gov

The Local Choice Health Benefits Program

Administered by the Department of Human Resource Management
Commonwealth of Virginia

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TABLE OF CONTENTS

Important Notice 1

Using Your Benefits to the Best Advantage 3

Coordination of Medicare and The Local Choice Retiree Plans 4

Who to Contact for Assistance 7

General Rules Governing Benefits 8

Institutional Services 19
Hospital Services 19
Skilled Nursing Facility Services 21

Professional and Other Part B Services 22

At-Home Recovery Services (Advantage 65 Only) 23

Major Medical Services (Out-of-Country Only – Advantage 65 Only) 25

Dental/Vision Services 29

Exclusions 30

Basic Plan Provisions 33

Definitions 42

Eligibility 50

IMPORTANT NOTICE

This handbook tells you what medical services are eligible for reimbursement under The Local Choice Retiree Health Benefits Program's Medicare-Coordinating Plans. These Plans include:

- Advantage 65
- Advantage 65 with Dental/Vision
- Medicare Complementary/Option I

If you are enrolled in a Plan that includes dental/vision coverage, this handbook will also include an insert describing the additional benefits that apply to you. This handbook (and the Dental/Vision insert if applicable) constitutes the description of the benefits, exclusions and limitations under these Plans.

Throughout this handbook 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 coverage is limited to the services specifically described in this handbook (and applicable insert) as eligible for reimbursement. There are specific exclusions for which the program will never pay. Even more important, payment for covered services is almost always conditional. That is, payment may be denied for covered services you receive without observing all of the conditions and limits under which they are covered.

Your benefits are governed strictly by the written provisions of the Plan. Only those services specifically named or described in this handbook (and applicable insert) are covered. You 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 if proper notice is given to you.

There are some rules which apply to all benefits (medical, dental or vision as applicable to your own coverage), including the General Rules Governing Benefits, Exclusions, Basic Plan Provisions, Eligibility and Definitions listed in this handbook. Any rules that apply specifically to dental or vision benefits will be included in the applicable insert.

You must have both Parts A and B of Medicare to receive maximum benefits under these plans.

Outpatient prescription drugs are not covered by Advantage 65, Advantage 65 with Dental/Vision or Medicare Complementary/Option I. Enrolling in Part D is recommended.

USING YOUR MEDICAL BENEFITS TO THE BEST ADVANTAGE

Because these Plans coordinate medical benefits with Original Medicare (the primary payer), you must also be enrolled in both Medicare Parts A and B to receive full benefits. If you are not enrolled in Medicare Parts A and B, these Plans will not pay for any services that should have been paid by Medicare had you been enrolled.

If you are enrolled in Medicare Advantage (HMO, PPO, Special Needs, Private Fee-for-Service) rather than Original Medicare, medical services you receive will not be covered by these Plans.

Outpatient prescription drugs are not covered by Advantage 65, Advantage 65 with Dental/Vision or Medicare Complementary/Option I. Enrolling in Part D is recommended.

Medicare Participating Providers

To help save on your medical expenses, use Medicare Participating Providers whenever possible. Hospitals and doctors who participate in Medicare agree to accept Medicare's Allowable Charge for covered services as payment in full and agree to file Medicare claims on your behalf. Non-Participating Providers may charge you more than the Medicare-approved amount, but not more than 15% over the Medicare-approved amount (the “limiting charge”). The limiting charge applies only to certain services and does not apply to some supplies and durable medical equipment.

To find out if your doctors and suppliers participate in Medicare, visit **www.medicare.gov/physician** or **www.medicare.gov/supplier**, call **800-MEDICARE**, or ask your doctors, Providers, or suppliers if they participate.

Filing Claims

In most instances, Medicare Participating Providers will file claims for your Secondary Coverage, or claims will automatically cross over after Medicare’s primary benefit is paid. However, if they do not, you must file the claim yourself. When you file your claim, the Medicare Summary Notice must be sent to the Claims Administrator with your claim.

COORDINATION OF MEDICARE AND THE LOCAL CHOICE MEDICARE-COORDINATING PLANS

These charts contain only basic information about Medicare coverage. They are intended to highlight how The Local Choice Medicare-Coordinating Plans supplement Original Medicare coverage.

Part A Services	Medicare
Hospital Inpatient	• Pays up to 60 days of Medically Necessary services, except Part A Hospital deductible • Pays up to an additional 30 days, except daily coinsurance • If more than a 90-day Hospital stay, can pay up to 60 Medicare Lifetime Reserve Days, except daily coinsurance • No payment for more than a 90-day Hospital stay if no Medicare Lifetime Reserve Days remain or if you choose not to use them
Skilled Nursing Facility	• Pays 100% for 20 days at a Medicare-certified Skilled Nursing Facility • Pays up to an additional 80 days at a Skilled Nursing Facility, except daily coinsurance • Medicare does not pay for more than 100 days at a Skilled Nursing Facility in a Benefit Period
Part B Services	
Physician and Other Services	• Generally pays 80% of Medicare-Approved Charges for services such as doctor's care and Outpatient Physical or Occupational Therapy (within limits) – see your “Medicare and You” publication for more information • An annual deductible may apply
Part D Services	
Prescription Drug Coverage	• Pays a benefit based on the specific Part D Plan in which the beneficiary is enrolled
Other Services	
Routine Vision	• Not covered
Routine Dental Benefits	• Not covered
Out-of-Country and Major Medical Services	• Not covered
At-Home Recovery Care and Visits	• Not covered

COORDINATION OF MEDICARE AND THE LOCAL CHOICE MEDICARE-COORDINATING PLANS

Part A Services	The Local Choice Advantage 65
Hospital Inpatient (medical)	• Pays Medicare Part A deductible except for first $100 • Pays Medicare Part A coinsurance • Pays 100% of the Allowable Charge for eligible expenses for an additional 365 days (requires use of Medicare Lifetime Reserve Days)
Skilled Nursing Facility	• Pays Medicare Part A coinsurance (days 21-100) • Pays above coinsurance amount for an additional 80 days per Medicare Benefit Period
Part B Services	
Physician And Other Services	• Does not pay Medicare Part B deductible, but does pay Part B coinsurance
Part D Services	
Prescription Drug Coverage	• Outpatient prescription drugs are not covered by The Local Choice Advantage 65 plan
Other Services	
Routine Vision Benefits	• See Dental/Vision insert if you are enrolled in this plan.
Routine Dental Benefits	• See Dental/Vision insert if you are enrolled in this plan.
Out-of-Country and Major Medical Services	**For Out-of-Country services only:** • Pays 80% of Allowable Charge after you pay $250 Calendar Year deductible
At-Home Recovery Care and Visits	• Pays up to $40 per visit, not to exceed $1,600 each Calendar Year and 7 visits each week

COORDINATION OF MEDICARE AND THE LOCAL CHOICE MEDICARE-COORDINATING PLANS

AVAILABLE ONLY TO EMPLOYER GROUPS CURRENTLY PARTICIPATING IN THIS PLAN

Part A Services	**The Local Choice Medicare Complementary/Option I**
Hospital Inpatient	• Pays Medicare Part A deductible except for first $100 • Pays Medicare Part A coinsurance • Pays 100% of the Allowable Charge for eligible charges for an additional 365 days (requires use of Medicare Lifetime Reserve Days)
Skilled Nursing Facility	• Pays Medicare Part A coinsurance (days 21-100) • Pays above coinsurance amount for an additional 80 days per Medicare Benefit Period
Part B Services	
Physician and Other Services	• Pays Medicare Part B coinsurance after you pay the $1,000 deductible, which includes the Part B deductible.
Part D Services	
Prescription Drug Coverage	Outpatient prescription drugs are not covered by The Local Choice Medicare Complementary plan
Other Services	
Routine Vision Benefits	• See Dental/Vision insert
Routine Dental Benefits	• See Dental/Vision insert
Out-of-Country and Major Medical Services	• Not covered
At-Home Recovery Care and Visits	• Not covered

WHO TO CONTACT FOR ASSISTANCE

Medical Coverage Claims Administrator

Anthem Blue Cross and Blue Shield

Member Services	800-552-2682
Web Address	**www.anthem.com/tlc** Select "Medicare Retirees" under Tools & Information
Mailing Address	Anthem Blue Cross and Blue Shield Member Services P. O. Box 27401 Richmond, VA 23279
Appeals Address for Claims Processed by Anthem (not including claims Adjudicated by Medicare)	Anthem Blue Cross and Blue Shield Attn: Corporate Appeals Department P. O. Box 27401 Richmond, VA 23279
ID Card Order Line	866-587-6713

Eligibility and Enrollment

Contact your Group Benefits Administrator with questions about eligibility and enrollment.

Program Administration

Department of Human Resource Management
The Local Choice Health Benefits Program

Web Address	**www.thelocalchoice.virginia.gov**
E-Mail	**tlc@dhrm.virginia.gov**

If you have dental/vision coverage under your Plan, please refer to your dental/vision insert for coverage information.

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**
   Your benefits start on your Effective Date. No benefits will be provided for any charges you incur before that date.

3) **When Benefits End**
   Benefits will not be provided for charges you incur after your coverage ends. There is one exception. If you are an Inpatient on the day your enrollment ends, the services to which you would have been entitled under the Hospital Services and Skilled Nursing Facility Services sections will be covered until your date of discharge for that admission. These benefits will be provided only to the extent they would have been provided had your enrollment not ended.

4) **When You Become Eligible**
   Retirees, if eligible, who wish to continue coverage through The Local Choice Employer Group when they become Medicare eligible must enroll in the Medicare Coordinating Plan within 31 days of gaining Medicare eligibility. Eligible retirees should also enroll in Parts A and B of Medicare. Enrollment with a Part D provider may also be advisable since the Medicare Coordinating Plans do not provide coverage for outpatient prescription drugs.

   Retirees who cancel or decline coverage may not enter or return to the plan in the future.

5) **Services Must Be Medically Necessary**
   Benefits will be denied if the Claims Administrator determines, in its sole discretion, that care is not Medically Necessary. Medicare adjudicates medical necessity when Medicare is the primary payer.

6) **Defining Services**
   For services covered under these Plans but not covered by Medicare when classifying a particular service, the Claims Administrator will use the most recent edition of a book published by the American Medical Association entitled Current Procedural Terminology (CPT). The Allowable Charge for a procedure will be based on the most inclusive code, and the Claims Administrator alone will determine the most inclusive code. No benefits will be provided for lesser included procedures or for procedures which are components of a more inclusive procedure.

7) **Payment To Participating Providers**
   For services covered under these Plans but not covered by Medicare, the Claims Administrator pays the Allowable Charge which remains after your copayment, coinsurance or deductible.

When an Enrollee receives services from a Participating Provider, the Claims Administrator will make payment for these services directly to the Provider. But, if the Enrollee has already paid the Provider and the Provider tells the Claims Administrator to do so, the Claims Administrator will pay the Enrollee. A Provider who participates in one of the Claims Administrator's Networks will accept the Claims Administrator's allowance as payment in full for that service. Payment by the Claims Administrator will relieve the Claims Administrator and the Plan of any further liability for the service.

8) Non-Participating Provider Payments

When a Participant receives services from a Non-Participating Provider for services not covered by Medicare, the Claims Administrator may choose to make payment directly to the Enrollee or, at the Claims Administrator's sole option, to any other person responsible for payment of the Provider's charge. Payment will be made only after the Claims Administrator has received an itemized bill and the medical information the Claims Administrator decides is necessary to process the claim. The Enrollee will also be responsible for the difference between the Plan's allowance and the Provider's charge. Payment by the Claims Administrator will relieve it and the Plan of any further liability for the Non-Participating Provider's services.

9) Complaint and Appeal Process

You have access to both a complaint process and an appeal process. Should you have a problem or question about your health Plan, the appropriate Plan Administrator's Member Services Department will assist you. Most problems and questions can be handled in this manner. **Anthem** is the Plan Administrator for medical and routine vision (if included in your health Plan). If you are enrolled in a health Plan that includes dental coverage, **Delta Dental** is the Plan Administrator.

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

Complaint Process

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

Important: Written complaints or any questions concerning your Medical or Dental coverage may be filed to the following addresses:

Anthem Blue Cross and Blue Shield (for Medical and Vision if applicable)
Attn: Member Services
P.O. Box 27401
Richmond, VA 23279

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

Claims Appeal Process

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

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

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

Internal Appeals

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

- **Pre-service claim**- a claim for a benefit under your health Plan for which you have not received the service or for which you may need to obtain approval in advance.
- **Post-service claim**- a claim for any benefit under your health Plan for which you have received the service.
- **Concurrent care claim**- a claim for a benefit where your health Plan is reducing or ending a service that it previously approved. **Note:** For concurrent claim appeals, the Plan Administrator must not reduce or terminate benefits prior to the resolution of the appeal.

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

(NOTE: For Advantage 65 Plans, when Medicare does not cover health care, Anthem will provide major medical benefits in certain circumstances. Anthem's decisions regarding Anthem's payments or claim denials may be appealed. However, Medicare's decisions regarding Medicare payments or claim denials, are final and cannot be appealed through the TLC plan.)

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

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

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

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

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

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

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

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

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

Standard Internal Appeals

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

Expedited Internal Appeals

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

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

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

Addresses and Telephone Numbers for Appeals

Anthem Address**:**	Anthem Blue Cross and Blue Shield Attn: Corporate Appeals Department P.O. Box 27401 Richmond, VA 23279 Telephone: 800-552-2682
Delta Dental Address:	Delta Dental of Virginia Attn: Appeals 4818 Starkey Road, S.W. Roanoke, VA 24018-8542

How the Plan Administrator will handle your appeal

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

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

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

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

External Claims (DHRM) Appeals

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

For external appeals, you may only appeal adverse benefit determinations by the Plan Administrator that are based on your health Plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or the failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational.

(NOTE: For Advantage 65 Plans, when Medicare does not cover health care, Anthem will provide major medical benefits in certain circumstances. Anthem's decisions regarding Anthem's payments or claim denials may be appealed. However, Medicare's decisions regarding Medicare payments or claim denials, are final and cannot be appealed through the TLC plan.)

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

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

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

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

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

Standard External Appeals

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

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

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

Please mark the envelope: Confidential –Appeal Enclosed.

To use email, send your request to **appeals@dhrm.virginia.gov**.

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

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

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

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

Expedited External Appeals

Expedited external appeals may be submitted to DHRM by telephone, facsimile or email at the time that you receive:

- An adverse decision from your Plan Administrator, if the adverse decision involves a medical condition for which the time frame for completing an expedited internal appeal (see **Expedited Internal Appeals** above) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you or your authorized representative has requested an expedited internal appeal from the Plan Administrator;
- A final adverse decision of an internal appeal from the Plan Administrator, if the adverse decision involves a medical condition for which the time frame for completing a standard external appeal (see **Standard External Appeals** above) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final adverse decision concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but have not been discharged from a facility; or
- A final adverse decision of an internal appeal from the Plan Administrator, if the adverse decision involves prescriptions to alleviate cancer pain.

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

To appeal by traditional mail, send your request to the following address:

Director, Virginia Department of Human Resource Management
101 N. 14th Street – 13th Floor
Richmond, VA 23219

Please mark the envelope: Confidential – Expedited Appeal Enclosed.

To use email, send your request to **appeals@dhrm.virginia.gov**.

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

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

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

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

However, if the expedited appeal involves a determination that a requested medical service is investigational or experimental, then the following rules apply:

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

10) Coordination Of Benefits

These Plans are designed to supplement Medicare. If you are enrolled in these Plans, Medicare will generally pay before this coverage for all Medicare-covered services. However, you are required to notify your Claims Administrator that you are enrolled under another Health Benefit Plan in addition to Medicare. The following rules apply to coordination of benefits for services that are covered under The Local Choice Medicare-Coordinating Plans but are not covered by Medicare (including, but not limited to, major medical benefits under the Advantage 65 and the dental/vision benefits that are described in the insert that will be included if you have enrolled in those benefits) and additional coverage that you have that may also supplement Medicare. In the following rules, the Plan that pays benefits first refers to the Plan that pays first after Medicare or, in the case of a service covered under The Local Choice Medicare-Coordinating Plans but not covered by Medicare, the primary payer.

Primary Coverage and Secondary Coverage

When a Covered Person is also enrolled in another group health Plan, one coverage will be primary and one will be secondary. The decision of which coverage will be primary or

secondary is made using the order of benefit determination rules. Highlights of these rules are described below:

- If the other coverage does not have COB rules substantially similar to your health plan's, the other coverage will be primary.
- If a Covered Person is enrolled as the named insured under one coverage and as a dependent under another, generally the one that covers him or her as the named insured will be primary.
- If a Covered Person is the named insured under both coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the dependent is covered as a dependent on their parent(s) plan and they are also covered as a dependent on their spouse's plan, the spouse's plan is primary.
- If the Covered Person is enrolled as a dependent child under both coverages (for example, when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the Calendar Year will be the primary.
- Special rules apply when a Covered Person is enrolled as a dependent child under two coverages and the child's parents are separated or divorced. Generally, the coverage of the parent or step-parent with custody will be primary. However, if there is a court order that requires one parent to provide health care for the child, that parent's coverage will be primary. If there is a court order that states that the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the Plan Year will be primary.

When your health Plan is the Primary Coverage, it pays first. When your health Plan is the Secondary Coverage, it pays second as follows:

- The Claims Administrator calculates the amount your health Plan would have paid if it had been the Primary Coverage, then coordinates this amount with the primary Plan's payment. The combination of the two will not exceed the amount your health Plan would have paid if it had been your Primary Coverage.
- Some Plans provide services rather than making a payment (i.e., a group model HMO). When such a Plan is the Primary Coverage, your health Plan will assign a reasonable cash value for the services and that will be considered the primary Plan's payment. Your health Plan will then coordinate with the primary Plan based on that value.
- In no event will your health Plan pay more in benefits as Secondary Coverage than it would have paid as Primary Coverage.

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).

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 you receive services that are covered under these Plans but not covered by Medicare and, 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.

If you receive services that are covered under these Plans but not covered by Medicare but you have other coverage that is primary, based on the above rules, 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. Benefits that would have been paid if you had filed a claim under the Primary Coverage will be counted and included as benefits provided. In a Calendar Year, benefits will be coordinated as claims are received.

At the option of the Claims Administrator, payments may be made to anyone who paid for the coordinated services you received. These benefit payments by the Claims Administrator 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 Claims Administrator will satisfy the obligation to provide benefits for covered services.

If the Claims Administrator provided Primary Coverage and discovers later that it should have provided Secondary Coverage, the Claims Administrator 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 Claims Administrator in exercising its right of recovery.

You are obligated to supply the Claims Administrator 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 Claims Administrator has the right to obtain or release information about covered services or benefits you have received. This right will be used only when working with another person or organization to settle payments for coordinated services. Your prior consent is not required.

11) Notice From The Claims Administrator To You

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

12) Notice From You To The Claims Administrator

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

13) Assignment of Payment

You may not assign the right to receive payment for covered services. Prior payments to anyone, whether or not there has been an assignment of payment, will not waive or restrict your Plan’s right to make future payments to a covered person or any other person. This provision does not apply to dentists or oral surgeons. Once covered services are rendered by a Provider, your Plan will not honor requests not to pay the claims submitted by the Provider. Your Plan will have no liability to any person because it rejects the request.

14) **Fraud and Abuse**
If you suspect fraud or abuse involving a claim, please notify the Claims Administrator by calling Member Services to report the matter for investigation.

INSTITUTIONAL SERVICES
HOSPITAL SERVICES

Services Which Are Eligible for Reimbursement

1) Medicare Part A services.

2) If you need Inpatient care beyond the 90-day Medicare Benefit Period (except for Medicare Lifetime Reserve Days):
- Bed and board in a Semi Private Room, including general nursing services and special diets. A bed in an intensive care unit is eligible for reimbursement for critically ill patients. Your Plan covers the charge for a private room if you need a private room because you have a highly contagious condition; you are at greater risk of contracting an infectious disease because of your medical condition; or if the Hospital only has private rooms. Otherwise, you have coverage for a Semi-Private Room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to any Copayment or Coinsurance that may apply.
- Customary ancillary services for Inpatient stays, including operating rooms, medications, oxygen and oxygen tents, dressings and casts, anesthesia, transfusions, Diagnostic and Therapy Services, emergency room services leading directly to admission or 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.

Conditions for Reimbursement

Services must be:
- approved by Medicare for all Medicare-covered services;
- prescribed by a Provider licensed to do so; and
- determined to be Medically Necessary by the Claims Administrator for Inpatient services beyond the 90-day Medicare Benefit Period (or Lifetime Reserve Days).

Special Limits

1) You are limited to 455 Days of Inpatient Care in a Hospital per Medicare Benefit Period (90 Medicare days plus 365 days under your Plan, not including your 60 Medicare Lifetime Reserve days).

2) You are limited to 60 additional Days of Inpatient Care in a Hospital under Medicare during your lifetime (your Medicare Lifetime Reserve days)

3) You must use all Medicare Inpatient Hospital coverage, including lifetime reserve days, before exercising the 365 additional days under your Plan.

4) You are entitled to 190 Days of Inpatient Care in a Hospital designated by Medicare as a psychiatric hospital during Your lifetime.

5) The amounts to which You are entitled under this section will not increase even if:
- You were not enrolled in Part A of Medicare; or
- The Hospital Facility providing services did not participate with Medicare at the time you received care.

Reimbursement

The Claims Administrator pays:
- The Medicare Part A deductible less $100 for days 1-60 per Medicare Benefit Period.
- The Medicare Part A coinsurance for days 61-90 per Medicare Benefit Period.
- 100% of the Allowable Charge for days 91-455 for services and supplies listed in item 2 of Services Which Are Eligible for Reimbursement in this section, not including the 60 Medicare lifetime reserve days.
- The Medicare Part A coinsurance for 60 additional Days of Inpatient Care in a Hospital during your lifetime (Medicare lifetime reserve days must be used before exercising the additional 365 days under your Plan).
- The Allowable Charge for the first three pints of blood if required as an Inpatient (not covered by Medicare).

Deductible

You pay $100 of the Medicare Part A deductible for days 1-60 per Medicare Benefit Period.

INSTITUTIONAL SERVICES
SKILLED NURSING FACILITY SERVICES

Services Which Are Eligible for Reimbursement

Medicare Part A services.

Conditions for Reimbursement

Services must be:
- approved by Medicare for all Medicare-covered services;
- prescribed by a Provider licensed to do so; and
- for services covered under these Plans but not covered by Medicare (days 101-180), services must be determined to be Medically Necessary by the Claims Administrator.

Special Limits

1) You are entitled to 180 Days of Inpatient Care in a Skilled Nursing Facility per Medicare Benefit Period. Medicare covers 100 days.

2) The amounts to which you are entitled under this section will not increase even if:
   - you were not enrolled in Part A of Medicare; or
   - the Skilled Nursing Facility providing services did not participate with Medicare at the time you received care.

Reimbursement

1) Medicare pays 100% for days 1-20 in a Skilled Nursing Facility per Medicare Benefit Period.

2) The Claims Administrator pays the Medicare Part A coinsurance for days 21-100 in a Skilled Nursing Facility per Medicare Benefit Period.

3) The Claims Administrator pays an amount equal to the days 21-100 Medicare part A coinsurance for days 101-180 in a Skilled Nursing Facility per Medicare Benefit Period.

PROFESSIONAL AND OTHER PART B SERVICES

Services Which Are Eligible for Reimbursement

1) Medicare Part B services.

Conditions for Reimbursement

1) Services must be:
- approved by Medicare for all Medicare-covered services; and
- performed or prescribed by a Provider licensed to do so.

Special Limitations

1) The amounts to which you are entitled under this section will not increase even if:
- you were not enrolled in Part B of Medicare; or
- the person or facility that furnished you a service did not participate with Medicare at the time you received care.

Reimbursement

Advantage 65 – The Claims Administrator pays the Medicare Part B coinsurance.

Medicare Complementary/Option I – The Claims Administrator pays the Medicare Part B coinsurance after you pay $1,000.

Deductible

You pay the Medicare Part B deductible.

AT-HOME RECOVERY SERVICES
This Benefit Applies to the Advantage 65 Plans Only

Services Which Are Eligible for Reimbursement

1) At-Home Recovery Visits for short-term, at-home assistance with the activities of daily living rendered by a care Provider are covered if you are recovering from a sickness, injury, or surgery.

Activities of daily living include any of the following:

- bathing
- dressing
- personal hygiene
- transferring (for example, wheelchair to bed)
- eating
- ambulating
- assistance with drugs that are normally self-administered
- changing bandages or other dressings

Conditions for Reimbursement

1) Your attending Physician must certify that the specific type and number of At-Home Recovery services are necessary because of a condition for which Medicare approves an at-home care treatment plan. The number of At-Home Recovery Visits cannot exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.

2) Services must be rendered in your home, which means your place of residence, if such a place would qualify as a residence for home health care services covered by Medicare. A Hospital or Skilled Nursing Facility is not a home.

3) You must receive At-Home Recovery Visits:

- while you are receiving Medicare-approved home care services, or
- no more than eight (8) weeks after the date of the last Medicare-approved home health care visit.

Special Limits

1) Benefits are limited to a maximum of seven (7) At-Home Recovery Visits in any one Week and $1,600 in each Calendar Year.

2) Each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

3) Benefits are not available for:

- home care visits paid for by Medicare or other government programs; or
- care provided by family members, unpaid volunteers or others who are not care Providers.

Reimbursement

1) The Claims Administrator pays the charges up to $40 per home visit up to $1,600 per Calendar Year.

Copayments

You pay any charges greater than the above limitations.

MAJOR MEDICAL SERVICES

Advantage 65 Plans Only

The following services are covered when they are received out of the country only. This benefit applies to the Advantage 65 Plans only.

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. Your Plan covers the charge for a private room if you need a private room because you have a highly contagious condition; you are at greater risk of contracting an infectious disease because of your medical condition; or if the Hospital only has private rooms. Otherwise, you have coverage for a Semi-Private Room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to any Copayment or Coinsurance that may apply.

2) Customary ancillary services for Inpatient stays, including operating rooms, medications, oxygen and oxygen tents, dressings and casts, anesthesia, transfusions, blood, blood plasma, blood derivatives, blood volume expanders, and professional donor fees, Diagnostic and Therapy Services, 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) Outpatient Hospital services including Diagnostic Services, Therapy Services, and Inpatient ancillary services when unavailable in an Inpatient facility.

4) Inpatient and Outpatient Medical, Surgical, Maternity, Anesthesia, and Psychiatric Services.

5) Outpatient Diagnostic Services.

6) Outpatient Therapy Services. Under this Major Medical Services section, services may be furnished and billed for by a registered occupational therapist, a certified speech therapist, physical therapist or a certified inhalation therapist.

7) Dental services (non-routine). Your Plan also provides coverage for the following non-routine dental services through the Claims Administrator medical benefits.

- Medically Necessary dental services resulting from an accidental injury, provided that you seek treatment within 60 days after the injury. You must submit a treatment plan from your dentist or oral surgeon for prior approval by Anthem;
- Medically Necessary dental services when required to diagnose or treat an accidental injury to the teeth if the accident occurs while you are covered under the plan. These services and appliances are covered for adults if rendered within a two-year period after the accidental injury. The two-year restriction may be waived for children under age 18. Actual treatment may be delayed if tooth/bone maturity is in question and standard industry protocols are followed. However, a treatment plan must be filed within six months of the accident and treatment must be completed

within two years of active treatment commencement and prior to age 20. For the waiver to be granted, continuous coverage under the Plan is required;
- the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face;
- dental services and dental appliances furnished when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and
- dental services to prepare the mouth for Radiation Therapy to treat head and neck cancer

8) Emergency services in an emergency room, if not covered under Hospital Services.

9) Prescribed services performed by a licensed private duty nurse.

10) The rental of prescribed durable medical equipment for temporary therapeutic use.

11) The following types of prescribed prosthetic devices, orthopedic appliances, and orthopedic braces including the fitting, adjustment, and repair are eligible for reimbursement:

a. Artificial arms and legs, including accessories
b. Leg braces, including attached shoes
c. Built up shoes for post polio patients
d. Arm braces
e. Back braces and neck braces
f. Surgical supporters
g. Head halters

12) Prescribed medical supplies are eligible for reimbursement, including:

a. Sterile dressings for conditions such as burns or cancer
b. Catheters
c. Colostomy bags
d. Oxygen
e. Syringes, needles and related medical supplies required by your medical conditions

13) The following prescribed eyeglasses or contact lenses are eligible for reimbursement:

a. Eyeglasses or contact lenses which replace human lenses lost as the result of intra ocular surgery or injury to the eye
b. "Pinhole" glasses used after surgery for a detached retina
c. Lenses used instead of surgery, such as:
  i. Contact lenses for the treatment of infantile glaucoma
  ii. Corneal or scleral lenses in connection with keratoconus
  iii. Scleral lenses to retain moisture when normal tearing is not possible or is not adequate
  iv. Corneal or scleral lenses to reduce a corneal irregularity (other than astigmatism)

A maximum of one set of eyeglasses or one set of contact lenses will be covered for your original prescription or for any change in your original prescription. Examination

and replacement for a prescription change are covered only when the change is due to the condition for which you needed the original prescription.

14) Ambulance services are eligible for reimbursement when used locally to or from a Covered Facility or Provider's office.

Conditions for Reimbursement

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

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

3) For coverage of ambulance services:
- the trip to the facility or office must be to the nearest one recognized by the Claims Administrator as having services adequate to treat your condition;
- the services you receive in that facility or Provider's office must be covered services; and
- if the Claims Administrator requests it, the attending Provider must explain why you could not have been transported in a private car or by any other less expensive means.

Special Limits

1) The Major Medical Services specifically covered in this section are not eligible for reimbursement if covered under any other section of this handbook, including Medicare benefits. The Claims Administrator will pay only once for a service. Services covered in this section and not covered by other sections of this handbook must be medically necessary as determined by the Claims Administrator.

2) The Major Medical Services discussed in this section must be rendered by a Hospital or Provider outside of the United States, The Commonwealth of Puerto Rico, The Virgin Islands, Guam, and American Samoa. They must be prescribed or performed by a Provider licensed to do so, and Medically Necessary.

3) Routine dental services and Outpatient prescription drug services are not available for reimbursement under Major Medical Services.

4) 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

5) Furthermore, the Claims Administrator will not pay for any other equipment which has both a non-therapeutic and therapeutic use. The Claims Administrator will pay for the least expensive item of equipment required by your medical condition. If the Claims Administrator determines that purchase of the durable medical equipment is less expensive than rental, or if the equipment cannot be rented, the Claims Administrator may approve the purchase as a covered service. If the equipment cannot be rented, the Claims Administrator may cover the purchase price.

6) Corrective shoes and shoe inserts are not eligible for reimbursement.

7) No claim for Major Medical Services will be paid if the Claims Administrator receives it more than one year after the end of the Calendar Year in which the service was rendered.

8) The lifetime maximum benefit for Major Medical Services is $250,000 per Participant. The Claims Administrator will annually reinstate the amount the Claims Administrator paid for your Major Medical Services during the immediately preceding Benefit Period, not to exceed $2,000 per Benefit Period.

9) When you incur $1,200 in Out-of-Pocket Expenses in one Benefit Period for out-of-country Major Medical Services, the Claims Administrator will pay your Out-of-Pocket Expenses for any other covered Major Medical Services you receive during the remainder of that Benefit Period.

Reimbursement

The Claims Administrator pays the remaining Allowable Charge minus your deductible and coinsurance.

Deductible

You pay $250 per Enrollee per Benefit Period.

Coinsurance

After you pay the deductible, you pay 20% of the Allowable Charge.

Dental/Vision Coverage

If you have dental/vision coverage under your Plan, please refer to your dental/vision insert for coverage information. The General Rules Governing Benefits, Exclusions, Basic Plan Provisions, Definitions and Eligibility sections of this handbook also apply, as appropriate, to your dental/vision benefit. However, any dental/vision-specific provisions are included in the insert.

EXCLUSIONS

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

1) Not listed or described in this handbook as covered services.

2) Received by you before your Plan Effective Date.

3) For or rendered during an Inpatient admission which began prior to your Plan Effective Date.

4) Payable under Medicare.

5) Not Original Medicare Eligible Expenses, except as specifically covered by this Plan.

6) Not reasonable and necessary under Medicare program standards for diagnosing or treating a sickness or injury or for restoring a bodily function, except for services covered as a Major Medical benefit under Advantage 65 or covered under the dental/vision benefit (if your Plan includes those benefits).

7) Not usually accompanied with a charge. Also excluded are services for which you would not have been charged if you did not have health care coverage. Charges for self-administered services, self-care, self-help training, biofeedback, and related diagnostic testing are not covered.

8) Furnished by a federal Provider or other federal agency.

9) Provided or available to you:

- **a.** under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits Plans offered to either civilian employees or retired civilian employees of the federal or a state government. These latter Plans are subject to the rules explained in the General Rules Governing Benefits section.
- **b.** under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payer after benefits under this handbook have been provided. This exclusion applies whether or not you waive your rights under these laws, amendments, programs, or terms of employment.

10) For injuries or diseases related in any way to your job when:

- **a.** you receive payment from your employer on account of the disease or injury;
- **b.** your employer is required by federal, state, or local laws or regulations to provide benefits to you, or;
- **c.** you could have received benefits for the injury or disease if you had complied with the laws and regulations.

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

11) For diseases contracted or injuries sustained as a result of any act of war (declared or undeclared), voluntary participation in civil disobedience, or other such activities.

12) Personal comfort items.

13) For rest cures, convalescent care, residential care, custodial care, care in a group home, halfway house, or residential setting.

14) For hearing aids and exams for their prescription, fitting, or changing.

15) For, or related to, cosmetic surgery, including routine complications thereof.

16) Determined to be not Medically Necessary by the Claims Administrator, in its sole discretion, for the treatment of an illness, injury, or pregnancy-related condition (for services specifically covered by these Plans but not covered by Medicare).

17) Determined to be Experimental/Investigative by the Claims Administrator, in its sole discretion. Also excluded are services to treat routine complications of any Experimental/Investigative service (for services specifically covered by these Plans but not covered by Medicare).

18) For routine foot care, the treatment of subluxation of the foot, the treatment of flat foot conditions, or orthopedic shoes and other supportive devices for the feet unless for treatment of injury or disease of the foot as approved for coverage by Medicare.

19) Provided by a member of your immediate family and services rendered by a Provider or Provider's Employee to a co-worker.

20) For surgical sex transformation and follow-up care.

21) For radial keratotomy and other surgical procedures to correct nearsightedness and/or farsightedness. This type of surgery includes keratoplasty and Lasik procedure.

22) For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, or charges for giving information concerning a claim.

23) For abortions, except in the following cases, and only if not otherwise contrary to law:

- **a.** when Medically Necessary to save the life of the mother;
- **b.** when the pregnancy occurs as a result of rape or incest which has been reported to a law-enforcement or public health agency; and
- **c.** when the fetus is believed to have an incapacitating physical deformity or an incapacitating mental deficiency, which is certified by a Physician.

24) Dental treatment except as specifically covered for those enrolled in the routine dental option (see dental/vision coverage described in the insert if you have elected that

coverage). There is an exception if you have Major Medical Dental Services under the Advantage 65 Plan, in which case you have coverage as described in the Major Medical Services section of this handbook. This exclusion also applies to dental treatment required as a result of a medical condition or treatment for a medical condition unless approved by Medicare. However, hospitalization required because of a medical condition which might become life-threatening if you were not hospitalized for the dental procedure is covered under the Major Medical Hospital Services provisions of the Advantage 65 Plan. Dental coverage may be available, if eligible and participating in the dental coverage outlined in a separate insert.

25) Services for vision training, vision therapy, or hearing aids are excluded from coverage except as described in the Major Medical provisions under the Advantage 65 Plan. (See dental/vision coverage described in the insert if you are enrolled in that coverage.)

26) Received through a Medicare Advantage Plan (HMO, PPO, Special Needs, Private Fee-for-Service). Claims paid in error for services covered through Medicare Advantage will be reversed.

BASIC PLAN PROVISIONS

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

These Plans are sponsored by the Commonwealth of Virginia and The Local Choice and are administered by the Department of Human Resource Management. The Department is authorized to, and reserves the right to change or terminate these Plans on behalf of the Commonwealth at any time. These retained rights extend, without limit, to all aspects of the Plans, including, for example, benefits, eligibility for benefits, premiums, copayments and contributions required of Enrollees. The Department is also authorized and empowered to exercise discretion in interpreting the terms of the Plan and such discretionary determination will be binding on all parties.

2) You and Your Provider

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

Similarly, the Claims Administrator is obligated only to pay, in part, for the services of your professional Provider to the extent the services are covered. Neither the Claims Administrator, COVA, nor The Local Choice guarantees the availability of a Provider's services. Neither the Claims Administrator COVA, nor The Local Choice will be responsible for acts or omissions of any Provider. Neither the Claims Administrator, COVA nor The Local Choice will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a Provider. Neither the Claims Administrator, COVA, nor The Local Choice 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 Health Insurance Portability and Accountability Act (HIPAA) and in the Virginia Insurance Information and Privacy Protection Act. A more detailed explanation of the Claims Administrator's information practices is available upon request.

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

By accepting coverage under the Plan, you authorize any individual, association, or firm which has diagnosed or treated your condition to furnish the Claims Administrator with necessary information, records, or copies of records. This authorization extends to any person or organization which has any information or records related to the service received or to the diagnosis and treatment of your condition.

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

Medical information is often highly confidential. You are entitled to review or receive only copies of medical information which applies to you. But, subject to the above, 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 Claims Administrator's right to direct future payments to you or any other individual or facility, even if there has been an assignment of payment in the past. This paragraph will not apply to assignments made to dentists and oral surgeons.

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

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

6) **Prompt Filing of Claims**
Payment of claims secondary to Medicare will be based on timely filing requirements per the provisions of the Patient Protection an Affordable Care Act (PPACA) which requires claims to be filed with the Medicare contractor no later than one Calendar Year (12 months) from the date of service. Claims for services that would be covered by Original

Medicare but which are denied due to late filing are excluded from coverage under this Plan. Claims that are not covered by Original Medicare but are specifically covered under this Plan will be paid if the Claims Administrator receives it no later than 12 months after the end of the Calendar Year in which the services were received.

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

8) **Group Benefits Administrator and Other Plan Information**
Your Group Benefits Administrator (see "Who to Contact for Assistance" section) is the appropriate person to assist you with your health care benefits. Your Group Benefits Administrator may also provide you information about your benefits. If there is a conflict between what your Group 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 handbook. The Group Benefits Administrator is never the agent of the Claims Administrator.

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

9) **Continuation of Coverage – Extended Coverage**
The right to Extended Coverage was created for private employers with 20 or more employees by federal law through the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and these rights are reflected in the continuation coverage provisions of the Public Health Service Act which covers employees of state and local governments. If your group qualifies, Extended Coverage can become available to you or covered family members when coverage would otherwise be lost.

For additional information about your rights and obligations under the Plan and under the law, you should contact your designated Group Benefits Administrator. Local retirees/survivors should contact their pre-retirement Group.

What is Extended Coverage?

Extended Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, Extended Coverage must be offered to each person who is a "qualified beneficiary." In general, as a Retiree Group Enrollee, you, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. These rights are also available to children covered through a Qualified Medical Child Support Order (QMCSO). Under the Plan, qualified beneficiaries who elect Extended Coverage must pay the full cost for Extended Coverage. Time limitations for making Extended

Coverage premium payments will be included in the Election Notice provided at the time of the qualifying event.

For groups with 20 or more employees, if one of the qualifying events listed below resulted in your loss of active employee coverage and enrollment in the retiree group and your retiree group coverage ends prior to the expiration of your initial 18-month Extended Coverage eligibility period, you may utilize any remaining months of that eligibility if you enroll within 60 days of the loss of retiree coverage.
- Your hours of employment were reduced (e.g., long-term disability).
- Your employment ended for any reason other than your gross misconduct.

If you are the spouse of a retiree group Participant, you will become a qualified beneficiary if you lose your coverage under the Plan because of any one of the following:
- Your spouse dies.*
- You become divorced from your spouse.

If you are a covered dependent child of a retiree group Participant, you will become a qualified beneficiary if you lose your coverage under the Plan because of any one of the following qualifying events:
- The parent/retiree group Participant dies
- The parents become divorced, resulting in loss of dependent eligibility;
- The child ceases to be eligible for coverage as a dependent child under the Plan.

*Extended Coverage rights are in addition to any right to survivor benefits which may be available.

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

<u>When is Extended Coverage Available?</u>

Your Group Benefits Administrator will automatically offer Extended Coverage to eligible retiree group qualified beneficiaries upon the death of the Enrollee.

<u>You Must Give Notice of Some Qualifying Events</u>

For the other qualifying events (divorce of the employee and spouse or a dependent child's loss of eligibility for coverage as a dependent child), you or your representative must notify your Benefits Administrator within 60 days of the date coverage would be lost due to the qualifying event by submitting written notification to include the following information:
- The type of qualifying event (e.g., divorce, loss of dependent child's eligibility--including reason for the loss of eligibility);
- The name of the affected qualified beneficiary (e.g., spouse's and/or dependent child's name/s);

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

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

How is Extended Coverage Provided?

Once the designated Group Benefits Administrator becomes aware or is notified that the qualifying event has occurred, Extended Coverage will be offered to each of the qualified beneficiaries. (One notice will cover all qualified beneficiaries living at the same address.) Each qualified beneficiary will have an independent right to elect Extended Coverage. Covered retiree group Participants may elect Extended Coverage on behalf of an eligible spouse, and parents may elect Extended Coverage on behalf of their eligible children.

Extended Coverage is a temporary continuation of coverage. When the qualifying event is the death of the retiree group Participant, divorce, or a dependent child's loss of eligibility as a dependent child, Extended Coverage lasts for up to a total of 36 months.

If You have questions:

Questions regarding Extended Coverage should be directed to your ***Group Benefits Administrator***.

10) Claims Administrator's Continuing Rights

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

11) Time Limits on Legal Actions and Limitation on Damages

No action at law or suit in equity may be brought against the Claims Administrator COVA or The Local Choice in any matter relating to (1) the Plan, (2) the Claims Administrator's performance COVA's performance or The Local Choice's under the Plan; or (3) any statements made by an employee/retiree, officer, or director of the Claims Administrator, COVA or The Local Choice 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 Claims Administrator, COVA, The Local Choice, or any director, officer, or employee of the Claims Administrator, COVA or The Local Choice acting in a capacity as a director, officer, or employee, your damages will be limited to the amount of your claim for covered services. The damages will not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. In no event will this contract be interpreted so that punitive or indirect damages, legal fees, or damages for emotional distress or mental anguish are available.

12) Services After Amendment of This Plan

A change in this Plan will change covered services available to you on the Effective Date of the change. This means that your coverage will change even though you are receiving covered services for an ongoing illness, injury, pregnancy-related condition, or if you may need more services or supplies in the future. However,

- 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.

13) Misrepresentation

An Enrollee's or covered dependent's coverage can be canceled by the Claims Administrator, COVA, or The Local Choice if it finds that any information needed to accept the Enrollee or covered dependent or process a claim was deliberately misrepresented by, or with the knowledge of, the Enrollee or covered dependent. When false or misleading information is discovered, the Claims Administrator, COVA, or The Local Choice may cancel coverage retroactive to the date of misrepresentation.

14) Non-Payment of Monthly Charges

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

15) Death of an Enrollee

Coverage will end for a dependent enrolled with the Enrollee if the Enrollee dies unless continuation of coverage is properly elected and maintained pursuant to Survivor benefits or Extended Coverage/COBRA provisions. Coverage for the dependent will end on the last day of the month in which the death occurs.

16) Divorce

Coverage will end for the enrolled spouse of an Enrollee on the last day of the month in which the final divorce decree is granted unless continuation of coverage is properly elected and maintained pursuant to Extended Coverage/COBRA provisions. Conversion privileges for the spouse will be extended if the spouse notifies the Claims Administrator of the divorce in writing within 31 days after the end of the month in which the divorce is granted or within 31 days of the end of Extended Coverage. Failure to terminate coverage of an ineligible dependent can result in the Enrollee's suspension from the program.

17) End of Dependent Coverage

When a dependent is no longer eligible for coverage, the Group Benefits Administrator must be notified, and coverage will terminate at the end of the month in which the loss of eligibility occurs. Failure to terminate coverage of an ineligible dependent can result in the Enrollee's suspension from the program. Continuation coverage may be elected pursuant to Extended Coverage/COBRA provisions. Conversion privileges for the dependent will be offered if the Claims Administrator 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 program or within 31 days of the end of Extended Coverage. Failure to terminate coverage of an ineligible dependent can result in the Enrollee's suspension from the program.

18) Disclosure of Protected Health Information (PHI) to the Employer

(1) Definitions. Whenever used in this Article, the following terms shall have the respective meanings set forth below.

(a) Plan - means "COVA and Local Health Benefits Programs."
(b) Employer means the “local employer group."
(c) Plan Administration Functions - means administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.
(d) Health Information - means information (whether oral or recorded in any form or medium) that is created or received by a health care Provider, health plan (as defined by the Health Insurance Portability and Accountability Act of 1996, subsequently referred to as HIPAA, in 45 CFR Section 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined by HIPAA in 45 CFR Section 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.
(e) Individually Identifiable Health Information - means Health Information, including demographic information, collected from an individual and created or received by a health care Provider, health plan, employer, or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.
(f) Summary Health Information - means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed: (1) names; (2) geographic information more specific than state; (3) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older); (4) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers; (5) facial photographs or biometric identifiers (e.g., finger prints); and (6) any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.
(g) Protected Health Information ("PHI") means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

(2) The Plan, and the agents acting on its behalf, may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

(3) The Plan, and the agents acting on its behalf, will disclose PHI to the Employer only in accordance with HIPAA in 45 CFR Section 164.504(f) and the provisions of this Section.

(4) The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to the Employer and acknowledges receipt of written certification from the Employer that the Plan has been so amended. Additionally, the Employer agrees:

   (a) not to use or further disclose PHI other than as permitted in Section (4) or as required by law;
   (b) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;
   (c) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;
   (d) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in Section (4);
   (e) to make PHI available to individuals in accordance with HIPAA in 45 CFR Section 164.524;
   (f) to make PHI available for individuals' amendment and incorporate any amendments in accordance with HIPAA in 45 CFR Section 164.526;
   (g) to make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA in 45 CFR Section 164.528;
   (h) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan and its agents available to the Department of Health and Human Services upon request; and
   (i) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.
   (j) to ensure that adequate separation between the Plan and the Employer, as required by HIPAA in 45 CFR Section 164.504(f), is established and maintained.

(5) The Plan will disclose PHI only to the following employees or classes of employees:
   - Director, Department of Human Resource Management
   - Director of Finance, Department of Human Resource Management
   - Staff Members, Office of Health Benefits

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

(6) Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section (5) shall be considered “failure to comply with established written policy” (a Group II offense) and must be addressed under the Commonwealth of Virginia’s Policy 1.60, Standards of Conduct Policy. The appropriate level of disciplinary action will be determined on a case-by-case basis by the agency head or designee, with sanctions up to or including termination depending on the severity of the offense, consistent with Policy 1.60.

(7) A health insurance issuer, HMO or third party administrator providing services to the Plan is not permitted to disclose PHI to the Employer except as would be permitted by the Plan in this Article and only if a notice is maintained and provided as required by HIPAA in 45 CFR Section 164.520.

DEFINITIONS

Throughout this handbook 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. Since Medicare is primary under these Plans (except where a non-Medicare-covered service is specifically covered), Medicare's definition of terms would apply to Medicare-covered services.

1) **Allowable Charge**
   For care by a Physician or other health care professional which is not covered by Medicare, the Allowable Charge is the lesser of the Claims Administrator's allowance for that service, or the Provider's charge for that service.

   For Hospital services not covered by Medicare, the Allowable Charge is the Claims Administrator's negotiated compensation to the facility for the covered service, or the facility's charge for that service, whichever is less.

   For other services that are not covered by Medicare which are not considered Provider or facility services, the Allowable Charge is the amount the Claims Administrator determines to be reasonable for the services rendered. Medicare's Allowable Charge is Medicare's allowance for a covered service.

2) **At-Home Recovery Visit**
   This means the period of a visit required to provide At-Home Recovery Care, without limit on the duration of the visit except as provided in Special Limits.

3) **Benefit Period**
   See Major Medical Benefit Period or Medicare Benefit Period.

4) **Calendar Year**
   This is the period beginning January 1 and ending on the following December 31.This is also the Major Medical Benefit Period.

5) **Claims Administrator**
   The administrator who adjudicates and processes claims. The Claims Administrator is indicated in the "Who To Contact For Assistance" section of this Member Handbook and its associated inserts, as applicable to your coverage.

6) **Covered Facility**
   This means an institution in which, or through which, you receive covered services. Covered Facilities under this Plan are:
   - Hospitals
   - Skilled Nursing Facilities

7) **COVA**
   This means the Commonwealth of Virginia.

8) Days of Inpatient Care

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

- the day you are admitted, if applicable, is subtracted.
- each day, up to the day of discharge, is subtracted.
- the day you are discharged is not subtracted.

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

9) Diagnostic Services

This means the following procedures when ordered by your doctor to diagnose a definite condition or disease because of specific signs and/or symptoms, including:

- laboratory and pathology services or tests;
- diagnostic EKGs, EEGs;
- radiology (including mammograms), ultrasound or nuclear medicine; and
- sleep studies.

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

10) Effective Date

This is the date coverage begins for you and/or your dependents enrolled under the health plan.

11) Emergency Services

These are Medically Necessary services provided to you in response to a sudden and acute illness or injury which, if left untreated, would result in death or severe physical or mental impairment.

12) Enrollee

This word means the person who applies for coverage in this Plan and through whom dependent coverage is obtained.

13) Experimental/Investigative

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

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular indication or application in question. Moreover, quantities of any drug or medication that could be covered under this medical coverage 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.

a) 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 three standard reference compendia defined below:

1) the U.S. Pharmacopoeia dispensing Information;
2) the American Medical Association Drug Evaluations; or
3) the American Hospital Formulary Service Drug Information; or

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

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

Despite the above 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.

2. There must be enough information in the peer-reviewed medical and scientific literature to let the Claims Administrator judge the safety and efficacy;
3. The available scientific evidence must show a good effect on health outcomes outside a research setting; and
4. 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 Plan Administrator determines that any one of the four criteria is not met.

14) Group 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.

15) 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 Nurses (R.N.s). Except in unusual cases approved in advance by the Claims Administrator, 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.

16) 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.

17) Major Medical Benefit Period (Advantage 65 Only)

This is a Calendar Year. It can also mean a part of a Calendar Year if your Effective Date is other than January 1 or if your enrollment ends other than on December 31. Your first Major Medical Benefit Period extends from your Effective Date to the next December 31. If your coverage is terminated for any reason, your Major Medical Benefit Period will end on the same day your enrollment ends.

18) Medically Necessary

To be considered Medically Necessary, a service must:

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

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

19) 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.

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

The Original Medicare plan has two parts. One part is called Hospital Insurance. This is Part A. Medical Insurance is Part B. Also, beginning January 1, 2006, Medicare Part D, the Medicare prescription drug benefit, became available to Medicare beneficiaries. See the Medicare handbook, published each year by the federal government, for more information about Medicare. You must have both Parts A and B of Medicare to receive maximum benefits under these plans. The Medicare supplemental plans do not cover outpatient prescription drugs.

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

22) Medicare Benefit Period
This means a period of time Medicare uses to measure Hospital or Skilled Nursing Facility services. It starts when you are admitted to a Covered Facility and ends when you have not been an Inpatient in any Covered Facility for 60 days in a row.

23) Medicare Lifetime Reserve Days
These are the extra Medicare Part A Hospital days you have left after you have used all of your regular Medicare Part A Hospital days.

24) 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.

25) 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.

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

27) Participating and Non-Participating Hospitals
A Participating Hospital is a Hospital listed as "participating" by the Claims Administrator. The Hospital must be listed as such at the time you receive the service for which coverage is sought. Any other Hospital is a Non-Participating Hospital. The Claims Administrator may, at its sole option, name one or more Non-Participating Hospitals as

ones in which you will receive covered services as if you were in a Participating Hospital. There is one difference. Payment will be made directly to the Enrollee or, at the Claims Administrator's sole option, any other person responsible for paying the Non-Participating Hospital's charge.

28) Participating and Non-Participating Providers
A Participating Provider is a Provider who is listed as a "Participating Provider" by the Claims Administrator. The Provider must be listed as such at the time you receive the service for which coverage is sought. A Participating Provider will accept the Claims Administrator's Allowable Charge for Major Medical Services not covered by Medicare. A Non-Participating Provider means any other Provider including a Provider who participates with another Blue Shield plan. A Non-Participating Provider has not agreed to accept the Claims Administrator's Allowable Charge as payment in full for Major Medical Provider Services rendered. This means that you are responsible for any difference between the Claims Administrator's Allowable Charge and the Non-Participating Provider's charge.

29) Physician
A Physician is a properly licensed Doctor of Medicine.

30) Plan
Plan, in this handbook, means the **Advantage 65, Advantage 65 with Dental/Vision** or the **Medicare Complementary/Option I** Plan.

31) 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. Enrollment in any of The Local Choice's Medicare-Coordinating Plans (Advantage 65or Medicare Complementary/Option I) indicates Medicare is primary for all Medicare-covered services.

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

33) 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 Claims Administrator will not pay a supervisory or other fee for the same service rendered by both the Provider and the Provider's Employee.

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

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

36) 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.

37) The Local Choice Group
This means the local employer participating in The Local Choice Health Benefits Program.

38) The Local Choice Health Benefits Program or The Local Choice
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 designated by the General Assembly or created by or under an act of the General Assembly.

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

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

c. 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.

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

e. **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.

f. **Respiratory Therapy**
This is treatment using the introduction of dry or moist gases into the lungs to treat 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.

ELIGIBILITY

This section explains availability of coverage for eligible The Local Choice retirees, their eligible family members and Survivors of retirees. Eligibility for the Plans described in this handbook requires eligibility for Medicare. Medicare will be the primary payer for retirees age 65 or older (or those who are otherwise eligible for Medicare). The Program's plans will serve as a complement to Medicare's coverage for such retirees.

Eligibility for The Local Choice Retiree Health Benefits Program requires that:

- The Local Choice Employer offer retiree coverage, **and**
- You must meet your employer's criteria for retirement. In addition, you must be at least 55 years of age, have at least five (5) years of service with the participating employer or be at least 50 years of age, have at least ten (10) years of service with the participating employer, **or** receive determination of disability from the Virginia Retirement System or the Social Security Administration, or another group long term disability provider **and**
- Your last employer before retirement was a The Local Choice Employer, **and**
- You were eligible for coverage as an active employee in The Local Choice Health Benefits Program until your retirement date (not including Extended Coverage), **and**
- Within 31 days of your retirement date, you submit an Enrollment Form to your Group Benefits Administrator to enroll.

OR

- You are an eligible participating survivor of a participating The Local Choice retiree, **and**
- Within 60 days of the retiree's death, you submit an Enrollment Form to your Group Benefits Administrator to enroll in the retiree group.

The Following Covered Family Members May Be Eligible for Coverage Under Your Health Plan

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

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

Natural children
Adopted children, and children placed for adoption

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

Incapacitated children
Adult children who are incapacitated due to a physical or mental health condition, as long as the child was covered by the health Plan and the incapacitation existed prior to the termination of coverage due to the child attaining the health Plan's Limiting Age. The retiree

must make written application, along with proof of incapacitation, prior to the child reaching the health Plan's Limiting Age. Such extension of coverage must be approved by the health Plan and is subject to periodic review. Should your health Plan find that the child no longer meets the criteria for coverage as an incapacitated child, the child's coverage will be terminated at the end of the month following notification from your health Plan to the Enrollee. The child must live with the retiree as a member of the retiree's household, be unmarried, and be dependent upon the retiree for financial support. In the cases where the natural or adoptive parents are living apart, living with the other parent will satisfy the condition of living with the retiree. Furthermore, the support test is met if either the retiree or other parent or combination of the retiree and other parent provide over one-half of the child's financial support.

Other Children

An unmarried child for whom a court has ordered the retiree (and/or the retiree's legal spouse) to assume sole permanent custody may be eligible. Eligibility requires that the principal place of residence must be with the retiree, the child must be a member of the retiree's household, the child must receive over one-half of his or her support from the retiree, and the custody was awarded prior to the child's 18th birthday.

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

When the minor child, who is the parent of the other child, reaches age 18, the retiree must obtain sole permanent custody of the other child and provide this documentation to the Group Benefits Administrator if coverage is to be continued.

When a child loses eligibility, coverage terminates at the end of the month in which the event that causes the loss of eligibility occurs. There are certain categories of persons who may not be covered as dependents under the program. These include dependent siblings, grandchildren, nieces, and nephews except where the criteria for "other children" are satisfied. Parents, grandparents, aunts and uncles are not eligible for coverage regardless of dependency status.

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

Enrollment and Plan or Membership Changes

- New Retiree Group Enrollees and Dependents: Coverage for eligible new retiree group Enrollees and their eligible dependents is effective the first of the month following the date that active employment ends if enrollment is completed within the required time limits. New Survivors will be covered the first of the month after the eligible Enrollee's death or loss of active coverage. The only Medicare-coordinating Plans that are available to new Medicare-eligible Enrollees or dependents (or existing Enrollees and dependents who become eligible for Medicare) is the Advantage 65 Plan. Medicare

Complementary/Option I is only available to members of groups already offering Medicare Complementary/Option I.

- Making Changes: Membership changes generally may be made the first of the month following receipt of an Enrollment Form when there is a consistent qualifying midyear event that would allow such a change, or as outlined in the policies and procedures of the Department of Human Resource Management. However, notification must be received within 31 days of the event. Membership changes due to the birth, adoption, or placement for adoption of a child will be made on the first day of the month in which the event occurs, as long as notice is given within 31 days of the event. Dependents that lose eligibility in the Plan will cease to be covered at the end of the month in which the loss-of-eligibility event takes place, regardless of the date of notification. Retiree group Enrollees may reduce membership or cancel coverage prospectively at any time, but retirees or survivors who cancel coverage may not re-enroll in the future.

  Limited Plan changes may be made prospectively by retiree group Enrollees based on the policies of the Department of Human Resource Management.

- Termination of Coverage: Coverage terminates on the last day of the month in which a Participant loses eligibility based on the policies and procedures of the Department of Human Resource Management or an Enrollee requests termination of coverage.

  Eligible dependent children of a retiree group Enrollee may be covered through the end of the year in which the child turns age 26 as long as the child remains otherwise eligible (see above).

  An eligible surviving spouse may continue coverage until death, remarriage, alternate health coverage is obtained, or the spouse otherwise ceases to be eligible based on the policies and procedures of the Department of Human Resources Management.

THE LOCAL CHOICE HEALTH BENEFITS PROGRAMS APPEAL FORM

Persons enrolled in TLC statewide plans may use this form to appeal to the Director of the Department of Human Resource Management (DHRM) regarding a denied claim regardless of the TLC plan in which the appellant is enrolled. ***To be considered a valid appeal, the Director must receive it within four (4) months of the final adverse decision of the Plan Administrator.***

NOTE: Matters in which the sole issue is disagreement with policies, rules, regulations, contract or law cannot be appealed to DHRM. The decision of the Plan Administrator is final in these cases.

Employer ____
Your Name ______________________ **Patient Name** ______________________
Name of Enrolled Employee ______________________ **Member ID #** ______________________
Address ____
City ______________________ **State** __________ **Zip** ______________
Home Phone (__) ______________________ **Business Phone** (__) ______________________
Service or Supply requested ______________________ **Date of Service** ______________
Name of Physician, Hospital, or Other Health Care Provider ______________________

CHECK ONE OR MORE OF THE FOLLOWING REASONS FOR THE APPEAL:

□ Believe the claim was for a covered service and should not be denied for payment.
□ Believe a service met the health Plan's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of a covered service, though denied, reduced or terminated.
□ Believe a service was medically necessary, though denied as experimental/investigational.

PLEASE DESCRIBE THE REASON(S) YOU ARE FILING THIS APPEAL:

____
____
____

WHAT SPECIFIC REMEDY DO YOU SEEK IN FILING THIS APPEAL?

____
____

DOES THIS QUALIFY FOR AN EXPEDITED APPEAL (please refer to your Member Handbook) AND ARE YOU REQUESTING AN EXPEDITED APPEAL? □ Yes or □ No

PLEASE ATTACH DOCUMENTS RELEVANT TO YOUR APPEAL. For example: Explanation of claims processed, other correspondence from plan, letter from your physician, bill from your health care provider, the plan administrator's final denial, or any other information you want considered. Are documents attached? □ Yes or □ No

APPEALS TO THE DIRECTOR OF THE DEPARTMENT OF HUMAN RESOURCE MANAGEMENT should be addressed as follows:

Director, Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, Virginia 23219-3657
Please mark the envelope **Confidential – Appeal Enclosed**

MEMBER'S SIGNATURE ______________________ **DATE** ______________

This form should be signed by the Member. If this form is signed by anyone other than the Member, please list an Authorized Representative below. An Authorized Representative should only be named if the member wishes to appoint someone to represent them during the appeals process.
NAME OF AUTHORIZED REPRESENTATIVE: ______________________

NOTE: For appeals related to **medical or mental health and substance abuse claims**, you must submit the following completed **HIPAA Authorization Form** to DHRM before the appeal can be processed. The form is also available on the TLC Website at **http://www.thelocalchoice.virginia.gov/policiesandproc/hipaa/hipaaauthorization.pdf** or from your Group Benefits Administrator.

Health Benefits Plan for State and Local Employees
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

EMPLOYEE/RETIREE
Name: ____ID Number: _________________________________
MEMBER
Name: ____________________________________ID Number: _____________________________________
Date of Birth: ___________________

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:
____
____

WHO IS AUTHORIZED TO USE OR DISCLOSE THE INFORMATION?
____
____

WHO IS AUTHORIZED TO RECEIVE THE INFORMATION?
____
____

REASON THE INFORMATION WILL BE USED OR DISCLOSED [if the member initiates the authorization, the statement "at the request of the individual" is sufficient]:
____
____

EXPIRATION DATE OR EVENT: ____ _______

Notice to Member

You may revoke this authorization at any time. To revoke this authorization, send a written statement to the Office of Health Benefits, 12th Floor, Privacy Official, 101 N. Fourteenth St., Richmond VA 23219. The statement must identify this authorization by referring to the date it was signed (below). The statement must include the date on which this authorization is no longer in force.

If you revoke this authorization, we may still use and disclose the information for the purposes listed above, if we have already taken action in reliance on this authorization. Also, if this authorization is to permit disclosure of information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest a claim or to contest your coverage.

You may refuse to sign this authorization. You do not need to sign this authorization to receive health care services.

You do not have to sign this authorization to receive payment, to enroll in Health Benefits Plan for State and Local Employees' health benefit plan, or to be eligible for benefits, except:

If this authorization is sought is for the purpose of determining your eligibility for benefits or enrollment, then you must authorize the Plan to obtain the necessary information or the benefits or enrollment may be denied.

Under Federal law, you do not have to authorize us to receive the private notes from counseling sessions, that are kept by a mental health professional, as a condition of payment, enrollment in a employee health benefit plan, or eligibility for benefits.

A person or organization that receives your information because of this authorization may have the legal right to disclose this information to other people or organizations without your knowledge or consent.

Signature: ____**Date:** __________________________

If this authorization is signed by someone who is not the member listed at the top of this form, provide a description of the signer's authority to act for the member. _____________________________________
____

A
Allowable Charge (AC), 5, definition – 42
Ambulance Services, 19, 25
Anesthesia Services, 19, 25
Appeals, 9
At-Home Recovery, 23, definition – 42

B
Basic Plan Provisions, 33
Benefit Period, (Medicare) 19, 20, 21,
definition - 42;
(Major Medical) definition – 45
Benefits Administrator, 35

C
Care Provider, 23
Chemotherapy, definition – 48
Claims, Prompt Filing of, 34
Continuation of Coverage, 35
Convalescent Care, exclusion – 31
Coordination of Benefits, 15

D
Deductible, 20, 22, 28
Definitions, 42
Dental/Vision Services, 29
(also see Dental/Vision Insert)
Diagnostic Services, 25, definition – 43

E
Effective Date, definition – 43
Eligibility, 50
Emergency Services, 26, definition – 43
Enrollee, 38, definition – 43
Enrollment, 51
Exclusions, 30
Experimental/Investigative, exclusion – 31,
definition – 43
Extended Coverage, 35

G
General Rules Governing Benefits, 8

H
Health Benefit Plan, 15, definition - 44
Hearing Aids, exclusion - 31
Home Health Care Services, 23
Hospital, Participating and Non-
Participating, definition – 46
Hospital Services, 19

I
Inhalation Therapy, definition – 48
Inpatient, definition - 45
Institutional Services, 19

M
Major Medical Services, 25
Medically Necessary, 8, definition – 45
Medically Skilled Services, 27,
definition – 46
Medicare, definition – 46
Medicare-Approved Charges,
definition – 46
Medicare Benefit Period, definition – 46
Medicare Lifetime Reserve Days,
definition - 46

N
Notice from the Claims Administrator to
you and you to the Claims
Administrator, 17

O
Occupational Therapy, definition – 48
Out-of-Pocket Expenses, 28,
definition – 46
Outpatient, definition – 46
Outpatient Hospital, 25

P
Participant, definition – 46
Payment Errors, 35
Physical Therapy, definition – 48
Physician, definition – 47
Plan, definition – 47
Primary Coverage, 15, definition – 47
Privacy Protection, 33
Professional Services, 22
Proof of Loss, 34
Provider, 33, definition – 47
Provider's Employee, definition – 47

Q
Qualified Beneficiary, 35
Qualifying Event, 36

R
Radiation Therapy, definition – 49
Respiratory Therapy, definition – 49

S
Secondary Coverage, 15, definition – 48
Semi Private Room, 19, 25, definition – 48
Skilled Nursing Facility, 21, definition – 48
Speech Therapy, definition – 49

T
Termination of Coverage, 52
Therapy Services, definition – 48

W
When Benefits Start and End, 8

T20734 (01/11)