

# Medicare Coordinating Plans Member Handbook

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*The Local Choice  
Commonwealth of Virginia  
Department of Human Resource Management*



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## 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) constitute 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.**



## **USING YOUR 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 or Medicare Complementary/Option I.**

### **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. However, doctors who do not accept assignment may not charge Medicare beneficiaries any more than 15% above the Medicare Allowable Charge.

### **Filing Claims**

In most instances, Medicare participating providers will file claims for Your Secondary Coverage. 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 Plan Administrator with Your claim.

## COMPARISON 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.

<b>Part A Services Medicare</b>	
<b>Hospital Inpatient</b>	<ul style="list-style-type: none"> <li>• Pays up to 60 days of Medically Necessary services, except Part A Hospital deductible</li> <li>• Pays up to an additional 30 days, except daily coinsurance</li> <li>• If more than a 90-day Hospital stay, possible use of up to 60 Medicare Lifetime Reserve Days, subject to daily coinsurance</li> <li>• No payment for more than a 90-day Hospital stay if no Lifetime Reserve Days remain or if You choose not to use them</li> </ul>
<b>Skilled Nursing Facility</b>	<ul style="list-style-type: none"> <li>• Pays 100% for 20 days at a Medically Necessary Skilled Nursing Facility</li> <li>• Pays up to an additional 80 days at a Skilled Nursing Facility, except daily coinsurance</li> <li>• Medicare does not pay for more than 100 days at a Skilled Nursing Facility in a Benefit Period</li> </ul>
<b>Part B services</b>	
<b>Physician And Other Services</b>	<ul style="list-style-type: none"> <li>• Generally pays 80% of Medicare-Approved Charges for services such as: - Doctor's care, Outpatient physical and Occupational Therapy and designated screenings</li> <li>• An annual deductible may apply</li> </ul>
<b>Part D services</b>	
<b>Prescription Drug Coverage</b>	<ul style="list-style-type: none"> <li>• Pays a benefit based on the specific Part D Plan in which the beneficiary is enrolled</li> </ul>
<b>Other Services</b>	
<b>Routine Vision Benefits</b>	<ul style="list-style-type: none"> <li>• Not covered</li> </ul>
<b>Routine Dental Benefits</b>	<ul style="list-style-type: none"> <li>• Not covered</li> </ul>
<b>Out-of-Country And Major Medical Services</b>	<ul style="list-style-type: none"> <li>• Not covered</li> </ul>
<b>At Home Recovery Care And Visits</b>	<ul style="list-style-type: none"> <li>• Not covered</li> </ul>



## COMPARISON OF MEDICARE AND THE LOCAL CHOICE MEDICARE COORDINATING PLANS

<b>Part A Services                      The Local Choice Advantage 65</b>	
<b>Hospital Inpatient</b>	<ul style="list-style-type: none"> <li>• Pays Medicare Part A deductible except for first \$100</li> <li>• Pays Medicare Part A coinsurance</li> <li>• Pays 100% of the Allowable Charge for an additional 30 days</li> </ul>
<b>Skilled Nursing Facility</b>	<ul style="list-style-type: none"> <li>• Pays Medicare Part A coinsurance (days 21-100)</li> <li>• Pays above coinsurance amount for an additional 80 days per Medicare Benefit Period</li> </ul>
<b>Part B services</b>	
<b>Physician And Other Services</b>	<ul style="list-style-type: none"> <li>• Does not pay Medicare Part B deductible, but does pay Part B coinsurance</li> </ul>
<b>Part D services</b>	
<b>Prescription Drug Coverage</b>	Outpatient prescription drugs are not covered by The Local Choice Advantage 65 plan.
<b>Other Services</b>	
<b>Routine Vision Benefits</b>	<ul style="list-style-type: none"> <li>• See insert if You are enrolled in this plan.</li> </ul>
<b>Routine Dental Benefits</b>	<ul style="list-style-type: none"> <li>• See insert if You are enrolled in this plan.</li> </ul>
<b>Out-of-Country And Major Medical Services</b>	<p><b>For Out-of-Country services only:</b></p> <ul style="list-style-type: none"> <li>• Pays 80% of Allowable Charge after You pay \$250 Calendar Year deductible</li> </ul>
<b>At Home Recovery Care And Visits</b>	<ul style="list-style-type: none"> <li>• Pays up to \$40 per visit, not to exceed \$1,600 each Calendar Year and 7 visits each week</li> </ul>

**COMPARISON OF MEDICARE AND  
THE LOCAL CHOICE  
MEDICARE COORDINATING PLANS  
NOT AVAILABLE TO NEW ENROLLEES**

<b>Part A Services      The Local Choice Medicare Complementary/Option I</b>	
<b>Hospital Inpatient</b>	<ul style="list-style-type: none"> <li>• Pays Medicare Part A deductible except for first \$100</li> <li>• Pays Medicare Part A coinsurance</li> <li>• Pays 100% of the Allowable Charge for an additional 30 days</li> </ul>
<b>Skilled Nursing Facility</b>	<ul style="list-style-type: none"> <li>• Pays Medicare Part A coinsurance (days 21-100)</li> <li>• Pays above coinsurance amount for an additional 80 days per Medicare Benefit Period</li> </ul>
<b>Part B Services</b>	
<b>Physician and Other Services</b>	<ul style="list-style-type: none"> <li>• Pays Medicare Part B coinsurance after You pay the \$1,000 calendar year deductible, which includes the Part B deductible.</li> </ul>
<b>Part D Services</b>	
<b>Prescription Drug Coverage</b>	Outpatient prescription drugs are not covered by The Local Choice Medicare Complementary plan.
<b>Other Services</b>	
<b>Routine Vision Benefits</b>	<ul style="list-style-type: none"> <li>• See insert if You are enrolled in this Plan</li> </ul>
<b>Routine Dental Benefits</b>	<ul style="list-style-type: none"> <li>• See insert if You are enrolled in this Plan</li> </ul>
<b>Out-of-Country and Major Medical Services</b>	<ul style="list-style-type: none"> <li>• Not covered</li> </ul>
<b>At Home Recovery Care and Visits</b>	<ul style="list-style-type: none"> <li>• Not covered</li> </ul>

## WHO TO CONTACT FOR ASSISTANCE

### Medical Coverage Plan Administrator

#### Anthem Blue Cross and Blue Shield

Member Services	800-552-2682
Web Address	<a href="http://www.anthem.com/tlc">www.anthem.com/tlc</a> Select "Medicare Retirees" under the Plan Information tab.
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

#### The Local Choice Health Benefits Program

Web Address	<a href="http://www.thelocalchoice.virginia.gov">www.thelocalchoice.virginia.gov</a>
E-Mail	<a href="mailto:tlc@dhrm.virginia.gov">tlc@dhrm.virginia.gov</a>

## 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) **Services Must Be Medically Necessary**

Benefits will be denied if the Plan Administrator determines, in its sole discretion, that care is not Medically Necessary. Medicare adjudicates medical necessity when Medicare is the primary payer.

### 4) **When Benefits End**

Benefits will not be provided for charges You incur after Your coverage ends. There is one exception. If You are an Inpatient on the day Your enrollment ends, the services to which You would have been entitled under the 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.

### 5) **Defining Services**

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

### 6) **Payment To Participating Providers**

For services covered under these plans but not covered by Medicare, the Plan Administrator pays the Allowable Charge which remains after Your copayment, coinsurance or deductible.

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

### 7) **Non-Participating Provider Payments**

When a Participant receives services from a Non-Participating Provider for services not covered by Medicare, the Plan Administrator may choose to make payment directly to the Enrollee or, at the Plan Administrator's sole option, to any other person responsible

for payment of the Provider's charge. Payment will be made only after the Plan Administrator has received an itemized bill and the medical information the Plan Administrator decides is necessary to process the claim. The Enrollee will also be responsible for the difference between the Plan's allowance and the Provider's charge. Payment by the Plan Administrator will relieve it and the Plan of any further liability for the Non-Participating Provider's services.

## 8) Appeals

### **Complaint and Appeal Process (not including complaints or appeals regarding Medicare benefits)**

You have access to both a complaint process and an appeal process. Should You have a problem or question about Your Plan, the Plan Administrator's Member Services Department will assist You. Most problems and questions can be handled in this manner. You may also file a written complaint or appeal. Complaints typically involve issues such as dissatisfaction about Your Plan's services, quality of care, the choice of and accessibility to Your Plan's Providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by Your Plan. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

#### **Complaint Process**

Upon receipt, Your complaint will be reviewed and investigated. You will receive a response within 30 calendar days of receipt of Your complaint. If we are unable to resolve Your complaint in 30 calendar days, You will be notified on or before calendar day 30 that more time is required to resolve Your complaint. We will then respond to You within an additional 30 calendar days.

**Important:** Written complaints or any questions concerning Your coverage, excluding those regarding Medicare benefits, may be filed at the address shown in the "Who to Contact for Assistance" section of this handbook and applicable insert.

#### **Appeal Process**

Your 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 appeals:

- Plan Administrator appeals are requests to reconsider coverage decisions of pre-service or post-service claims. A separate expedited emergency appeals procedure is available to provide resolution within one business day of the receipt of a complaint or appeal concerning situations requiring immediate medical care. All appeals to the Plan Administrator must be exhausted before an appeal can be made to the Department of Human Resource Management (DHRM).

- After Plan Administrator appeals are exhausted, You may request of DHRM an appeal process that includes an impartial clinical review by an independent, external reviewer of the final coverage decision made by the Plan Administrator. Additionally, other Plan related issues may be appealed to DHRM. More information about this appeal may be found in the **Final DHRM Appeal Process** of this section.

### **How to appeal a coverage decision**

To appeal a coverage decision, please send a written explanation to the Plan Administrator's address of why You feel the coverage decision was incorrect. Alternatively, the Plan Administrator will accept a verbal request for appeal by calling a Member Services representative. You may provide any comments, documents or information that You feel the Plan Administrator should consider when reviewing Your appeal. Please include with the explanation:

- the patient's name, address and telephone number;
- Your identification and group number (as shown on Your identification card); and
- the name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge.

### **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 coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing Your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as one who typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

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

- for pre-service claims, the Plan Administrator will respond in writing within 30 days after receipt of the request to appeal;
- for post-service claims, the Plan Administrator will respond in writing within 60 days after receipt of the request to appeal; or
- for expedited emergency appeals, the Plan Administrator will respond orally within one working day after receipt from the member or treating Provider of the request to appeal, and will then provide written confirmation of its decision to the member and treating Provider within 24 hours thereafter. In no event will the notification be provided later than 72 hours after receipt of the request to appeal.

When the review of Your appeal by the Plan Administrator has been completed, You will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the Plan provision(s) on which the determination is based. You will also be entitled to receive, upon request and at no charge, the following:

- reasonable access to, and copies of, all documents, records, and other information relevant to the appeal
- any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- the explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- the identification of medical or vocational experts whose advice was obtained by the Plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

### **Final DHRM Appeal Process**

The Department of Human Resource Management does not accept claim appeals for:

- specific coverage exclusions listed in this handbook. However, denials of claims or coverage for services involving medical necessity (e.g., Experimental/Investigational procedures) can be appealed;
- matters in which the sole issue is disagreement with policies, rules, regulations, contract or law;
- amounts above the Allowable Charge which are billed by a Non-Participating Provider when the Allowable Charge has already been paid,
- claims amounts or service denials when the member's cost is less than \$300; or
- Medicare payments or claim denials.

In these cases, the Plan Administrator's or Medicare's decision is final.

Except as listed above, to further appeal the final coverage decision made by Your Plan through its internal appeal process, You must submit to the Director of the Commonwealth of Virginia, Department of Human Resource Management, in writing within 60 days of Your Plan's denial, the following:

- Your full name;
- Your identification number;
- the date of the service;
- the name of the Provider for whose services payment was denied; and
- the reason You think the claim should be paid.

You are responsible for providing DHRM with all information necessary to review the denial of Your claim. The Department will ask You to submit any additional information You wish to have considered in this review, and will give You the opportunity to explain, in person or by telephone, why You think the claim should be paid. Claims denied due to such things as policy or eligibility issues will be reviewed by the director of DHRM.

Claims denied because the treatment provided was considered not Medically Necessary will be referred to an independent medical review organization.

For issues of Medical Necessity, the medical review organization will examine the final denial of claims or treatment authorizations to determine whether the decision is objective, clinically valid, and comparable with established principles of health care. The decision of the medical review organization will:

- be in writing;
- contain findings of fact as to the material issues in the case and the basis for those findings; and
- be final and binding if consistent with law and policy.

With all plan-related appeals to DHRM, if after review, the denial is upheld, that denial is final.

Beyond any final denial, You may appeal that determination as per the provisions of the Administrative Process Act within 30 days of the final DHRM determination.

You may download an external appeals form at [www.thelocalchoice.virginia.gov](http://www.thelocalchoice.virginia.gov).

## **9) 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 Plan 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 these The Local Choice Medicare-coordinating Plans but are not covered by Medicare (including, but not limited to, major medical benefits under the Medicare Complementary/Option I, 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 these The Local Choice Medicare-coordinating Plans but not covered by Medicare, the primary payer.

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

- (1)** The Health Benefit Plan which lists the person receiving services as the Enrollee, insured or policyholder, not as a dependent, will provide benefits first. There is one exception. If the person is also entitled to Medicare, and as a result of federal law Medicare is (1) secondary to the Health Benefit Plan covering the person as a dependent; and (2) primary to the Health Benefit Plan covering the person as other than a Dependent (e.g., a retired Employee), then the benefits of the Health Benefit Plan covering the person as a Dependent are determined before those of the Health Benefit Plan covering the person as other than a Dependent.



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

- E. When a Health Benefit Plan provides benefits in the form of services, a reasonable cash value will be assigned to each Covered Service. This cash value will be considered a "benefit payment."
- F. At the option of the Plan Administrator, payments may be made to anyone who paid for the coordinated services You received. These benefit payments by the Plan 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 Plan Administrator will satisfy the obligation to provide benefits for covered services.
- G. If the Plan Administrator provided Primary Coverage and discovers later that it should have provided Secondary Coverage, the Plan 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 Plan Administrator in exercising its right of recovery.
- H. You are obligated to supply the Plan 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 Plan 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.

**10) Notice From The Plan Administrator To You**

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

**11) Notice From You To The Plan Administrator**

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

**12) 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.

## **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 Plan Administrator for Inpatient services beyond the 90-day Medicare Benefit Period (or Lifetime Reserve Days).

#### **Special Limits**

- 1) You are limited to 120 Days of Inpatient Care in a Hospital per Medicare Benefit Period (90 Medicare days plus 30 days under Your Plan).
- 2) You are limited to 60 additional Days of Inpatient Care in a Hospital under Medicare during Your lifetime.
- 3) You are entitled to 190 Days of Inpatient Care in a Hospital designated by Medicare as a psychiatric hospital during Your lifetime.

- 4) 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 Plan 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 91-120 for services and supplies listed in item 2 of Services Which Are Eligible for Reimbursement in this section.
- the Medicare Part A coinsurance for 60 additional Days of Inpatient Care in a Hospital during Your lifetime.
- 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.

## **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 Plan 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 Plan Administrator pays the Medicare Part A coinsurance for days 21-100 in a Skilled Nursing Facility per Medicare Benefit Period.
- 3) The Plan 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.
- 2) Other services:
  - rental of a wheel chair, iron lung, or other durable equipment used for medical treatment;
  - professional ambulance service used locally to or from the Hospital for Inpatient services and for Outpatient treatment of accidental injury;
  - orthopedic braces, crutches, and prosthetic appliances such as artificial limbs and eyes (This includes replacement, repair, or adjustment of prosthetic appliances. It does not include corrective shoes.);
  - hospital Outpatient services which are not covered under Medicare Part A but are covered under Medicare Part B.
- 3) Diabetic Equipment (and education)
  - insulin pumps
  - home glucose blood monitors
  - blood glucose test strips
  - outpatient education

### Conditions for Reimbursement

- 1) Services must be:
  - approved by Medicare for all Medicare-covered services;
  - performed or prescribed by a Provider licensed to do so; and
  - determined to be Medically Necessary by the Plan Administrator for services or supplies covered under these Plans but not covered by Medicare.

### 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 Plan Administrator pays the Medicare Part B coinsurance.

**Medicare Complementary/Option I** - The Plan 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 Plan 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) 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 Plan 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

The following services are covered when they are received out of the country only. This benefit applies to the Advantage 65 Plan 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, or a certified inhalation therapist.
- 7) Dental services (non-routine). Your Plan also provides coverage for the following non-routine dental services through the Plan Administrator medical benefits. The covered services listed below are subject to the Major Medical Services Calendar Year Deductible and Out-of-Pocket Expense Limit:
  - 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 condition

- 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 Plan Administrator as having services adequate to treat Your condition;
  - the services You receive in that facility or Provider's office must be covered services; and
  - if the Plan Administrator requests it, the attending Provider must explain why You could not have been transported in a private car or by any other less expensive means.

### **Special Limits**

- 1) The Major Medical Services discussed in this section are not eligible for reimbursement if the same service is available under some other section of this handbook. The Plan Administrator will pay only once for a service and will not increase or extend benefits available under other sections of this contract.
- 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 Plan Administrator will not pay for any other equipment which has both a non-therapeutic and therapeutic use. The Plan Administrator will pay for the least expensive item of equipment required by Your medical condition. If the Plan Administrator determines that purchase of the durable medical equipment is less expensive than rental, or if the equipment cannot be rented, the Plan Administrator may approve the purchase as a covered service. If the equipment cannot be rented, the Plan 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 Plan 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 Plan Administrator will annually reinstate the amount the Plan 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 Plan 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 Plan 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 are enrolled in 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 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 You enrolled in the dental/vision coverage benefit).
- 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 Plan 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 Plan 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 Plan 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.
- 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, including care for the teeth and their supporting tissues including services for temporomandibular joint dysfunction, periodontal care, prosthodontal care, orthodontic care, and other forms of dental care, including dental x-ray of the teeth (see dental/vision coverage described in the insert if You are enrolled in 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.
- 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 Medicare Advantage (HMO, PPO, Special Needs, Private Fee-for-Service).

## **BASIC PLAN PROVISIONS**

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

These Plans are sponsored by the Commonwealth of Virginia and administered by the Department of Human Resource Management. The Department is authorized to, and reserves the right to change or terminate 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 Plan Administrator, the State, nor The Local Choice guarantees admission or the availability of any specific type of room or kind of service. Neither the Plan Administrator, the State, nor The Local Choice will be responsible for acts or omissions of any facility. Neither the Plan Administrator, the State, 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 Plan Administrator, the State, nor The Local Choice will be liable for breach of contract because of anything done, or not done, by a facility.

Similarly, the Plan Administrator is obligated only to pay, in part, for the services of Your professional Provider to the extent the services are covered. Neither the Plan Administrator, the State, nor The Local Choice guarantees the availability of a Provider's services. Neither the Plan Administrator, the State, nor The Local Choice will be responsible for acts or omissions of any Provider. Neither the Plan Administrator, the State, 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 Plan Administrator, the State, 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 Virginia Insurance Information and Privacy Protection Act. A more detailed explanation of the Plan Administrator's information practices is available upon request.

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

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

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

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

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

#### **5) Proof of Loss**

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

#### **6) Prompt Filing of Claims**

With the exception of claims for covered Major Medical Services (see Major Medical Services section), no claim will be paid if the Plan Administrator receives it more than

one year after the date on which the service was rendered. You are responsible for making sure the individual or facility rendering the service knows You are eligible for covered services. You are also responsible for making sure these facilities and individuals submit claims for covered services within the time permitted. No claim for Major Medical Services will be paid if the Plan Administrator received it more than one year after the end of the Calendar Year in which the service was rendered.

**7) Payment Errors and Appeals**

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

**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 Plan Administrator.

The Plan 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. Extended Coverage can become available to You or covered family members when coverage would otherwise be lost if your group qualifies.

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 or optional retirement plan retirees/survivors should contact their pre-retirement Group Benefits Administrator.

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”. 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 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 are reduced (e.g., long-term disability).
- Your employment ends for any reason other than Your gross misconduct (e.g., retirement).

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 events:

- 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 stops being 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.

### **When is Extended Coverage Available?**

Your Group Benefits Administrator will automatically offer Extended Coverage to eligible retiree group qualified beneficiaries upon the occurrence of the following qualifying event:

- death of the Enrollee.

### **You Must Give Notice of Some Qualifying Events**

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

- the type of qualifying event (e.g., divorce, loss of dependent child's eligibility-- including reason for the loss of eligibility);
- the name of the affected qualified beneficiary (e.g., spouse's and/or dependent child's name/s);
- the date of the qualifying event;
- documentation to support the occurrence of the qualifying event (e.g., final divorce decree, dependent child's marriage certificate);
- 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 may 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 Your designated Group Benefits Administrator becomes aware or is notified that the qualifying event has occurred. Extended Coverage will be offered to each of the eligible qualified beneficiaries. 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.

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

**10) Plan Administrator's Continuing Rights**

On occasion, the Plan Administrator, the State, 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 Plan Administrator, the State or The Local Choice waives or gives up any future rights it may have. The Plan Administrator, the State 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 Plan Administrator, the State or The Local Choice in any matter relating to (1) the Plan, (2) the Plan Administrator's performance, the State's performance or The Local Choice's performance under the Plan; or (3) any statements made by an employee/retiree, officer, or director of the Plan Administrator, the State 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 Plan Administrator, the State, The Local Choice, or any director, officer, or employee of the Plan Administrator, the State 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. The following is an exception:

If You are an Inpatient on the day a change becomes effective, covered services Your Hospital provides You will not be changed for that admission.

**13) Misrepresentation**

An Enrollee's coverage can be canceled by the Plan Administrator, the State, or The Local Choice if it finds that any information needed to accept the Enrollee or process a claim was deliberately misrepresented. This would also apply to any other family members enrolled with the Enrollee. When false or misleading information is discovered, the Plan Administrator, the State, 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 Plan Administrator has the right to suspend payment of Your claims. The Plan Administrator will not be responsible for claims for any period for which full monthly charges have not been paid. If Your monthly charges remain unpaid 31 days from the date due, the State 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 paragraph 9) of this section. Coverage for the dependent will end on the last day of the month in which the death occurs.

**16) Divorce**

Coverage will end for the enrolled spouse of an Enrollee on the last day of the month in which the final divorce decree is granted unless continuation of coverage is properly elected and maintained pursuant to paragraph 9) of this section. Conversion privileges for the spouse will be extended if the spouse notifies the Plan 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 paragraph 9) of this section. Conversion privileges for the dependent will be offered if the Plan 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 to the Employer As Defined and Outlined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulation.**

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

- (a) Plan means the "State 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 Plan 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 Plan 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 Plan Administrator determines to be reasonable for the services rendered.

### 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 that, each consecutive 4 hours in a 24-hour period of services provided by a care Provider is one visit.

### 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.

### 5) **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

### 6) **Days of Inpatient Care**

This means the number of days of care for which You are covered as an Inpatient.

Days of Inpatient Care You use in a Covered Facility are subtracted from those available in this way:

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

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

**7) 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; and
- radiology (including mammograms), ultrasound or nuclear medicine;
- sleep studies.

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

**8) Effective Date**

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

**9) 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.

**10) Enrollee**

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

**11) Experimental/Investigative**

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

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular indication or application in question. Moreover, quantities of any drug or medication 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 following resources:
    - the following standard reference compendia:
      - 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 Plan 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.

## 12) 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.

### **13) 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 Plan 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.

### **14) 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.

### **15) Major Medical Benefit Period**

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.

### **16) 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.

**17) 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.

**18) 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.**

**19) 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.

**20) Medicare Benefit Period**

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

**21) 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.

**22) 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.

**23) 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.

**24) Participant**

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

**25) Participating and Non-Participating Hospitals**

A Participating Hospital is a Hospital listed as "participating" by the Plan 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 Plan

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 Plan Administrator's sole option, any other person responsible for paying the Non-Participating Hospital's charge.

**26) Participating and Non-Participating Providers**

A Participating Provider is a Provider who is listed as a "Participating Provider" by the Plan 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 Plan 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 Plan 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 Plan Administrator's Allowable Charge and the Non-Participating Provider's charge.

**27) Physician**

A Physician is a properly licensed Doctor of Medicine.

**28) Plan**

Plan, in this handbook, means the **Advantage 65** or the **Medicare Complementary/Option I Plan**.

**29) 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 65 or Medicare Complementary/Option I) indicates Medicare is primary for all Medicare-covered services.

**30) Provider**

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

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

**32) Secondary Coverage**

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

**33) Semi Private Room**

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

**34) 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.

**35) State**

This means the Commonwealth of Virginia.

**36) The Local Choice Group**

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

**37) 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 created by or under an act of the General Assembly.

**38) Therapy Services**

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

**a. Radiation Therapy**

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

**b. Respiratory Therapy**

This is treatment using the introduction of dry or moist gases into the lungs to treat illness or injury.

**c. Chemotherapy**

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

**d. Renal Dialysis**

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

**e. Physical Therapy**

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

**f. Intravenous Therapy**

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

**g. 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.

**h. 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.

**i. Inhalation Therapy**

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

**39) You, Your, or Yourself**

These words refer to a Participant.

## ELIGIBILITY

This section explains availability of coverage for eligible The Local Choice retirees and Survivors of retirees and their eligible family members. 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 offers retiree coverage, **and**
- You must meet the 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.
- You are a retiring The Local Choice employee who is eligible for a monthly annuity from the Virginia Retirement System or a periodic benefit from the primary retirement program of The Local Choice Employer, **and**
- You are receiving (not deferring) Your annuity or periodic benefit immediately upon retirement, **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 survivor of a participating The Local Choice employee, 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.

### Covered Family Members

The following family members may be covered if coverage is available:

#### The retiree group Enrollee's spouse

The marriage must be recognized as legal in the Commonwealth of Virginia.

#### Children

Under the health benefits program, the following eligible children may be covered until the end of the year in which they turn age 23, regardless of student status (age requirement is waived for adult incapacitated children), if the child lives at home or is away at school, is not married and receives over one-half of his/her support from the retiree group Enrollee. In the case of natural or adopted children, living at home may mean living with the other parent if the retiree group Enrollee is divorced. Also, if the biological parents are divorced, the support test is met if a natural or adopted child receives over one-half of his or her support from either parent or a combination of support from both parents. However, in order for the non-custodial parent to cover the child, the non-custodial parent must be

entitled to claim the child as a dependent on his/her federal income tax return, or the custodial parent must sign a written declaration that he/she will not claim the child as a dependent on his/her federal income tax return.

Unmarried stepchildren living with the retiree group Enrollee in a parent-child relationship may be covered. However, stepchildren may not be covered as dependents unless their principal place of residence is with the retiree group Enrollee and they are members of the retiree group Enrollee's household. A stepchild must receive over one-half of his/her support from the retiree group Enrollee.

An adult child who is incapacitated due to a physical or mental health condition may be covered as long as the child was covered by the Plan and the incapacitation existed prior to the termination of coverage due to the child attaining the limiting age. The retiree group Enrollee must make written application, along with proof of incapacitation, prior to the child reaching the limiting age. Such extension of coverage must be approved by the Plan and is subject to periodic review. Should the 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 the Plan to the Enrollee.

Other children may be covered in certain circumstances. A child for whom the court has ordered the retiree group Enrollee to assume sole permanent custody may be covered. The principal place of residence must be with the retiree group Enrollee, and the child must be a member of the retiree group Enrollee's family. Additionally, if the retiree group Enrollee or spouse shares custody with the 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 who has custody must be living in the same household as the retiree group Enrollee.

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

### **Not Eligible for Coverage**

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

### **Enrollment and 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 who 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 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 23 as long as the child remains otherwise eligible (see above).

An eligible surviving spouse may continue coverage until either 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.

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