YOUR 2021
BENEFIT BOOKLET

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Thank You for Choosing Highmark

Welcome to Highmark. We appreciate your choosing us for your health coverage.

Take the time to review this booklet; it contains important information about your health insurance, including:

- How to use your member ID card
- The importance of selecting a primary care provider or provider of record
- Getting quality care and service
- Definitions of common health care insurance terms
- The Health Care Certificate for your plan

If you have any questions regarding your plan, please call the Member Service toll-free telephone number on the back of your ID card. For TTY/TDD hearing-impaired service, please dial 711 and the number on the back of your ID card.

Table of Contents

Your Identification Card Is Your Key to Care

You will receive your identification (ID) card in a separate mailing. Your ID card is your key to letting providers know that you have health coverage. You should carry your card with you. You can also view and fax it to a provider by logging in to **www.HighmarkBCBSWV.com** with your web-enabled phone.

Show your card to the health care provider when you need care. Use it at the pharmacy when you buy prescription drugs. You can even use your ID card nationwide for emergency and urgent care.

Your ID card is your source for important information. It includes:

- Your name and/or dependent's name (when applicable)
- Your identification number
- Your group number
- Effective date of your plan
- Office visit, specialist visit, and emergency room copayment amounts (if applicable)
- Pharmacy network
- Toll-free Member Service phone number
- Member website address
- Blues On Call℠ nurse line
- Toll-free phone numbers for authorizing services
- Addresses for filing claims for emergency care that is provided out of the network or out of the coverage area

If your ID card is lost or stolen, please contact Member Service immediately. You can order a replacement ID card on **www.HighmarkBCBSWV.com**. It's illegal to lend your ID card to anyone who is not eligible to use your benefits.

Select a Physician of Record

A Physician of Record (POR) is the doctor or practice that you visit for your primary and routine health care services. This could be an internal medicine physician, general practitioner, family practitioner, certified registered nurse practitioner, or pediatrician.

Often your least costly option for getting care, your POR can deliver routine services, such as physicals and immunizations, and can recommend and help you select appropriate specialist care when you need it. Physicians of record, or their covering providers, are on call 24 hours a day, seven days a week. This includes specialists for behavioral health. You are not required to select a POR, but we encourage you to do so.

A physician of record can help you to:

- Achieve health goals.
- Monitor chronic health conditions and care maintenance.
- Make sure you receive preventive services, like annual exams.
- Coordinate the care you receive from other providers, such as specialists, labs, and imaging centers. This prevents gaps or overlaps in service.
- Improve your patient experience.

How to Obtain Information Regarding Your Provider

To learn more about a provider or to find a physician of record:

1. Visit **www.HighmarkBCBSWV.com**.
   a. Select **Find a Doctor or Rx**.
   b. Select **Find a Doctor, Hospital or other Medical Provider**.
   c. Enter the name of your plan by entering the first three letters of your member ID and selecting the appropriate plan from the **Select a Plan** menu,
   d. Enter **"primary care"** into the search field.
   e. Click on the **SEARCH** button to locate providers near you who participate in your network.
   f. Select **See More** to learn more about a specific provider.
   g. Click **More Details** then select **Physician Details** to locate the physician of record's nine-digit Physician ID number.

2. Call Member Service at the number on the back of your Member ID card to ask for help in locating a physician of record with an office near you.

When you search for a provider at **www.HighmarkBCBSWV.com,** you can view the following information:

- Physician name
- Location/Office Hours/Phone numbers
- Whether the provider is accepting new patients
- Professional qualifications
- Clinical specialties
- Medical school attended
- Residency completion
- Board certification status
- Hospital affiliations
- Medical group affiliations
- Patient ratings
- Performance in 13 categories of care
- Parking and public transit nearby
- Handicap accessibility
- Languages spoken
- Gender

You may also obtain more information on network providers by calling Member Service at the number on the back of your member ID card.

To select a Physician of Record:

- Log in to the member website.
- Go to **Settings**.
- Select **Physician Information** to update your physician of record.

Selecting a physician of record is optional and does not impact your benefits or claims payments in any way.

How to Use Your Plan

Your Highmark plan gives you more value than ever before! With network access to a network of high-quality providers that includes PCPs, specialists, imaging centers, hospitals, and other facilities, you can select any network facility of your choice.

Benefits Included with Your Plan

Free Preventive Vaccines

To help you and your family stay healthy, preventive vaccines are included with your plan when given at participating providers' offices and pharmacies. These vaccines require no copay or coinsurance, and you do not have to have met your deductible to take advantage of these services. Visit **www.HighmarkBCBSWV.com** to find participating providers and pharmacies near you.

Preventive vaccines available through this program are for members who meet all necessary state requirements that apply to the administration of vaccines in a retail pharmacy (such as specific vaccines that are allowed in the retail setting, age of patient, prescription requirements, etc.). These regulations vary by state. Check with your pharmacy for any such restrictions.

Free Telemedicine Services

Speak with a network provider in just 5 – 10 minutes using your mobile phone, tablet, or laptop to get help with a variety of minor illnesses, such as colds, sore throats, pink eye, allergies, and rashes. Visit AmWell.com to set up your account so that you can visit a doctor from the comfort of your home.

If you have a catastrophic or high-deductible health plan, subject to the terms of your Health Benefits Certificate, you must meet your deductible before your plan pays the full cost of telemedicine services.

Network Care

Before you see a provider, it's always important to make sure they are within the network. By keeping care in the network, medically necessary and appropriate services specified in the Health Care Certificate will be covered.

Find Network Providers, Hospitals, and Facilities

It's easy to find in-network providers, hospitals, and facilities:

- Visit **www.HighmarkBCBSWV.com**. Just log in, click the **Find a Doctor** tab, and follow the directions.
- Call My Care Navigator at 888-258-3428.
- Call Member Service at the number on the back of your member ID card.

Out-of-Network & Out-of-Area BlueCard Coverage

Care can be delivered in a variety of settings for various situations. To understand how care will be covered, it is helpful to know the types of care that are available:

Emergency Care - Emergency care is needed for the treatment of serious or life-threatening medical conditions that require immediate care. **If you think that you are having a medical emergency, call 911 or go immediately to the nearest emergency room.** The hospital will provide needed care, and it will be covered at network rates — even if that hospital is out of network.

If inpatient care is required, once the patient is stabilized and able to be transported to a network facility, Highmark will work with the patient or the patient's family, and the treating hospital, to arrange transfer.

Urgent Care - Urgent care is care needed for an unexpected illness or injury that is not life-threatening but must be treated and cannot reasonably be postponed.

How each of these types of care are covered is often dependent upon your location when seeking care.

Out-of-Network Care - Care received from non-network providers or at non-network facilities.

If an out-of-network provider or facility is selected for non-emergency or non-urgent care, and you have not received an approved exception, you are responsible for all costs associated with that out-of-network care, including an admission that results from an emergency department visit, if you choose not to be transferred to a network facility after you are stabilized. Please refer to your Health Care Certificate for additional details about how to request an out-of network exception.

Out-of-Area Care with BlueCard – Subject to the terms of your Certificate, BlueCard® is a program that allows you to obtain certain health care services while traveling outside of Highmark West Virginia's service area. The program links participating health care providers with the independent Blue Cross Blue Shield Plans across the country and allows providers to submit claims for processing and reimbursement, so you don't have to. However, certain services still require you to work with your BlueCard participating provider to obtain prior authorization. To determine if your care requires prior authorization, call Member Service at the number on the back of your ID card.

You can find BlueCard participating providers by calling BlueCard Access at 1-800-810-BLUE. You can also search on the member website for a BlueCard provider by ZIP code and provider specialty, or by city and state. Or visit the BlueCard Doctor and National Hospital Finder website at **bcbs.com**.

Preventive Schedule

Preventive care helps you to stay well or find problems early, when they may be easier to treat. The preventive guidelines in the schedule on the next few pages depend upon your age, gender, health, and family history and can be an important part of your overall health and well-being. Take some time to review the preventive schedule and discuss it with your doctor.

The following preventive schedule is current as of January 1, 2021. Periodic updates may be made to the schedule. Visit the Highmark website at **www.HighmarkBCBSWV.com** to view the current schedule.

2021 Preventive Schedule

Effective 1/1/2021

Plan your care: Know what you need and when to get it

Preventive or routine care helps us stay well or finds problems early, when they are easier to treat. The preventive guidelines on this schedule depend on your age, gender, health and family history. As a part of your health plan, you may be eligible to receive some of these preventive benefits with little to no cost sharing when using in-network providers. Make sure you know what is covered by your health plan and any requirements before you receive any of these services.

Some services and their frequency may depend on your doctor's advice. That's why it's important to talk with your doctor about the services that are right for you. CHIP Members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

Questions?

- Call Member Service
- Ask your doctor
- Log in to your account

Adults: Ages 19+

Female Male

GENERAL HEALTH CARE	
Routine Checkup* (This exam is not the work- or school-related physical)	• Ages 19 to 49: Every 1 to 2 years • Ages 50 and older: Once a year
Depression Screening	Once a year
Pelvic, Breast Exam	Once a year
SCREENINGS/PROCEDURES	
Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
Cholesterol (Lipid) Screening	• Ages 20 and older: Once every 5 years • High-risk: More often
Colon Cancer Screening (Including Colonoscopy)	• Ages 50 and older: Every 1 to 10 years, depending on screening test • High-risk: Earlier or more frequently
Certain Colonoscopy Preps With Prescription	• Ages 50 and older: Once every 10 years • High-risk: Earlier or more frequently
Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
Hepatitis B Screening	High-risk
Hepatitis C Screening	Ages 18-79
Latent Tuberculosis Screening	High-risk
Lung Cancer Screening (Requires prior authorization and use of authorized facility)	Ages 55 to 80 with 30-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years

* Routine checkup could include health history; physical; height, weight and blood pressure measures; body mass index (BMI) assessment; counseling for obesity, fall prevention, skin cancer and safety; depression screening; alcohol and drug abuse, and tobacco use assessment; age-appropriate guidance, and intimate partner violence screening and counseling for reproductive age women.

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Adults: Ages 19+

SCREENINGS/PROCEDURES	
Mammogram	Ages 40 and older: Once a year including 3-D
Osteoporosis (Bone Mineral Density) Screening	Age 65 and older: once every 2 years. Younger if at risk as recommended by physician
Cervical Cancer Screening	• Ages 21 to 65 PAP: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if HPV only or combined PAP and HPV are negative • Ages 65 and older: Per doctor's advice
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)	Sexually active males and females
IMMUNIZATIONS**	
Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
Diphtheria, Tetanus (Td/Tdap)	One dose Tdap, then Td or Tdap booster every 10 years
Flu (Influenza)	Every year (Must get at your PCP's office or designated pharmacy vaccination provider; call Member Service to verify that your vaccination provider is in the Highmark network)
Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
Hepatitis A	At-risk or per doctor's advice: One 2 or 3 dose series
Hepatitis B	At-risk or per doctor's advice: One 2 or 3 dose series
Human Papillomavirus (HPV)	• To age 26: One 3-dose series • Beginning on 9/1/2020: Ages 27-45 at-risk per doctor's advice
Measles, Mumps, Rubella (MMR)	One or two doses
Meningitis*	At-risk or per doctor's advice
Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime
Shingles	• Zostavax - Ages 60 and older: One dose • Shingrix - Ages 50 and older: Two doses
PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Aspirin	• Ages 50 to 59 to reduce the risk of stroke and heart attack • Pregnant women at risk for preeclampsia
Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
Chemoprevention drugs such as raloxifene, tamoxifen or aromatase*** inhibitor beginning on 10/1/2020	At-risk for breast cancer, without a cancer diagnosis, ages 35 and older
Tobacco Cessation (Counseling and medication)	Adults who use tobacco products

* Meningococcal B vaccine per doctor's advice.
** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.
*** Aromatase inhibitors effective 10.1.2020 when the other drugs can't be used such as when there is a contraindication or they are not tolerated.

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Low to Moderate Dose Select Generic Statin Drugs For Prevention of Cardiovascular Disease (CVD)	Ages 40 to 75 years with 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater.
Select PrEP Drugs for Prevention of HIV Infection	Adults at-risk for HIV infection, without an HIV diagnosis
PREVENTIVE CARE FOR PREGNANT WOMEN	
Screenings and Procedures	• Gestational diabetes screening • Hepatitis B screening and immunization, if needed • HIV screening • Syphilis screening • Smoking cessation counseling • Depression screening during pregnancy and postpartum • Depression prevention counseling during pregnancy and postpartum • Rh typing at first visit • Rh antibody testing for Rh-negative women • Tdap with every pregnancy • Urine culture and sensitivity at first visit • Alcohol misuse screening and counseling
PREVENTION OF OBESITY, HEART DISEASE AND DIABETES	
Adults With BMI 25 to 29.9 (Overweight) and 30 to 39.9 (Obese) Are Eligible For:	• Additional annual preventive office visits specifically for obesity and blood pressure measurement • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – ALT – AST – Hemoglobin A1c or fasting glucose – Cholesterol screening
ADULT DIABETES PREVENTION PROGRAM (DPP)	
Applies to Adults • Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and • Overweight or obese (determined by BMI) and • Fasting Blood Glucose of 100–125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140–199mg/dl.	Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.

2021 Preventive Schedule

Plan your child's care: Know what your child needs and when to get it

Preventive or routine care helps your child stay well or finds problems early, when they are easier to treat. Most of these services may not have cost sharing if you use the plan's in-network providers. Make sure you know what is covered by your health plan and any requirements before you schedule any services for your child.

It's important to talk with your child's doctor. The frequency of services, and schedule of screenings and immunizations depends on what the doctor thinks is right for your child.

Questions?

- Call Member Service
- Ask your doctor
- Log in to your account

Children: Birth to 30 Months[1]

GENERAL HEALTH CARE	BIRTH	1M	2M	4M	6M	9M	12M	15M	18M	24M	30M
Routine Checkup* (This exam is not the preschool- or day care-related physical.)	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening	●										
SCREENINGS											
Autism Screening									●	●	
Critical Congenital Heart Disease (CCHD) Screening WithPulse Oximetry	●										
Developmental Screening						●			●		●
Hematocrit or Hemoglobin Screening							●				
Lead Screening						●	●			●	
Newborn Blood Screening and Bilirubin	●										
IMMUNIZATIONS											
Chicken Pox							Dose 1				
Diphtheria, Tetanus, Pertussis (DTaP)			Dose 1	Dose 2	Dose 3			Dose 4			
Flu (Influenza)**					Ages 6 months to 30 months: 1 or 2 doses annually						
Haemophilus Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3		Dose 4				
Hepatitis A							Dose 1		Dose 2		
Hepatitis B	Dose 1	Dose 2			Dose 3						
Measles, Mumps, Rubella (MMR)							Dose 1				
Pneumonia			Dose 1	Dose 2	Dose 3		Dose 4				
Polio (IPV)			Dose 1	Dose 2	Ages 6 months to 18 months: Dose 3						
Rotavirus			Dose 1	Dose 2	Dose 3						

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance. Additional: Instrument vision screening to assess risk for ages 1 and 2 years.

** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

Children: 3 Years to 18 Years[1]

GENERAL HEALTH CARE	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)	●	●	●	●	●	●	●	●	Once a year from ages 11 to 18			
Ambulatory Blood Pressure Monitoring**												●
Depression Screening									Once a year from ages 11 to 18			
Hearing Screening***		●	●	●		●		●		●	●	●
Visual Screening***	●	●	●	●		●		●		●	●	●
SCREENINGS												
Hematocrit or Hemoglobin Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Cholesterol (Lipid) Screening							Once between ages 9-11 and ages 17-21					
IMMUNIZATIONS												
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5							One dose Tdap			
Flu (Influenza)****	Ages 3 to 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9-14. 3 doses all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2										
Meningitis*****									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor's advice											
Polio (IPV)		Dose 4										
CARE FOR PATIENTS WITH RISK FACTORS												
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice							
Cholesterol Screening	Screening will be done based on the child's family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor's advice			
Hepatitis C Screening											High-risk	
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)									For all sexually active individuals. HIV routine check once between ages 15-18			
Tuberculin Test	Per doctor's advice											

*Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance; alcohol and drug abuse, and tobacco use assessment. ** To confirm new diagnosis of high blood pressure before starting treatment. *** Hearing screening once between ages 11-14, 15-17 and 18-21. Vision screening covered when performed in doctor's office by having the child read letters of various sizes on a Snellen chart. Includes instrument vision screening for ages 3, 4 and 5 years. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit. **** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network. ***** Meningococcal B vaccine per doctor's advice.

Children: 6 Months to 18 Years[1]

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Oral Fluoride	For ages 6 months to 16 years whose primary water source is deficient in fluoride
PREVENTION OF OBESITY AND HEART DISEASE	
Children With a BMI in the 85th to 94th Percentile (Overweight) and the 95th to 98th Percentile (Obese) Are Eligible For:	• Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening
ADULT DIABETES PREVENTION PROGRAM (DPP) AGE 18	
Applies to Adults • Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and • Overweight or obese (determined by BMI) and • Fasting Blood Glucose of 100–125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140–199mg/dl.	Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.

Women's Health Preventive Schedule

SERVICES	
Well-Woman Visits (Includes: preconception and first prenatal visit, urinary incontinence screening)	Up to 4 visits each year for age and developmentally appropriate preventive services
Contraception (Birth Control) Methods and Discussion*	All women planning or capable of pregnancy
SCREENINGS/PROCEDURES	
Diabetes Screening	• High-risk: At the first prenatal visit • All women between 24 and 28 weeks pregnant • Postpartum women without Diabetes but with a history of gestational diabetes
HIV Screening and Discussion	All sexually active women: Once a year
Human Papillomavirus (HPV) Screening Testing	Beginning at age 30: Every 3 years
Domestic and Intimate Partner Violence Screening and Counseling	Once a year
Breast-feeding (Lactation) Support and Counseling, and Costs for Equipment	During pregnancy and/or after delivery (postpartum)
Sexually Transmitted Infections (STI) Discussion	All sexually active women: Once a year
Screening for Anxiety	The Women's Preventive Services Initiative recommends screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum.

* FDA-approved contraceptive methods may include sterilization and procedures as prescribed. One form of contraception in each of the 18 FDA-approved methods is covered without cost sharing. If the doctor recommends a clinical service or FDA-approved item based on medical necessity, there will be no cost sharing.

Information About the Affordable Care Act (ACA)

This schedule is a reference tool for planning your family's preventive care, and lists items and services required under the Affordable Care Act (ACA), as amended. It is reviewed and updated periodically based on the advice of the U.S. Preventive Services Task Force, laws and regulations, and updates to clinical guidelines established by national medical organizations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your doctor is always your best resource for determining if you're at increased risk for a condition. Some services may require prior authorization. If you have questions about this schedule, prior authorizations or your benefit coverage, please call the Member Service number on the back of your member ID card.

Highmark Blue Cross Blue Shield West Virginia is an independent licensee of the Blue Cross and Blue Shield Association.

Discrimination Is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

[1] Information About Children's Health Insurance Program (CHIP)

Because the Children's Health Insurance Program (CHIP) is a government-sponsored program and not subject to ACA, certain preventive benefits may not apply to CHIP members and/or may be subject to copayments.

The ACA authorizes coverage for certain additional preventive care services. These services do not apply to "grand-fathered" plans. These plans were established before March 23, 2010, and have not changed their benefit structure. If your health coverage is a grandfathered plan, you would have received notice of this in your benefit materials.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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HIGHMARK. WEST VIRGINIA

4/2020

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highmarkbcbswv.com

Using Your Prescription Drug Coverage

Your benefits include prescription drug coverage. You can fill prescriptions at pharmacies in your plan's pharmacy network. To locate a network pharmacy, go to your member website, **www.HighmarkBCBSWV.com**, log in, and click the **Prescriptions** tab. Scroll down to **Find a Pharmacy** and click on **Search Pharmacies**. Or call Member Service at the number on the back of your ID card.

For maintenance prescription drugs, you have two choices:

- Your prescriptions can be delivered to your home.
- You can pick up your prescriptions at a retail pharmacy.

You may save money on medications that you take on an ongoing basis by choosing the convenient home delivery option. You can arrange for home delivery from the Express Scripts Pharmacy by calling 1-800-820-9730. You can change your preference for retail or mail order delivery at any time by contacting Express Scripts.

Prescription Drug Management for Your Formulary

Your formulary is a list of Food and Drug Administration (FDA)-approved prescription drugs. It covers products in every major treatment category. Your drug formulary may limit coverage of certain drugs to the generic formulation(s) or it may prefer generic formulations by assigning a lower cost share to those products as compared to the brand name formulations. Generic drugs have been determined by the FDA to be equivalent to the brand name drug. A list of drugs included on your formulary is on the Highmark member website. You can also call Member Service at the number on the back of your member ID card for more information. Please note that formulary changes may occur throughout a plan year, so be sure to check the Highmark website often.

Highmark may impose quantity level limits on certain prescription drugs. Limits are based on the manufacturer's recommended dosage and Highmark's determination. The limits control the quantity the pharmacy provider gives you for each new prescription or refill. Additional quantity restrictions may be imposed on your first prescription for certain covered drugs. This means that the quantity you get will be reduced as necessary while it is established that you can tolerate the drug.

Additional quantity restrictions may be imposed that limit the duration of therapy for a medication to ensure it's used for an appropriate length of time. A prescribing provider may contact Highmark if an additional quantity of the drug is medically necessary and appropriate. If Highmark determines that it is medically necessary and appropriate, additional quantities of the drug will be covered.

Certain drugs that your physician may prescribe require a prior authorization from Highmark. You can find out what specific drugs or drug classifications require prior authorization by

simply calling the Member Service number on your ID card. Once the prescription is written, the provider or the member must request prior authorization from Highmark.

To obtain a prescription medication that is not included in the formulary, or to request prior authorization, your physician must complete the "Prescription Drug Medication Request Form" and return it to Highmark using either the fax number or the address as shown on the form for clinical review.

To print a copy of the "Prescription Drug Medication Request Form" for your provider to complete, log in to **www.HighmarkBCBSWV.com,** click on the **Coverage** tab, and then click on **Prescriptions Summary & Drug List**. Scroll down to the **Drugs Coverages** section and then click on the **Prescription Drug Medication Request Form** link.

You may also initiate this process yourself by following these steps: Log in to **www.HighmarkBCBSWV.com,** click on the **Coverage** tab, and then click on **Prescriptions Summary & Drug List**. Scroll down to the **Drugs Coverages** section and then click on **"Submit an online request."** Complete the form and click **Submit**.

Once a clinical decision has been made, a decision letter will be mailed to you and your provider. If your request for an exception is not granted, you can ask for a review of Highmark's decision by making an appeal.

See your Member Certificate for more details about your prescription drug benefits.

Women's Health and Cancer Rights Act of 1998

A diagnosis of breast cancer can be devastating. And while we hope you never face such a situation, we want you to know that Highmark Blue Cross Blue Shield West Virginia will be there if you need us.

Our health plans are in compliance with the Women's Health and Cancer Rights Act of 1998. The federal act requires group health plans that cover mastectomies to also cover all stages of reconstruction and surgery of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. The act also requires such plans to offer coverage for prostheses and treatment of physical complications of a mastectomy, including lymphedema. Coverage may be subject to deductibles and coinsurance. If you have any questions, please call Member Service at the number on the back of your ID card.

Info Is a Call Away

If you are facing decisions about breast cancer, you can discuss your options or concerns with a Blues On Call health coach anytime, day or night, by calling 1-888-BLUE-428.

Paying Your Monthly Premium

It's important to pay your monthly premiums to ensure that your coverage is active when you seek medical care. There are several ways to pay your premium, just pick the one that's right for you!

e-Bill
When you sign up online for e-Bill, your monthly premium is automatically deducted from your checking or savings account on the first day of each month — saving you time and eliminating the need to write checks. Set up recurring payments or pay month by month.

Set up your safe, secure and convenient e-Bill account today!

1. Visit **HighmarkBCBSWV.com**
2. Select **Pay Premium**
3. Select **Log In** if you have already set up your online account and follow the prompts.
4. Select **Pay as a Guest** to make a payment without logging in and follow the prompts.
5. Select **Register Here** to set up your online account.*
6. Once registered, select Pay Premium and follow the prompts.

* By registering, you'll gain full access to your member website in addition to e-Bill. Your member website allows you to view claims, keep track of your prescriptions and request refills, learn more about your coverage and benefits, locate doctors, hospitals, and other providers, and find a variety of wellness tools.

Electronic Funds Transfer (EFT)
EFT is a convenient way to pay your premiums by having them automatically withdrawn from your bank account each month. To set up EFT payments:

1. Go to **HighmarkBCBSWV.com**
2. Scroll down to **Helpful Links**
3. Select **Forms Library**
4. Select **Automatic Premium Payment**
5. Download the PDF file
6. Complete the form and mail it with a voided check and your bill to the address indicated

Please note that it takes 6 – 8 weeks for EFT set up and you must continue to pay your premium payments by another method during this time.

Mail
To pay your premium by mail, just include a check with your invoice and mail both to the address on the invoice.

Pay by Phone
To make your payment by phone, just call the Member Service number on the back of your member ID card. Be sure to have your account number and the bank's routing number available when you call.

Changes That Affect Your Premium

Here are three things that can change your premium amount that you need to report to us:

1. **Changes in Membership Status**
   You must report when you or any of your dependents have a change that can affect your enrollment, such as:
   - Marriage or divorce
   - Adding or removing a domestic partner or dependent
   - Termination or death of a dependent or policyholder
   - Eligibility for employer group health insurance coverage*
   - Eligibility for Medicare*

   To report a change for coverage you bought directly from Highmark that is not eligible for premium credits or cost-sharing reductions, call the Member Service number on the back of your ID card. For coverage purchased on the Health Insurance Marketplace, call 1-800-318-2596 or visit **www.healthcare.gov**.

   *These situations won't affect your premium, but they should be reported.

2. **Changes in Household Income**
   If you bought your health coverage from the Health Insurance Marketplace, you must report changes in your household income. Increases or decreases in your income can affect your eligibility for the federal Advance Premium Tax Credit and/or cost-sharing reductions. To report changes, you must call 1-800-318-2596 or visit **www.healthcare.gov**.

   You can also check for increased or reduced premium credits or cost-sharing reductions on **healthcare.gov.**

3. **Changes in Tobacco Use**
   Tobacco use means that you used tobacco products on average four or more times per week within the past six months. If you indicated that you are a tobacco user when you enrolled for health coverage, your premium includes a tobacco surcharge. This means you pay a higher rate.

   If you are tobacco-free for six months, the new health care law no longer considers you to be a tobacco user. You are then eligible for an adjustment in your health insurance premium rate. After you have stopped using tobacco for six months, let us know so that we can adjust your rate. Simply call the Member Service number on the back of your ID card.

If You Need to Cancel or Terminate This Plan or Your EFT/eBill Payments

This section applies only to plans purchased directly from Highmark and does not affect those purchased through Healthcare.gov.

If you purchased your plan directly from Highmark and are not eligible for premium credits or cost-sharing reductions and you would like to cancel or terminate coverage under this plan, the policy holder must contact the plan to request cancellation/termination of your individual policy. The policy holder must provide notice by calling the Member Service number on the ID card prior to the requested termination date. Member-requested cancellation/termination effective dates can only occur on the first of the month. Coverage will be canceled/terminated as of the first of the month following receipt of notification or as of your account paid-to date (whichever is earlier). Cancellations will void the coverage and must be requested prior to the coverage effective date or no later than ten (10) days after receipt of the Member Certificate. Member Service can instruct you on cancellation/termination procedures. Please do **not** send policy change requests back with your monthly premium payment/invoice coupon. Contact Member Service instead.

In the event you plan to enroll in other coverage, the policy holder must contact the plan to request cancellation/termination of the individual policy. If applicable, it is the subscriber's responsibility to notify any third party that is paying the premium on the policy holder's behalf (the plan will not refund premium payments because the policy holder's request to the plan or the third-party payer was not provided in a timely fashion).

You are solely responsible for payment setup and cancellation for any EFT/eBill recurring payments, even when a third-party payer is paying your premium on your behalf. Requesting cancellation/termination of your policy will cancel the recurring payment/EFT payments; however, you must first contact Member Service to request cancellation/termination of your policy. Member Service can explain how recurring payments are done and can provide the date the next payment is scheduled to be withdrawn.

Highmark will communicate renewal, enrollment discontinuation, and premium information to you using the billing/correspondence addresses you have provided. Communications sent to a third-party address provided by you or your agent/broker acting on your behalf do not relieve you of the responsibility for providing payment and timely requests for cancellation/termination to the plan.

Additional information can be found in the Member Certificate located in this booklet.

If you would like to cancel or terminate coverage under this plan and are not sure whether to contact Highmark or Healthcare.gov, please call the Member Service number on the back of your member ID card.

Paying for Your Care

Paying in the Provider's Office

A copayment, or copay, is a fixed amount you pay for a health service, such as a doctor's visit. If you owe a copayment, you need to pay it when you check in for your visit. Coinsurance is a percentage of the total cost of care that you also may need to pay. Network providers may have online tools to estimate your coinsurance costs. They can do this at the time of your visit. This lets you talk about costs with your provider before getting services. It also allows you to pay your share of the cost for services before leaving the office. Please note that copayments and coinsurance may not be required for some covered services.

The Explanation of Benefits

Once your claim is processed, you may receive an Explanation of Benefits (EOB) from us. The EOB is not a bill. It's a statement that gives you information about services you received. Services can be from physicians, facilities, or other professional providers. The EOB also includes costs you may owe for these services.

The EOB includes:

- The provider's charge
- The allowable amount
- The copayment, deductible, and coinsurance amounts, if applicable, that you're required to pay
- The total benefits payable
- The total amount you owe

You can get your EOB online by simply registering on the member website. Your EOB can also be mailed to you if that is your preference.

Filing Claims

A claim is a request you make for payment of the charges or costs for a covered service you received. If you receive services from a network provider, you do not have to file a claim. Your network provider takes care of that for you. If you go to an out-of-network provider, you may have to file the claim yourself. It is important to note that if you have an EPO plan, you only have coverage for emergency and urgent care when out-of-network. If you have to file the claim yourself, simply follow these easy steps:

1. Know your benefits. Review your Member Certificate to see if the services you received are eligible under your plan.

2. Get a detailed bill that includes:
   - The name and address of the service provider
   - The patient's full name
   - Date of service

- Description of the service/supply
- Amount charged
- Diagnosis or nature of illness
- Doctor's certification for durable medical equipment
- Nurse's license number and shift worked for private duty nursing
- Total mileage for ambulance services

Canceled checks, cash register receipts, or personal lists are not acceptable as bills.

3. Copy bills for your records. You must submit original bills. Once your claim is received, we cannot return bills.

4. Complete a claim form. Make sure all information is completed properly. Date the form. To download claim forms, go to **www.HighmarkBCBSWV.com,** click **Spending,** then **Forms Library**. You can also get a claim form by calling Member Service.

After you complete steps 1 through 4, attach all detailed bills to the claim form. Mail the form to the address on the form.

You can file multiple services for the same family member with one claim form. However, you must complete a separate claim form for each covered member. You must submit your claim no later than 15 months after the date you received services.

How to Submit a Complaint

You can submit a complaint if you are not satisfied with:

- Any part of your health care benefits
- A participating health care provider
- Coverage
- Operations
- Management policies

Please contact Member Service at the number on the back of your member ID card or by mail at the address listed below. Please include your identification and group numbers as displayed on your ID card.

For plans purchased on the Health Insurance Marketplace:
Highmark Blue Cross Blue Shield West Virginia
Member Grievance
Attn: Review Committee
P.O. Box 1988
Parkersburg, WV 26102-1988

For all other plans:
Highmark Blue Cross Blue Shield West Virginia
Member Grievance
P.O. Box 7026
Wheeling, WV 26003-7026

If this process does not meet your needs, your objection can be reviewed through an appeal process. Please refer to your Member Certificate in the back of this booklet for more details regarding your appeal rights. You may also call Member Service at the number on your member ID card.

Appeal Procedure

If you receive notification that your coverage has been rescinded or that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. You can file an appeal in writing or on the phone by calling the Member Service number on the back of your member ID card. If you file in writing, please include your identification and group numbers as displayed on your ID card. Mail your appeal to:

For plans purchased on the Health Insurance Marketplace:
Highmark Blue Cross Blue Shield West Virginia
Member Grievance and Appeals
Attn: Review Committee
P.O. Box 1988
Parkersburg, WV 26102-1988

For all other plans:
Highmark Blue Cross Blue Shield West Virginia
Member Grievance and Appeals
P.O. Box 7026
Wheeling, WV 26003-7026

If you decide to appeal by calling, you can call Member Service at the number on the back of your ID card. You must submit this appeal no later than 180 days from the date we notified you in order for your appeal to be reviewed. You should submit information to support your appeal.

We will review your appeal. You will be notified in writing of the appeal decision. Please refer to your Member Certificate in the back of this booklet for more details regarding your appeal rights.

Get Quality Care

Your plan pays for covered services, supplies, or medications that are medically necessary and appropriate. These might be to prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms. They must:

- Be generally accepted standards of medical practice.
- Be clinically appropriate in type, frequency, extent, site, and duration.
- Be considered effective for your illness, injury, or disease.
- Not be for your or your provider's convenience.
- Not be more costly than another service that may give you similar results.

If your care requires prior authorization, and you are receiving care from a BlueCard or out-of-network provider, you or your family will be responsible for contacting our Utilization Management (UM) team in Clinical Services to review the medical necessity of the service being requested. This includes inpatient and outpatient non-emergency care. This review helps to determine if a service, supplies, or medication are medically necessary and appropriate. For requests related to planned or non-emergency care, this review is done before the care is given. This must be done before your plan pays benefits. Your plan will not pay benefits if our team of doctors and nurses determine that the service, supplies, or medication are not medically necessary and appropriate.

If you have a prior authorization that was approved under your previous coverage, that authorization may apply under this Policy for up to 3 months from your Effective Date of Coverage. Services must be covered under your policy and be provided within West Virginia. You must notify us of your request to continue these services as soon as possible, or you may be required to request a new prior authorization.

Out-of-Network Services for EPO Plans

Your plan does not include coverage for out-of-network services except in the case of emergencies or urgently needed care, or for approved exceptions. If you choose to receive care from an out-of-network provider for a non-emergent or non-urgent situation, or an approved exception, you will be responsible for all costs associated with that care. This includes if you are admitted as an inpatient to an out-of-network facility (provider) because of an emergency department visit and you refuse to be transferred to a network facility once your condition is stable. Your out-of-pocket costs will also include the charges from the out-of-network facility under these circumstances. If there are no network practitioners to provide the specialty care you need would require unreasonable travel or a delay in care, we may consider approving that out-of-network care on a case-by-case basis before it is provided to you.

Out-of-network emergency care services

In a medical emergency when you think you need immediate treatment go directly to a hospital emergency room or call 911. Emergency care is care needed for the treatment of serious or life-threatening medical conditions that require immediate care. Emergency care is covered. You or your designated representative should contact Highmark Member Service at the number on the back of your member ID card and your PCP after the crisis has passed. When emergency care is provided at an out-of-network facility, if you require hospitalization as an inpatient, you may be stabilized and transferred to a network facility for care to be covered at the network level of benefits.

Out-of-network urgent care services

If you have a condition that is not life threatening but must be treated and cannot reasonably be postponed, your care that is medically necessary and appropriate will be covered – even if that provider is out-of-network. However, if the service or treatment requires authorization, the out-of-network provider will need to contact UM for medical necessity review.

Out-of-network providers are not obligated to contact UM. If they do, they do not have to accept UM's decision, if not approved. As a result, you may receive services that are considered not medically necessary and appropriate under your plan and therefore not covered. You could be responsible for the cost of those services, so it is important to understand your health plan coverage.

You or your designated representative should ask the out-of-network provider to request an authorization for these services. However, if your provider refuses that request, you or your designated representative should contact Highmark at the Member Service number on the back of your ID card.

Get Quality Service

How We Decide if a Technology or Drug Is Experimental

Medical researchers constantly experiment with new medical equipment, drugs, and other technologies. They also look for new applications for existing technologies. These could be for medical and behavioral health procedures, drugs, and devices.

A panel of medical professionals must evaluate these new technologies and new applications for existing technologies for:

- Safety
- Effectiveness
- Product efficiency

After these evaluations are completed, Highmark may recommend that the technology be considered a medical practice and a covered benefit. Or the technology may be considered "experimental or investigative." This technology is not generally covered. We may also reevaluate it in the future.

Evaluating New Drugs

A Pharmacy and Therapeutics (P&T) Committee composed of pharmacists and physicians evaluates new FDA-approved drugs based on items such as:

- National and international data
- Current research
- Opinions from leading clinicians

The review process addresses factors such as:

- Safety
- Drug effectiveness
- Unique value
- Patient compliance
- Local physician and specialist input
- Financial impact of the drug

The P&T Committee then makes a recommendation on the new FDA-approved drug.

You may decide to pursue an experimental or investigative treatment. If a service you are going to receive may be experimental or investigational, find out if it's covered. You, the hospital, or a professional provider can call Member Service about coverage for experimental or investigational medications.

If You Suspect Fraud or Provider Abuse

If you think that a provider is committing fraud, please let us know. Examples of fraud include, but are not limited to, the following:

- Submitting claims for services that you did not get.
- Adding extra charges for services that you did not get.
- Giving you treatment for services you did not need.

Please call the toll-free Fraud Hotline at 1-800-438-2478.

Your Rights and Responsibilities

As a Highmark member, you have certain rights and responsibilities as a part of your membership. These rights and responsibilities can enhance your health care benefits:

Your Rights

1. You have the right to get information about the following:
    - Our company, products, and services
    - Our doctors, facilities, and other professional providers
    - Your rights and responsibilities
2. You have the right to be treated with respect. You have the right to have your dignity and right to privacy recognized.
3. You have the right to make decisions about your health care with your providers. This includes identifying your problem, illness, or disease and treatment plan in words you can understand. You have the right to help make decisions about your care.
4. You have the right to openly discuss treatment decisions that are right and necessary for you. You have the right to do this without concern for cost or coverage. We do not restrict information shared between you and your providers. We have policies telling providers to openly discuss all treatment options with you.
5. You have the right to voice a complaint or appeal about your coverage or care. You have the right to get a reply in a reasonable amount of time.
6. You have the right to recommend rights and responsibilities to us.

Your Responsibilities

1. You have the responsibility to give us as much information as you can. We need this information to make care available to you. It's also what providers need to take care of you.

2. You have the responsibility to follow the plans and instructions for care that you agree to with your providers.

3. You have the responsibility to talk openly with the provider you choose. Ask questions. Make sure you understand explanations and instructions you get. Help develop treatment goals you agree to with your providers. Develop a trusting and cooperative relationship with your providers.

If you have any questions, please call Member Service at the number on the back of your identification card.

Definitions of Health Care Terms

Definitions of health care terms to help you understand your benefits and rights:

Balance billing — When an out-of-network provider bills you for the difference between the provider's charge and the plan allowance. For example, if the provider's charge is $100 and the plan allowance is $70, the provider may bill you for the remaining $30. Providers who are in network may not balance bill you for covered services.

Coinsurance — Your part of a medical bill that you pay after reaching your deductible. For example, if your medical bill for covered, network services is $100 and your coinsurance is 20 percent, you pay $20. The insurance company pays $80. (See balance billing for details on out-of-network care.)

Copayment (copay) — The fixed amount you pay for a health service, such as a PCP visit, specialist visit or urgent care. The copay may vary by plan. The copay for each service may be different. For example, a PCP visit may require a $30 copay. But a visit to a specialist may require a $50 copay. You usually have to pay the copay when you get a health care service, such as at your doctor's office or at the drugstore.

Deductible — The dollar amount you must pay each benefit period (usually a year) for your health care expenses before your plan begins to pay for covered services. For example, if you have a $500 network deductible, that's the amount you will pay before your insurance plan will pay for covered network services. Copayments are not included.

Exchange (Health Insurance Marketplace) — Governmental agencies or non-profit entities that will serve as marketplaces to facilitate the purchase of health insurance in the individual and small group markets, assist individuals who are eligible to receive premium tax credits and cost-sharing reductions and support enrollment in federal or state insurance programs.

Network provider — A doctor, hospital, or other provider in the plan's network. Network providers have agreed to accept the plan allowance plus any member copayment, coinsurance, and deductible as payment in full for covered services. You pay less when you use a network provider instead of an out-of-network provider. With the exception of care for emergent and urgent conditions, if the plan does not offer out-of-network coverage, you must see a network provider for all care and services.

Out-of-area provider — A doctor, hospital, or other provider outside the Highmark West Virginia Service Area.

Out-of-pocket maximum — The most you pay during a coverage period (usually a year) before your health insurer begins to pay 100 percent of the plan allowance. The maximum never includes your premium, balance-billed charges, or payments for services your health

plan doesn't cover. All of your copayments, deductibles, coinsurance payments, or other expenses count toward this maximum.

Out-of-network provider — A provider who does not have a contract with your health insurer to provide services to you at a discount. You will generally pay more to see an out-of-network provider. Your EPO plan, does not have coverage for out-of-network services (except for emergency and urgent care services).

Plan allowance — The most a health plan will pay for a health service. A health service could be a test or a procedure. Your plan's network providers have signed a contract to provide services at a discount. They agree not to charge more than this plan allowance to members of the health plan. Out-of-network providers may charge more than the plan allowance. If you see an out-of-network provider who charges more, you may have to pay the extra cost. (See balance billing.)

Premium — The dollar amount you pay each month for your health insurance or plan.

How We Protect Your Right to Privacy

We have policies and procedures to protect your privacy. This includes your Protected Health Information (PHI). PHI may be oral, written, or electronic.

- We do not discuss PHI outside of our offices.
- We confirm who you are before we discuss PHI on the phone.
- Our employees sign privacy agreements.
- Our employees use computer passwords to limit PHI access.

We include privacy language in our provider contracts.

Highmark Notice of Privacy Practices

The Notice of Privacy Practices describes:

- How your medical information may be used and disclosed.
- How you can get access to this information.
- How we collect, use, and disclose non-public personal financial information.

To review our complete notice of privacy practices, please see the next page.

Sí necesita ayuda para traducir esta información, por favor comuníquese con el departamento de Servicios a miembros de Highmark West Virginia al número al réves desu tarjeta de identificación de Highmark West Virginia. Estos servicios están disponibles de lunes a viernes, de 8:00 a 16:00.

HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA
NOTICE OF PRIVACY PRACTICES

PART 1 – NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE ALSO DESCRIBED HOW WE COLLECT, USE AND DISCLOSE NON-PUBLIC PERSONAL FINANCIAL INFORMATION

Our Legal Duties

At Highmark Blue Cross Blue Shield West Virginia (Highmark WV), we are committed to protecting the privacy of your protected health information. "protected health information" (PHI) is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by applicable federal and state laws to maintain the privacy of your protected health information. We also are required by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We are also required to notify affected individuals following a breach of unsecured health information.

We will inform you of these practices the first time you become a Highmark WV customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice becomes effective September 23, 2013, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health

information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change. Any change to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. Uses and Disclosures of Protected Health Information

In order to administer our health benefit programs effectively, we will collect, use and disclose protected health information for certain of our activities, including payment and health care operations.

A. Uses and Disclosures of Protected Health Information for Payment and Health Care Operations

The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations:

Payment

We may use and disclose your protected health information for all activities that are included within the definition of "payment" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the Activities included within the definition of "payment," so please refer to 45 C.F.R. § 164.501 for a complete list.

►For example:

We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits/payments to the person who subscribes to the health plan in which you participate.

Health Care Operations

We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "health care operations," so please refer to 45 C.F.R. § 164.501 for a complete list.

►For example:

We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct Quality assessment and

improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business.

B. Uses and Disclosures of Protected Health Information To Other Entities

We also may use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering services to our members.

(i) Business Associates.

In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

(ii) Other Covered Entities.

In addition, we may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain of their health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

II. Other Possible Uses and Disclosures of Protected Health Information

In addition to uses and disclosures for payment and health care operations, we may use and/or disclose your protected health information for the following purposes.

A. To Plan Sponsors

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issue regarding claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

B. Required by Law

We may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

C. Public Health Activities

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

D. Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

E. Abuse or Neglect

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

F. Legal Proceedings

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information.

G. Law Enforcement

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

H. Coroners, Medical Examiners, Funeral Directors, and Organ Donation

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

I. Research

We may disclose your protected health information to researchers when an institutional review board or privacy board has:

(1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

J. To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

K. Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

L. Inmates

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

M. Workers' Compensation

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

N. Others Involved in Your Health Care

Unless you object, we may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

O. Underwriting

We may disclose your protected health information for underwriting purposes; however, we are prohibited from using or disclosing your genetic information for these purposes.

P. Health Information Exchange

We will participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur.

The HIE allows your health information to be shared among authorized participating healthcare providers, such as health systems, hospitals and physicians, for the purposes of Treatment, Payment or Healthcare Operations purposes. Examples of this health information may include:

- General laboratory, pathology, transcribed radiology reports and EKG Images.
- Results of outpatient diagnostic testing (GI testing, cardiac testing, neurological testing, etc.)
- Health Maintenance documentation/Medication
- Allergy documentation/Immunization profiles
- Progress notes/Urgent Care visit progress notes
- Consultation notes
- Inpatient operative reports
- Discharge summary/Emergency room visit discharge summary notes

All participating providers who provide services to you will have the ability to access your information. Providers that do not provide services to you will not have access to your information. Information may be provided to others as necessary for referral, consultation, treatment or the provision of other healthcare services, such as pharmacy or laboratory services. All participating providers have agreed to a set of standards relating to their use and disclosure of the information avail- able through the HIE. Your health information shall be available to all participating providers through the HIE.

You cannot choose to have only certain providers access your information. Patients who do not want their health information to be accessible through the HIE may choose not to participate or may "opt-out."

In order to opt-out, you must call the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but providers will not be able to access this information. Additionally, your opt-out does not affect the ability of

participating providers to access health information entered into the HIE prior to your opt-out submission.

III. Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make:

A. Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. Disclosures to You

We are required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information

Sometimes we are required to obtain your written authorization for use or disclosure of your health information. The uses and disclosures that require an authorization under 45 C.F.R. § 164.508(a) are:

1. For marketing purposes
2. If we intend to sell your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:

    a. Used by the person who created the psychotherapy note for treatment purposes, or
    b. Used or disclosed for the following purposes:
        (i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
        (ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
        (iii) if required for enforcement purposes;
        (iv) if mandated by law;
        (v) if permitted for oversight of the provider that created the note
        (vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
        (vii) if needed to avert a serious and imminent threat to health or safety.

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

V. Your Individual Rights

The following is a description of your rights with respect to your protected health information:

A. Right to Access

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies in a format other than photo- copies. We will use the format you request unless we cannot practicably do so, if you request the information in an electronic format that is not readily producible, we will provide the information in a readable electronic format as mutually agreed upon. You must make a request in writing to obtain access to your protected health information.

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. The first request within a 12-month period will be free. If you request access to your designated record set more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

B. Right to an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment or health care operations. You should know that most disclosures of protected health information will be for purposes of payment or health care operations.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or sub- mitting your request in writing to the Highmark West Virginia Privacy Office, 614 Market Street, Parkersburg, WV 26101. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

The first list you request within a 12-month period will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional re- quests. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. We have a right to terminate this restriction, however if we do so, we must inform you of this restriction.

You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark West Virginia Privacy Office, 614 Market Street, Parkers- burg, WV 26101. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work e-mail.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the alternative location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits/ payments to the subscriber of the health plan in which you participate.

In the event that a Confidential Communication is placed against you, then you will no longer have the ability to access any of your health and/ or policy information online.

E. Right to Request Amendment

If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended.

We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

F. Right to a Paper Copy of this Notice

If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

VI. Questions and Complaints

If you want more information about our privacy policies or practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Highmark West Virginia Privacy Office
Telephone: 1-304-424-9026
Fax: 1-304-424-0322
Address: 614 Market Street Parkersburg, WV 26101

PART II – NOTICE OF PRIVACY PRACTICES (GRAMM-LEACH-BLILEY)

Highmark Blue Cross Blue Shield West Virginia is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group becomes a Highmark WV member and will annually reaffirm our privacy policy for as long as the group remains a Highmark WV customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

In order to administer our health benefit programs effectively, we must collect, use and disclose non-public personal financial information. Non-public personal financial information is information that identifies an individual member of a Highmark WV health plan. It may include the member's name, address, telephone number and Social Security number or it may relate to the member's participation in the plan, the provision of health care services or the payment for health care services. Non-public personal financial information does not include publicly available information or statistical information that does not identify individual persons.

Information we collect and maintain: We collect non-public personal financial information about our members from the following sources:

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.

- We collect and create information about our members' transactions with Highmark WV, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only as necessary to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.

- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.

- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.

- We may disclose information under order of a court of law in connection with a legal proceeding.

- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.

- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

How we protect information: We restrict access to our members' non-public personal information to those employees, agents, consultants and health care providers who need to know that information to provide health products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard non-public personal financial information from unauthorized access, use and disclosure.

For questions about this Privacy Notice, please contact:
Contact Office: Highmark West Virginia Privacy Office
Telephone: 1-304-424-9026
Fax: 1-304-424-0322
Address: 614 Market Street Parkersburg, WV 26101

SUMMARY OF THE
WEST VIRGINIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT
(Effective July 1, 2019)

Residents of West Virginia who purchase life insurance, annuities or health insurance should know that the insurance companies and health maintenance organizations licensed in this state to write these types of insurance are members of the West Virginia Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policy and contract owners, certificate holders and enrollees of covered policies and contracts will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurers for the money to pay the claims of covered persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these member insurers through the Guaranty Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The West Virginia Life and Health Insurance Guaranty Association may not provide coverage for this policy or contract. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or health maintenance organization or in selecting an insurance policy or contract. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

Coverage is NOT provided for any portion OF YOUR CONTRACT that is not guaranteed by the insurer or for which you have assumed the risk.

Insurance companies and health maintenance organizations or their agents are required by law to give or send you this notice. *However, insurance companies, health maintenance organizations and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy or health maintenance organization coverage.*

The Guaranty Association or the West Virginia Insurance Commission will respond to questions you may have which are not answered by this document. Policyholders with additional questions may contact:

West Virginia Life and Health Insurance Guaranty Association
P.O. Box 816
Huntington, West Virginia 25712

West Virginia Insurance Commissioner
Consumer Services Division
900 Pennsylvania Avenue
P.O. Box 50540
Charleston, West Virginia 25305-0540
Toll Free 1-888-879-9842
TDD 1-800-435-7381

The state law that provides for this safety-net coverage is called the West Virginia Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the West Virginia Life and Health Insurance Guaranty Association if they live in West Virginia and hold a life, health or annuity policy, plan or contract, or if they are insured under a group life, health or annuity policy, plan or contract, issued by a member insurer. Member insurer also includes non-profit service corporations (W. Va. Code §33-24), health care corporations (W. Va. Code §33-25) and health maintenance organizations (W. Va. Code §33-25A). The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies, plans or contracts are not protected by this Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent member insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The member insurer was not authorized to do business in this state;
- The policy, plan or contract was issued at a time when the member insurer was not licensed or authorized to do business in the state;
- The policy, plan or contract was issued by a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policy, plan or contract holder is subject to future assessments, an insurance exchange, an organization that has a certificate or license limited to the issuance of charitable gift annuities or any entity similar to the above.

The Guaranty Association also does not provide coverage for:

- Any policy, plan or contract, or portion of a policy, plan or contract that is not guaranteed by the member insurer or for which the individual or contract holder has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends;
- Credits given in connection with the administration of a policy, plan or contract by a group contract holder;
- Employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
  i. multiple employer welfare arrangement;
  ii. minimum premium group insurance plan;
  iii. stop loss group insurance plan; or
  iv. administrative services only contract;
- Any unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension guaranty corporation;
- Any portion of any unallocated contract that is not issued to or in connection with a specific employee, union or association's benefit plan or a governmental lottery.
- Any policy, plan or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C and D or Medicaid;
- An obligation that does not arise under the written terms of the policy, plan or contract, including claims based on marketing materials; claims based on side letters or riders not approved by the Commissioner; misrepresentations regarding policy benefits; extracontractual claims or claims for penalties or consequential or incidental damages.
- A contractual agreement that establishes the member insurer's obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or trustee, which is not an affiliate of the insurer;
- Structured settlement annuity benefits, the rights to which have been transferred by the payee or beneficiary in a structured settlement factoring transaction.

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the member insurer would owe under a policy, plan or contract. Also, for any one insured life, regardless of the number of policies, plans or contracts, the Guaranty Association will only pay:

- $300,000 in life insurance benefits, but no more than $100,000 in net cash surrender and net cash withdrawal values;
- $300,000 for disability income insurance;
- $300,000 for long term care insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
- $500,000 for health benefit plans (W. Va. Code §33-26A-5(10)); and
- $100,000 for all other types of accident and sickness insurance coverages not defined as disability income insurance, long term care insurance, or health benefit plans.

Also for any one insured life, the Guaranty Association will only pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company for all policies or contracts other than health benefit plans, in which case the aggregate limit shall not exceed $500,000 with respect to any one individual.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund governmental retirement plans under §§401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in the present value of annuity benefits including net cash surrender and net cash withdrawal values per participating individual. In no event shall the Guaranty Association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition.
Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito.
Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung.
Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。
ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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An Independent Licensee of the Blue Cross and Blue Shield Association

my Blue Access WV EPO Silver 2900

Non-Group

HEALTH CARE CERTIFICATE

YOUR HEALTH CARE BENEFITS
AND
HOW TO USE THEM

West Virginia
Health Care Certificate

TABLE OF CONTENTS

IMPORTANT INFORMATION ABOUT THIS COVERAGE

TTY Number. For TTY/TDD Hearing Impaired services, please dial 711 and the number on the back of your ID card.

My Blue Access WV EPO Policy is an Exclusive Provider Organization (EPO) product. This means that you will receive benefits only when you receive care from Network Providers, except for covered emergency care and approved exceptions. The status of Network Providers is subject to change. You should check the status of your Provider before receiving Covered Services.

If Covered Services are not received from a Network Provider, Prior Authorization must be obtained from Highmark WV.

Remember, in an emergency, always go to the nearest appropriate medical Facility or call 911 for assistance.

A. MEMBER SERVICES

If you have questions about your coverage or are directed to contact Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield West Virginia ("Highmark WV"), you should contact Member Services, unless directed otherwise. Member Services can be reached using the number and address located on the back of your ID Card.

B. NOT A PROVIDER OF SERVICES

We do not provide Services. We only pay for Covered Services you receive from Providers. We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Services to you. Any decision to receive care is solely between you and your Provider. Any action by Highmark WV pursuant to any utilization management, referral management, discharge planning, Medical Necessity and Appropriateness determination or other functions in no way absolves the Provider of the responsibility to provide appropriate medical care to the Covered Person.

C. PRE-CERTIFICATION REVIEW

This Policy contains a Pre-Admission Certification Review Limitation as described in Sections V and VII. Pre-Certification Review is limited solely to determining Medical Necessity and Appropriateness. It is not a guarantee of coverage or payment.

D. NOTICE

Policyholder hereby expressly acknowledges his/her understanding this agreement constitutes a Contract solely between the Policyholder and Highmark WV, which is an independent corporation operating under a license from the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Highmark WV to use the Blue Cross and Blue Shield Service Marks in the state of West Virginia, and that Highmark WV is not contracting as the agent of the Association.

The Policyholder further acknowledges and agrees that he/she has not entered into this agreement based upon representations by any person or entity, other than Highmark WV and that no person, entity or organization other than Highmark WV shall be held accountable or liable to the Policyholder for any of Highmark WV's obligations to the Policyholder created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Highmark WV other than those obligations created under other provisions of this agreement.

E. ADDRESS

Highmark Blue Cross Blue Shield West Virginia
614 Market Street
Parkersburg, WV 26101

F. MEDICAL NECESSITY AND APPROPRIATENESS REQUIREMENT AND MEMBER LIABILITY

All Services must be Medically Necessary and Appropriate unless otherwise specified. Medical Necessity and Appropriate is determined by qualified Highmark WV personnel. Generally, Network Providers are prohibited from billing you for Services determined by Highmark WV to not be Medically Necessary and Appropriate. However, you could be responsible for such Charges in certain circumstances. In order to charge you, among other things, the Network Provider must provide you with advance notice, in writing, that the Service or Supply may not be Medically Necessary and Appropriate along with estimated Charges. You must also agree in writing to proceed with such Services and Supplies and to assume the cost thereof. In addition to the preceding requirements, Highmark WV requires some Network Providers to specifically request a determination in advance that a Service or Supply is not Medically Necessary and Appropriate. For more information, refer to Section VII. Out-of-Network Providers may bill you for Services which are not covered under this Policy and the Member will be responsible for all Charges Incurred.

G. UTILIZATION REVIEW

When conducting a Utilization Review, only the information necessary will be collected. We will ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in performing the Utilization Review or benefit determination.

H. PRIOR AUTHORIZATION

Certain Services require Prior Authorization. For more information, go to Section VII, call Member Services or visit Highmark WV's website at www.highmarkbcbswv.com. After you log in go to Your Coverage Tab, Useful Coverge Information, and then Procedures That Require Authorization.

I. WV Non-Group Policy

A. NOTICE TO BUYER

This Policy may not cover all of the costs associated with medical care Incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

B. EXAMINATION RIGHT

This Policy can be cancelled by returning it within 10 days of having it in your possession, by mail or in person to:

Highmark Blue Cross Blue Shield West Virginia
614 Market Street
P.O. Box 1948
Parkersburg, West Virginia 26102

Any paid premiums will be fully refunded.

C. AGREEMENT

In consideration of your Application and in return for the payment of premiums, we offer this Non-Group Policy to you. Highmark WV **may** be called **we, us,** or **our.** We will refer to the Policyholder as **you** or **your**. Any reference to Highmark WV may also include its Designated Agent as defined herein and with whom Highmark WV has contracted, either directly or indirectly, to perform a function or service in the administration of this Contract.

This Non-Group Policy, with the Application, Identification Card and any Riders, is the entire Policy between you and us.

By paying for and accepting this Non-Group Policy, you are entitled to benefits that are explained in this document. Your coverage will begin on the Effective Date of your Policy and will continue subject to monthly renewals until the Policy is terminated, cancelled, or coverage ends.

D. RENEWAL, CONTINUATION AND NON-RENEWAL

This Policy constitutes an agreement with us. You may renew this Policy from month to month by paying the premiums as specified below. Except as authorized by the West Virginia Insurance Commission, we shall neither cancel nor non-renew this Policy. Any non-renewal by us will be without prejudice to any Claim Incurred prior to the date of non-renewal. We may change the premiums for this Policy by notifying you at least 30 days in advance of the premium change.

E. PREMIUMS

1. Initial

You must pay the initial premium on or before the Effective Date of this Policy. This Policy will not be in force until we have received this premium.

2. Grace Period, Cancellation for Nonpayment and Reinstatement

This Policy will automatically renew monthly as long as you pay the premiums when due. For further periods of coverage, the required premiums must be paid in advance or within a grace period of thirty-one (31) days after the due date. The grace period does not apply when we refuse to renew this Policy on an anniversary date.

If we do not receive the required premium from you by the end of the grace period, your coverage will be cancelled effective as of the due date for which the required premium was not received. Your billing statement from us may be used to provide you with final notice of cancellation of your coverage. Section III contains additional information regarding grace periods and eligibility.

If premiums are delinquent for a Member who receives Advance Premium Tax Credit, and at least one month's premium has been paid in full during the benefit year, coverage will be terminated after the exhaustion of a three (3) month grace period. Benefits will only be provided under this Policy for Covered Services received during the first month of the three (3) month grace period if payment of the appropriate premium amount by the Covered Person is not received prior to the end of the grace period. Failure of Highmark WV to receive Advance Payment of Premium Tax Credits shall not be grounds for termination of this Policy.

F. HOW TO USE YOUR POLICY

This Policy gives you the details you need to understand your health care benefits. We have tried to write it in simple terms that are easy to understand. Please read this Policy carefully and completely to understand the benefit coverage. It is important that you keep a copy of this Policy and refer to it if you have any questions about the benefits. Please refer to www.highmarkbcbswv.com to assure you have the most current version. You may also call Member Services to have a new Policy sent to you.

G. HOW AND WHEN YOUR BENEFITS MAY CHANGE

We reserve the right to change or revise the benefits provided by this Policy at any time in order to comply with benefit changes required by law. If the provisions of this Policy are changed or revised, you will be given a notice thirty (30) days prior to the changes becoming effective. If you continue paying the premium, it is conclusively determined that you have accepted the changes.

We reserve the right to change or revise the benefits provided by this Policy at any time as a result of extraordinary circumstances, including but not limited to a public health emergency, natural disaster or other catastrophe. If the provisions of this policy are changed or revised we will provide notice of the change as soon as reasonably practicable. We will do everything in our power to ensure benefits are provided as described in this certificate, but cannot be responsible for delays during a public health emergency, natural disaster or other catastrophe.

If you are receiving Covered Services under the Policy at the time your new benefits become effective, we will only pay for such services to the extent that they continue to be Covered Services under the new benefits.

H. DEFINITIONS

Certain words in this Policy are defined. The defined words have precise meanings and will be capitalized throughout this text so that you will pay special attention to them. They are either defined in Section II or where used in the text.

I. CANCELLATION

You may cancel this Policy at any time by giving written notice. This Policy will be canceled on the last day of the month for which a premium has been received or on such later date as specified in the notice. This Policy represents a monthly contract between you and us. Premium will not be pro-rated.

J. FRAUD

We may void, terminate, refuse to renew or modify this Policy, or deny any Claim in whole or in part for any of the following reasons:

- You try to obtain benefits to which you know you are not entitled;

- You help someone try to obtain or obtain benefits to which you know that person is not entitled;
- Misrepresentation, fraud or forgery relating to Covered Services;
- Misrepresentation, fraud or forgery relating to the Application; or
- For unauthorized use of the ID Card issued to you to obtain benefits to which you or another person is not entitled.

Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

K. NOTIFICATION PROVISIONS

Any notice from you concerning this Policy will be sufficient if sent to:

Highmark Blue Cross Blue Shield West Virginia
614 Market Street
PO Box 1948
Parkersburg, West Virginia 26102

L. INFORMATION FOR NON-ENGLISH SPEAKING MEMBERS

Members who do not speak English can call the toll-free number on the back of their ID Card to be connected to the language services interpreter line. Member Services representatives are trained to make this connection.

M. MEMBER RIGHTS AND RESPONSIBILITES

You have the right to:

- Receive information about Highmark WV, its products and its services, its practitioners and Providers, and your rights and responsibilities.
- Be treated with respect and recognition of your dignity and right to privacy.
- Participate with practitioners in decision-making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.
- Have a candid discussion of appropriate and/or Medically Necessary and Appropriate treatment options for your condition(s), regardless of cost or benefit coverage.
- Have a candid discussion of appropriate and/or Medically Necessary and Appropriate treatment options for your condition(s), regardless of cost or benefit coverage.
- Voice a Complaint or file an Appeal about Highmark WV or the care provided and receive a reply within a reasonable period of time.
- Make recommendations regarding the Highmark WV Members' Rights and Responsibilities policies.

You have a responsibility to:

- Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and Providers need in order to care for you.
- Follow the plans and instructions for care that you have agreed on with your practitioners.
- Communicate openly with the Physician you choose. Ask questions and make sure you understand the explanations and instructions you are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with your Physician based on trust and cooperation.

N. HOW WE PROTECT YOUR RIGHT TO CONFIDENTIALITY

We have established policies and procedures to protect the privacy of our Members' protected health information ("PHI") in all forms, including oral PHI, from unauthorized or improper use. Some of the ways we protect your privacy include not discussing PHI outside of our offices, e.g., in hallways, elevators,

as well as verifying your identity before we discuss PHI with you over the phone. As permitted by law, we may use or disclose PHI for treatment, payment and health care operations, such as: Claims management, routine audits, coordination of care, quality assessment and measurement, case management, Utilization Review, performance measurement, Member service, credentialing, medical review and underwriting. With the use of measurement data, we are able to assist you by offering care management programs including health, wellness and disease management programs.

If we ever use your PHI for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas.

You have the right to access the information your Physician has been keeping in your medical records, and any such request should be directed first to your Network Physician.

You benefit from the many safeguards we have in place to protect the use of data we maintain. This includes requiring our employees to sign statements in which they agree to protect your confidentiality, using computer passwords to limit access to your PHI, and including confidentiality language in our contracts with Physicians, Hospitals, vendors and other health care Providers.

Our Privacy Department reviews and approves policies regarding the handling of confidential information.

O. CARE MANAGEMENT PROGRAMS

Care management programs are designed to help you maintain good health, and to work with you to manage chronic conditions or special health care needs and reduce risk factors.

You may be offered care and disease management Services as deemed appropriate from time to time by us.

You may also be offered an opportunity to participate in certain care management programs that offer devices or durable medical equipment at no additional cost.

Whether or not you decide to participate in such programs will not affect your continued eligibility, your premium, or reduce your benefits. We reserve the right to modify or discontinue any such program at any time.

P. DIGITAL PROGRAMS

Highmark WV may offer Members incentives to encourage the use of electronic or digital services. Such incentives may take the form of cash or cash equivalents and, therefore, may be subject to taxation as miscellaneous income. Any such programs will not affect your continued eligibility, your premium, or reduce your benefit under this Policy.

Highmark WV reserves the right to modify or discontinue any such program at any time.

II. Definitions

Actual Charge. The amount ordinarily charged by a Provider for Services. Actual Charges do not include the application of any discount, allowance, incentive, adjustment or settlement.

Advance Payment of Premium Tax Credits (APTC). Tax credit payments made on behalf of the Member on an advance basis and in amounts as determined by the Exchange, which are applied to the premium amounts due under this Policy.

Adverse Benefit Determination. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's or Eligible Dependent's eligibility to participate in a group health plan, a determination that a benefit is not a covered benefit; source-of-injury exclusion, Network exclusion, or other limitation on otherwise covered benefits, or a determination that a benefit is Experimental, Investigational, or not Medically Necessary and Appropriate. An Adverse Benefit Determination also includes any Rescission of coverage, whether or not there is an adverse effect on any particular benefit at the time.

Affordable Care Act (ACA). The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) and its implementing regulations.

Ambulatory Medical Facility. A Facility Other Provider with an organized staff of Physicians that:

- Provides treatment by or under the supervision of Physicians and nursing Services whenever the patient is in the Facility;
- Does not provide Inpatient accommodations;
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or Professional Other Provider; and
- Has met all state health planning and licensure requirements.

Ambulatory Surgical Facility. A Facility Other Provider with an organized staff of Physicians that:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing Services whenever the patient is in the Facility;
- Does not provide Inpatient accommodations;
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or Professional Other Provider; and
- Has met all state health planning requirements.

Ancillary Provider. A person or entity licensed where required and performing services within the scope of such licensure. Ancillary Providers include, but are not limited to:

- Ambulance Service
- Clinical Laboratory
- Home Infusion and Suite Infusion Therapy Provider
- Independent Diagnostic Testing Facility (IDTF)
- Suppliers

Annual Open Enrollment Period. The period each year during which an Eligible Individual may enroll or change coverage for the following Benefit Period under this Agreement.

Anti-Cancer Medication. An FDA-approved medication prescribed by a treating Physician who determines that the medication is Medically Necessary and Apprpopriate to kill or slow the growth of cancerous cells in a manner consistent with nationally accepted standards of practice.

Appeal. An Appeal is when a Member is seeking reconsideration of a Claim or authorization decision.

Application. All questionnaires and forms required by us to determine your eligibility and insurability.

Applied Behavior Analysis. The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder. Any pervasive developmental disorders defined by the mos recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor, including Autism Spectrum Disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Benefit Period. The specified period of time during which Charges for Covered Services must be Incurred in order to be eligible for payment by the Plan. A Charge shall be considered Incurred on the date a Member receive the Service or Supply for which the Charge is made.

Birthing Center. A Facility Other Provider that meets the specifications and is licensed in accordance with West Virginia law. Outside of West Virginia, it is a Facility Other Provider that we recognize as a Birthing Center which:

- Has an organized staff of Physicians or nurse-midwives;
- Has permanent facilities and equipment for the primary purpose of providing prenatal, postpartum, labor, vaginal delivery, and newborn care for uncomplicated pregnancies;
- Provides Treatment by or under the supervision of Physicians or nurse-midwives and nursing Services when the patient is in the Facility;
- Does not provide primarily Inpatient accommodations;
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or Professional Other Provider; and
- Has met all state licensure and health planning requirements.

Certificate of Exemption. Evidence that a determination has been made by the Exchange or such other permissible legal authority that the individual to whom the certificate applies is currently not required to maintain minimum essential as defined by the Affordable Care Act by reason of its unaffordability or specific hardship.

Charges. See Actual Charge.

Certified Behavior Analyst. An individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.

Claim. A Claim is a request made by or on behalf of a Member for Precertification or prior approval of a Service as required under this Policy, or for the payment or reimbursement associated with a Service that has been received by a Member. A Claim is only a request for approval or payment. It must contain the information requirements and be in the format required by us. Approval or payment is specifically conditioned by the terms of this Policy.

Coinsurance. A percentage of the Plan Allowance for Covered Services for which you are responsible, after the Deductible has been met and benefits for Covered Services have been paid by us. See Sections IV and VII.

Commissioner. The West Virginia Insurance Commissioner.

Complaint. A Complaint is any correspondence in which a Member has concerns about his or her plan not relating to a Claim or authorization decision.

Concurrent Care. An ongoing course of Treatment to be provided over a period of time or number of Treatments.

Co-Pay or Copayment. An upfront set amount that is the responsibility of the Covered Person for Office Visits and other Services as specified in Section IV or on your ID Card.

Covered Person. The Policyholder and, if other than individual coverage is selected, the Eligible Dependents of the Policyholder.

Covered Service. A Provider's Service or Supply, that is eligible as described in this Policy, and is Medically Necessary and Appropriate and within generally accepted medical standards.

Craniomandibular Disorders (CMD). Problems of the stomatognathic system, including disorders of the Temporomandibular Joint, muscles of mastication and the related occlusion.

Custodial Care. Care which is not Skilled Care or which does not require the constant supervision of skilled medical personnel including, but not limited to:

- Administration of medication, which can be self-administered or administered by a layperson with training;
- Help in walking, bathing, dressing, feeding, or the preparation of special diets;
- Assisting the patient in meeting activities of daily living;
- Care that can be taught or administered by a layperson;
- Rest care; or
- Care for someone's convenience.

Custodial Care does not include care provided for its therapeutic value in the treatment of injury, ailment, condition, disease, disorder or illness.

Day/Night Psychiatric Facility. A Facility Other Provider which is primarily engaged in providing Diagnostic Services and therapeutic Services for the Treatment of Mental Illness only during the day or during the night.

Deductible. The amount of the Plan Allowance for Covered Services, usually stated in dollars, for which you are responsible, before we start to pay.

Dependent. See Eligible Dependent.

Dentally Necessary. Dental services determined by a Dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the Dentist and the prevailing standards of care in the professional community. This determination will be made by the Dentist in accordance with guidelines established by Highmark WV.

Dentist. A person who is a doctor of dental Surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.) licensed where required and performing services within the scope of such licensure.

Designated Agent. An entity that has contracted, either directly or indirectly, with Highmark WV to perform a function and/or service in the administration of this Contract. Such function and/or service may include, but is not limited to, medical management and Provider referral.

Diabetes Prevention Program. Benefits are provided for those Members meeting certain medical criteria of having a high risk of developing type 2 diabetes when enrolled in a Diabetes Prevention Program that is offered through a Network Diabetes Prevention Program. Coverage is limited to one (1) enrollment in a Diabetes Prevention Program per year, regardless of whether you complete the Diabetes Prevention Program.

Diabetes Prevention Provider. An entity that offers, among other services, a Diabetes Prevention Program based on an in-person/onsite model.

Diagnostic Service. A test or procedure performed when you have specific symptoms to detect or monitor your injury, ailment, condition, disease, disorder, or illness. It must be ordered by a Physician or Professional Other Provider performing within the scope of their license. These Services are limited to the Diagnostic Services listed in this Policy.

Dialysis Facility. A Facility Other Provider that mainly provides Dialysis Treatment, maintenance, or training to patients on an Outpatient or home care basis.

Domestic Partner. A member of a domestic partnership consisting of two (2) partners, each of whom has registered with a Domestic Partner registry in effect in the municipality/governmental entity within which the

Domestic Partner currently resides, or who meets the definition of a Domestic Partner as defined by the state or local government where the individual currently resides or meets all of the following:

- Is unmarried, at least eighteen (18) years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
- Is not related to the other party by adoption or blood;
- Is the sole Domestic Partner of the other partner and has been a member of this domestic partnership for the last six (6) months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and
- Meets (or agrees to meet) the requirements of any applicable federal, state or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future.

To be eligible for Dependent coverage, proof that Dependents meet the above criteria may be required.

Effective Date. 12:01 a.m. on the date when your coverage begins as indicated in the Eligibility Section of this Policy.

Eligible Dependent. **A** Covered Person other than the Policyholder, as shown in the Eligibility Section of this Policy.

Eligible Individual. Eligible Individuals are those who have been approved for coverage under the terms of this Policy and Highmark WV policies and procedures.

Emergency Admission. An admission as an Inpatient in a Hospital from a Hospital emergency room as a result of an Emergency Medical Condition such that the Covered Person is unstable and unable to be transferred to another Hospital and which, in the absence of immediate and ongoing medical attention as an Inpatient, would reasonably result in:

- Permanently placing the Covered Person's health in jeopardy;
- Serious impairment to bodily functions;
- Serious and permanent dysfunction of any body organ or part; or
- Other serious medical consequences.

Emergency Medical Condition. A condition that manifests itself by the sudden and unexpected onset of acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of any bodily part or organ. Emergency Medical Conditions include heart attacks, strokes, loss of consciousness or respiration, convulsions and other acute conditions which we determine to be a Medical Emergency only if:

- Severe symptoms occur suddenly and unexpectedly;
- Immediate care is secured; and
- The illness or condition, as finally diagnosed or as indicated by its symptoms, is one, which would normally require immediate Medical Care.

Emergency Medical Condition for the Prudent Layperson. A condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the Prudent Layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health, or, with respect to a pregnant women, the health of the unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Enteral Foods. A liquid source of nutrition administered under the direction of a Physician which may contain some or all of the nutrients necessary to meet the minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

Exchange (Health Insurance Marketplace). Governmental agencies or non-profit entities that will serve as marketplaces to facilitate the purchase of health insurance in the individual and small group markets, assist individuals who are eligible to receive premium tax credits and cost-sharing reductions and support enrollment in federal or state insurance programs.

Experimental and Investigational. A Treatment, procedure, Facility, equipment, drug, Service or Supply ("intervention") that has been determined not to be medically effective for the condition being treated and therefore is considered Experimental or Investigative in nature. An intervention is considered to be Experimental or Investigative if:

- the intervention does not have FDA approval to be marketed for the specific relevant indication(s); or
- available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or
- the intervention is not proven to be as safe or effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or
- the intervention does not improve health outcomes; or
- the intervention is not proven to be applicable outside the research setting.

The above criteria apply even if there is no available alternative to treat an injury, ailment, condition, disease, disorder, or illness. This determination will be made by Highmark WV, in its sole discretion, and will be conclusive.

Highmark WV believes that decisions for evaluating new technologies, as well as new Applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with our nationally recognized Medical Affairs Committee to review new technologies and new Applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered "Experimental or Investigative" and is not generally covered. However, it may be re-evaluated in the future.

A similar process is followed for evaluating new pharmaceuticals. The Pharmacy and Therapeutics (P & T) Committee assesses new pharmaceuticals based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark-employed pharmacist and/or medical director, five board-certified, actively practicing Network Physicians and two Doctors of Pharmacy currently providing clinical pharmacy services within the Highmark WV Service Area. At the committee's discretion, advice, support and consultation may also be sought from Physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local Physician and specialist input and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

Highmark WV recognizes that situations may occur when you elect to pursue Experimental or Investigative Treatment. If you have a concern that a Service you will receive may be Experimental or Investigational, you or the Hospital and/or professional Provider may contact Highmark WV's Member Service to determine coverage.

Facility. An institution providing Health Care Services or a health care setting, including but not limited to Hospitals and other licensed Inpatient centers, Ambulatory Surgical or treatment centers, skilled nursing centers, Residential Treatment Centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Facility Other Provider. The following entities that are licensed, where required, and which for compensation from their patients render Services. Only the following facilities are included in this definition:

- Ambulatory Medical Facility
- Ambulatory Surgical Facility
- Birthing Center
- Day/Night Psychiatric Facility
- Dialysis Facility
- Substance Use Treatment
- Freestanding Renal Dialysis Centers
- Home Health Care Agency
- Hospice
- Psychiatric Facility
- Psychiatric Hospital
- Rehabilitation Facility
- Skilled Nursing Facility

Fees. See Office Visit Fees and Co-Pay.

Final Adverse Benefit Determination. An Adverse Benefit Determination that has been upheld by Highmark WV at the completion of the Internal Grievance or Appeal Procedures or an Adverse Determination with respect to which the Internal Grievance or Appeal Procedures have been exhausted.

Grievance. A written Complaint or, if the Complaint involves an Urgent Care request submitted by or on behalf of the Member, an oral Complaint regarding availability, delivery or quality of Health Care Services, or matters pertaining to the contractual relationship between the Member and Highmark WV, or a request for an approved exception to obtain Covered Services from an Out-of-Network Provider.

Habilitation Services. Health Care Services that help a person keep learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology and other Services for people with disabilities in a variety of Inpatient and/or outpatient settings.

Health Care Services. Services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Home Health Care Agency. A Facility Other Provider which:

- Provides Skilled Care and other Services on a visiting basis for Covered Persons who are Homebound; and
- Is responsible for supervising the delivery of such Services under a group health plan prescribed and approved in writing by the attending Physician.

Home Infusion and Suite Infusion Therapy Provider. A Provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide Infusion Therapy to patients at their place of residency or at an infusion suite.

Homebound. A condition due to an illness or injury which restricts ability to leave the residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if the individual has a condition that leaving home is medically contraindicated (e.g. quarantined due to immunocompromised host, communicable disease).

Hospital. An institution which meets the specifications of Article 5B, Chapter 16 of the West Virginia Code or hospital licensure laws of the state in which the Facility is located.

Identification Card (ID Card). The health care card provided to you by Highmark WV, which shows your identification number.

Immediate Family. You and your spouse/Domestic Partner (if applicable), parents, stepparents, grandparents, nieces, nephews, aunts, uncles, brothers, sisters, children and stepchildren by blood, marriage, or adoption.

Incurred (Incur). A Charge is considered Incurred on the date the Covered Person receives the Service or Supply for which the Charge is made.

Independent Review Organization (IRO). A entity, approved by the Commissioner, to conduct external reviews of Adverse Benefit Determinations and Final Adverse Benefit Determinations.

Indian. An individual that meets the requirements of section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638).

Indian Health Service (IHS) Provider. The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization as defined in 25 U.S.C. §1603.

Infusion Therapy Provider. A Provider, which has been licensed by the state, accredited by The Joint Commission and Medicare, if appropriate, who provides Infusion Therapy to Members.

Initial Open Enrollment Period. A designated period during which an Eligible Individual may enroll for coverage for the designated Benefit Period under this Agreement.

Inpatient. A Covered Person who receives care as a registered bed patient in a Hospital or Facility Other Provider for whom a room and board Charge is made.

Intensive Outpatient. Multi-disciplinary, structured Services (either in an approved Hospital or non-Hospital setting) provided at a greater frequency and intensity than routine Outpatient treatment. These are generally up to three hours per day, up to five days per week. Common treatment modalities include individual, family, group and medication therapies.

Investigational. See Experimental or Investigational.

Local PPO Network. All Ancillary Providers, Facility Providers, Professional Providers and Suppliers who have an agreement, either directly or indirectly, with any licensee of the Blue Cross Blue Shield Association located Out-of-Area pertaining to payment as a participant in that licensee's PPO network for Covered Services rendered to a Member under this Agreement.

Medicaid / Medicaid Program. A state program of medical aid for low income persons established under Title XVIII of the Social Security act of 1965, as amended.

Medical Care. Professional Services given by a Physician or a Professional Other Provider to treat an injury, ailment, condition, disease, disorder, or illness.

Medically Necessary and Appropriate (or Medical Necessity and Appropriateness). Services or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and
- not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service, sequence of services or site of service at least as likely to produce equivalent therapeutic or diagnostic results given the nature of the patient's diagnosis, treatment, illness, injury, or disease, the severity of the patient's symptoms, or other clinical criteria.

The Plan reserves the right, utilizing the criteria set forth in this Definition, to render the final determination as to whether a Service or supply is Medically Necessary and Appropriate. No benefits hereunder will be provided unless the Plan determines that the Service or supply is Medically Necessary and Appropriate.

Medical Screening Examination. An appropriate examination within the capability of the Hospital's emergency department, including ancillary Services routinely available to the emergency department, to determine whether an Emergency Medical Condition exists.

Medicare / Medicare Program. The program of health care for the aged and disabled established by Title XIX of the Social Security Act of 1965, as amended.

Medicare Approved. The status of a Provider that is certified by the United States Department of Health and Human Services to receive payment under Medicare.

Member. See Covered Person.

Member Liability. The amount a Member is personally responsible for under the terms of this Policy. Such amounts include Deductibles, Fees, Coinsurance, Out-of-Network Liability and non-Covered Services.

Network. The aggregate of all Network Providers for a Highmark WV policy.

Network Coinsurance. A percentage of the Plan Allowance for Covered Services for which you are responsible when the Covered Services are received from a Network Provider, after the Deductible has been met and benefits for Covered Services have been paid by us as indicated in Section IV.

Network Diabetes Prevention Provider. A Diabetes Prevention Provider that contracts with the Plan to offer a Diabetes Prevention Program based on a digital model or on an in-person/onsite model.

Network Provider. The status of a Provider as designated by Highmark WV as a part of a Network. It is to your financial advantage to use a Network Provider.

All Network Providers have agreed to file Claims for Highmark WV's Covered Persons. When you receive Services from Network Providers, normally all you have to do is show your ID Card. The Network Provider will file a Claim on your behalf, and will be reimbursed directly from us for Covered Services. A Network Provider has the right to request proof that any required Deductible, Fee or Network Coinsurance, if any, have been met before filing your Claim with Highmark WV, and in the event these amounts have not been met, to request that you pay for the Covered Services (up to those amounts), at the time Services are rendered. The Network Provider will still file a Claim on your behalf to ensure that the amount you paid is credited toward meeting these amounts.

Office Visit. Visit Services provided in the office of Physicians or Professional Other Providers.

Office Visit Fee. An upfront fee, for Office Visits with Physicians and Professional Other Providers.

Originating Site. A physical setting from which the Member's Physician or the treating Specialist communicate via interactive audio and streaming video telecommunications.

Out-of-Area Provider. A Provider located outside the Service Area.

Outpatient. A Covered Person who receives Services or Supplies while not an Inpatient.

Partial Hospitalization. An intensive, non-residential, level of Service where multi-disciplinary medical and nursing Services are required. This care is provided in a structured setting (either in an approved Hospital or non-Hospital setting) similar in intensity to Inpatient, requiring more than three hours per day, up to seven days per week. Common modalities include individual, family, group, and medication therapies.

Participating Dentist. A Dentist who has an agreement with Highmark WV, either directly or indirectly, pertaining to payment as a participant in the United Concordia Advantage Provider Network for Covered Services rendered to a Member.

Participating Provider. A Provider who, under a contract with Highmark WV or with its contractor or subcontractor, has agreed to provide Health Care Services to Covered Persons with an expectation of receiving payment, other than Coinsurance, Copayments or Deductibles, directly from Highmark WV.

Participating Vision Provider. A Vision Provider who has an agreement with Highmark WV, either directly or indirectly, pertaining to payment as a participant in the Davis Vision Network for the payment of Covered Services rendered to a Member.

Physician. A person who is qualified as a Physician under state law and licensed to diagnose, treat and perform procedures within the scope of their license.

Plan Allowance. The amount used to determine reimbursement by Highmark WV for Covered Services provided on behalf of a Covered Person based on the type of Provider who renders such Services or as required by law. The Plan Allowance is used to calculate Highmark WV's payment, as set forth in Section IV, and to determine Member Liability. You will receive benefits only when Services are received from a Network Provider.

The Plan Allowance is determined by Highmark WV in its sole discretion and in most circumstances unrelated to Actual Charges. Any waiver of a Covered Person's cost sharing obligations or Out-of-Network Liability by a Provider will be deemed an equivalent reduction of the Plan Allowance. The Plan Allowance may exceed Actual Charges in some circumstances.

Policy. This document, including the Application, ID Card and any Riders.

Policyholder. An individual who is enrolled under the terms and conditions of this Policy.

Precertification. See Prior Authorization.

Primary Care Provider (PCP). A Physician who limits his or her practice to family, general, internal or pediatric medicine, or a certified registered nurse practitioner each of whom has an agreement with the Plan pertaining to payment as a Network participant and has specifically contracted with the Plan to: a) be designated as a PCP; b) supervise, coordinate and provide specific basic medical services to Members; and c) maintain continuity of patient care.

Prior Authorization. A determination made by Highmark WV that a Health Care Service proposed for or provided to a Member is Medically Necessary and Appropriate. Prior Authorization may also be referred to as Precertification. Prior Authorization is a determination of Medical Necessity and Appropriateness only and does not guarantee coverage or payment.

Professional Other Provider. Persons or entities, designated by Highmark WV as Professional Other Providers or, for whose Services payment would be required by law when they provide Covered Services within the scope of their licenses, including, but not limited to:

- Certified registered nurse anesthetist
- Dentist
- Doctor of chiropractic medicine
- Durable medical equipment Providers
- Infusion Therapy Provider
- Hospice
- IV therapists
- Laboratory (must be Medicare Approved)
- Licensed practical nurse (L.P.N.)
- Licensed vocational nurse (L.V.N.)
- Nurse Practitioner
- Nurse-midwife
- Physical therapist
- Physician's Assistant
- Podiatrist
- Psychologist
- Psychotherapist
- Registered nurse (R.N.)
- Social Worker

Provider. A Hospital, Facility Other Provider, Physician or Professional Other Provider.

Prudent Layperson. A person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an Emergency Medical Condition exists for which emergency treatment should be sought.

Psychiatric Facility. A Facility Other Provider that primarily provides Diagnostic Services and therapeutic Services for the treatment of Mental Illness on an Outpatient basis.

Psychiatric Hospital. A Facility Other Provider which is primarily engaged in providing Diagnostic Services and therapeutic Services for the Inpatient Treatment of Mental Illness. Such Services are provided by or under the supervision of an organized staff of Physicians, with continuous nursing Services provided under the supervision of a registered nurse.

Psychologist. A Professional Other Provider who is a licensed Psychologist having either a doctorate in psychology or a minimum of five years of clinical experience. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

Qualified Health Plan (QHP). A health plan that has met certification criteria established by the U.S. Department of Health and Human Service to offer health insurance coverage through an Exchange.

Qualified Individual. An individual who seeks to enroll in a QHP offered through an Exchange, resides in the state that has established the Exchange and who is determined eligible by the Exchange.

Rehabilitation Hospital. A Facility Provider approved by The Joint Commission or by the Commission on Accreditation of Rehabilitation Facilities or certified by Medicare which, for compensation from its patients, is primarily engaged in providing Skilled Rehabilitation Services on an Inpatient basis.

Rehabilitation Services. Includes diagnostic tests, assessment, monitoring or treatments which are designed to remediate a patient's condition or to restore the patient to his or her optimal physical, medical, psychological, social, emotional, vocational and economic status. These Services do not include Services for Vocational Rehabilitation, long-term maintenance, or Custodial Care.

Rescission. A cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. This does not include a cancellation or discontinuance of coverage under a health benefit plan having only a prospective effect or is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Residential Treatment Center/Facility. A credentialed Facility Provider primarily engaged in intensive, structure psychological Service either directly by or under the supervision of a medical professional to treat individuals with behavioral, emotional, mental or psychological problems. This Facility must also meet the minimum standards set by appropriate governmental agencies.

Responsible Party. Any individual, partnership, society, association, firm, institution, company, public or private corporation, trust, estate, syndicate, or any federal, state, county, municipal or other governmental entity or any agency thereof or any other entity who or which may be liable for payment to a Covered Person as a result of negligence, contract or otherwise, including, but not limited to, that Covered Person's own insurance company (for example, that Covered Person's own uninsured or underinsured motorist coverage for automobile insurance, medical payments provisions or homeowners coverage).

Retail Clinic. A small, consumer-driven, retail-based clinic that provides basic and preventive Health Care Services to all populations seven days a week, including evenings and weekends. The Clinic is generally staffed by Certified Registered Nurse Practitioners (CRNPs) that diagnose and treat common health problems, triage patients to appropriate levels of care, advocate for medical homes for all patients and reduce unnecessary Visits to emergency rooms.

Serious Mental Illness. For purposes of Mental Health Parity, "Serious Mental Illness" means an illness included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, under the diagnostic categories or subclassifications of: (A) Schizophrenia and other psychotic disorders; (B) bipolar disorders; (C) depressive disorders; (D) substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; (E) anxiety disorders; and (F) anorexia and bulimia.

Service or Supply. A Service, procedure, treatment, Supply, product, drug, technology, equipment, device, setting or accommodation furnished or prescribed by a Provider. In order to qualify as a Covered Service, among other things, a Service must be within a Provider's scope of permitted practices under their applicable license.

Service Area. West Virginia and Washington County, Ohio.

Skilled Care. Care that requires the skill, knowledge, and training of a Physician or one of the following performing under the supervision of a Physician:

- Registered Nurse;
- Licensed Practical Nurse; or
- Physical Therapist.

In the absence of such care, the Covered Person's health would be seriously impaired. Skilled Care is care that cannot be taught to or administered by a layperson.

Skilled Nursing Facility. A Facility Other Provider that primarily provides continuous 24-hour Inpatient Skilled Care and related Services to patients requiring convalescent and rehabilitative care. Such care must be given by a Physician or one of the following performing under the supervision of a Physician:

- Registered Nurse;
- Licensed Practical Nurse; or
- Physical Therapist

A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- Custodial Care, rest, ambulatory or part-time care; or
- Treatment for pulmonary tuberculosis.

Specialist. A Physician, other than a Primary Care Provider, whose practice is limited to a particular branch of medicine or Surgery.

Stabilize. To provide medical treatment for an Emergency Medical Condition necessary to assure with reasonable medical probability that no medical deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. This definition is not intended to prohibit, limit or delay the transportation required for a higher level of care than that possible at the treating Facility.

Substance Use Disorder. Any use of alcohol or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Use Treatment Facility. A credentialed Facility Provider which, for compensation from its patients, is primarily engaged in providing detoxification and/or rehabilitation treatment for alcohol abuse and/or drug abuse. This facility must also meet the minimum standards set by appropriate governmental agencies.

Suite Infusion Therapy Provider. An Ancillary Provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide Infusion Therapy to patients at an infusion suite.

Supply. See Service.

Surgery.

- The performance of generally accepted operative and other invasive procedures.
- The correction of fractures and dislocations.
- Usual and related preoperative and postoperative care.
- Other procedures as reasonably approved by us.

Telehealth Services. The use of real time telecommunications technology by a health care practitioner to provide Health Care Services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration.

Telemedicine Services. Telehealth Services provided by our approved telemedicine vendors via real-time interactive audio and video telecommunications technology.

Temporomandibular Joint Disorders (TMD). A group of musculo-skeletal conditions, often overlapping, that involve the Temporo-mandibular Joint or Joints, the masticatory musculature, or both. These conditions are typically characterized by pain in the preauricular area which is usually aggravated by chewing or jaw function, and are frequently accompanied, either singularly or in combination, by limitation of jaw movement, joint sounds, palpable muscle tenderness or joint soreness. Benefits for TMD are limited to pain and dysfunction arising in and from the masticatory muscle-skeletal system.

Therapy Services. Services and supplies used to promote recovery from an injury, ailment, condition, disease, disorder, or illness. The Services or supplies must be ordered by a Physician or Professional Other Provider performing within the scope of their license. These Services and supplies are limited to the Therapy Services listed below:

- **Radiation Therapy**
  The Treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.
- **Chemotherapy**
  The Treatment of malignant disease by chemical or biological antineoplastic agents.
- **Dialysis Treatments**
  The Treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.
- **Respiratory Therapy.**
  Introduction of dry or moist gasses into the lungs for treatment purposes.
- **Hyperbaric and Pulmonary Therapy**
  The administration of oxygen in a pressurized chamber. Under pressurization, oxygen levels are increased.
- **Infusion Therapy**
  The treatment by administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein.

- **Speech Therapy**
  The treatment for the correction of a speech impairment.
- **Occupational Therapy**
  The treatment by means of constructive activities designed and adapted to promote the ability to satisfactorily accomplish the ordinary tasks of daily living and those required by a particular occupational role.
- **Cardiac Rehabilitation**
  The physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.
- **Physical Therapy**
  The treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities.

Treatment(s). When a Covered Service is limited to a maximum number of Treatments, Treatment refers to each individual Service that can be billed by a Physician, Professional Other Provider, Hospital, or Facility Other Provider under a separate procedure code. When more than one Treatment is provided during one Visit to a Physician, Professional Other Provider, Hospital, or Facility Other Provider, each Treatment billed under a separate procedure code will be counted toward any maximum number of Treatments that applies to that particular Service. See Section IV in this Policy for maximums that apply to Covered Services.

Urgent Care. Medical Care or Treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment.

Urgent Care Center. Urgent Care Center is a formally structured Hospital-based or freestanding full-Service, walk-in health care clinic that is accessible to all patients, 12 hours per day, Monday thru Friday and 8 hours each on Saturday and Sunday, no appointment required, outside of a Hospital-based emergency room (ER). Urgent Care Centers generally provide the same Services as a family or primary Medical Care Physician, such as treatment of minor illnesses and injuries, physicals, x-rays, and immunizations.

Utilization Review. A system for the evaluation of the necessity, appropriateness and efficiency of the use of Health Care Services, procedures and Facilities.

Virtual Services. Telehealth Services provided by a Network Provider via real-time interactive audio and video telecommunications technology.

Vision Care Services. Vision Care Services as specified in this Agreement rendered by a Participating Vision Provider which the Plan is contractually obligated to pay or provide as a benefit to a Member.

Vision Provider. A Physician or Professional Provider licensed, where required, and performing services related to the examination, diagnosis and treatment of conditions of the eye and associated structures.

Visit(s). When a Covered Service is limited to a maximum number of Visits, Visit refers to one session or appointment with a Physician, Professional Other Provider, Hospital, or Facility Other Provider, regardless of the number of treatments or Services provided during that Visit. See Section IV of this Policy for maximums that apply to Covered Services.

Vocational Rehabilitation. The process of facilitating an individual in the choice of, or return to, a suitable situation. When necessary, assisting the individual to obtain training for such a vocation. Vocational training can also mean preparing an individual regardless of age, status, or physical condition to cope emotionally, psychologically, and physically with changing circumstances in life, including remaining at school or returning to school, work, or work equivalent.

III. Schedule of Eligibility

A. APPLYING FOR COVERAGE

When you apply for coverage, you will choose one of the following:
- Individual coverage; or
- Family coverage.

An Application must be completed in all instances. You must be a resident of West Virginia. In deciding whether or not to approve an Application, we may request more information. Coverage will not begin until your Application has been approved and you have been provided with an Effective Date.

1. Nondiscrimination

Subject to all limitations within this Policy, individuals will not be excluded from coverage under the terms of the Policy, or charged more for benefits, based on specified factors related to health status, medical condition (both physical and mental), Claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

Highmark WV does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

B. ELIGIBLE POLICYHOLDER

To be eligible to enroll as a Policyholder for coverage under this Policy, an individual must:
- be a U.S. citizen, national or other individual lawfully present in the United States;
- not be entitled for benefits under Medicare Part A or be enrolled in Medicare Part B, Medicaid or CHIP;
- not be incarcerated (other than incarceration pending the disposition of Charges);
- reside in the Service Area; and
- (if applicable) be an Indian, as defined for purposes of the Affordable Care Act.

C. ELIGIBLE DEPENDENTS

1. Eligible Dependent

An Eligible Dependent is a U.S. citizen, national or other individual lawfully present in the United States:
- not entitled for benefits under Medicare Part A or enrolled in Medicare Part B, Medicaid or CHIP;
- not incarcerated (other than incarceration pending the disposition of charges);
- be an Indian, as defined for purposes of the Affordable Care Act; and
- who has been identified by the Policyholder through the appropriate enrollment process or on an Application form accepted by the Plan as:

  a. The Policyholder's spouse under a legally valid existing marriage;
  b. The Policyholder's Domestic Partner for the duration of the Domestic Partnership. In addition, the child(ren) of the Domestic Partner shall be considered, for eligibility purposes, as if they were the child(ren) of the Policyholder as long as the Domestic Partnership exists; or

  c. The Policyholder's child, including a newborn child, step-child, child legally placed for adoption, child awarded coverage pursuant to an order of court, and legally adopted child of the Policyholder or Policyholder's spouse. The limiting age for a covered child is

twenty-six (26), unless the period of eligibility for such Dependent is otherwise extended pursuant to applicable state or federal law.

Eligibility will be continued past the date that a Dependent child turns age twenty-six (26) for the Policyholder's unmarried child who, as medically certified by a Physician, is incapable of self-support due to intellectual disability or physical disability that started before age twenty-six (26). The Plan may require proof of such Dependent's disability from time to time.

2. Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and the child will not be considered a late entrant for Dependent insurance. A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state agency that satisfies all of the following:

- the order specifies your name and last known address, and the child's name and last known address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- the order specifies each plan that it applies to.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the Policy.

3. Custodial Parent Rights

If a child has health coverage through an insurer of a noncustodial parent, the custodial parent may be provided information as may be necessary for the child to obtain benefits. The custodial parent or the Provider, with the approval of the custodial parent, may submit Claims for Services without the noncustodial parent's approval and payment for such Claims may be sent directly to the custodial parent, the Provider or the state Medicaid agency.

The payment to the custodial parent, the Provider or the state Medicaid agency fully satisfies our obligation to the noncustodial parent under this Policy with respect to the covered child's Claims.

D. EFFECTIVE DATE

Coverage starts on the Effective Date and upon acceptance by us of your Application. No benefits will be provided for Services, Supplies or Charges Incurred prior to your Effective Date. No benefits will be provided for any Services, Supplies or Charges Incurred related to an Inpatient stay that begins before, and continues beyond, your Effective Date.

E. ELIGIBILITY CHANGES AND SPECIAL ENROLLMENT

1. Changes in Eligibility

For Highmark WV to administer consistent coverage for you and your Dependents, you must inform us immediately of any changes in eligibility (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage. Changes in coverage regarding Deductibles can only be made at the time of renewal.

Each new Dependent must be added by Application to your Policy within 60 days of the event, regardless of whether you have individual or family coverage in effect.

If you applied for individual coverage, you can change to family coverage if you marry or acquire a child or children. You must notify us of the change within 60 days of the event.

NOTE: ***To notify us of changes, you must submit all necessary forms to us within 60 days of the event to add a newly acquired dependent.***

Family coverage should be changed to individual coverage when only the Policyholder is an eligible individual. **In addition, you must notify us when a Covered Person under your Policy becomes eligible for Medicare.**

2. Annual Enrollment

If you are covered by a Qualified Health Plan (QHP) offered through an Health Insurance Marketplace Exchange ("Exchange"), you may be required to enroll annually. You will receive a notification prior to the Annual Open Enrollment Period.

3. Special Enrollment

You may be permitted a Special Enrollment Period of 60 days through an Exchange from the date of occurrence of any of the following triggering events:

- A Qualified Individual or Dependent (including a spouse/Domestic Partner) of an enrollee loses other minimum essential coverage – including, for example, a loss of coverage due to divorce or legal separation; a Dependent child who reaches the Dependent age limitation; termination of employment or a reduction in hours; relocation outside a QHP's Service Area; loss of Medicaid or CHIP coverage; or decertification of a QHP outside the Annual Enrollment Period (if the individual does not select a new QHP before the Effective Ddate of the decertification);
- Qualified Individuals who lose minimum essential coverage are eligible for a Special Enrollment Period even if they are offered COBRA continuation coverage, provided that they do not actually enroll in such COBRA coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption, or placement for adoption;
- An individual who was not previously a U.S. citizen or national, or lawfully present in the U.S., gains such status;
- A Qualified Individual's previous enrollment or non-enrollment in a QHP was unintentional, inadvertent, or erroneous, and resulted from an error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS;
- An individual is determined to be newly eligible or ineligible for Advance Payments of The Premium Tax Credit, or has a change in eligibility for cost-sharing reductions, regardless of whether or not he or she is already enrolled in a QHP;
- The Exchange must provide a Special Enrollment Period to an individual whose existing coverage under an eligible employer-sponsored plan will no longer be "affordable" or provide "minimum value" for the employer's upcoming plan year;
- A Qualified Individual or enrollee gains access to new QHPs offered through the Exchange, as a result of a permanent move;
- An Indian may enroll in a QHP, or change from one QHP to another, once per month; or
- An individual meets "other exceptional circumstances" as the Exchange or HHS may provide, including those that would impede his or her ability to enroll on a timely basis, through no fault of his or her own (*e.g.*, a natural disaster).

F. YOUR IDENTIFICATION CARD (ID CARD)

You will receive an ID Card. It contains information you will need when filing a Claim or making an inquiry. Your ID Card is the property of Highmark WV. The ID Card must be returned to Highmark WV if your coverage ends for any reason. Further use of the ID Card is not permitted and may subject you to legal action.

G. HOW AND WHEN YOUR COVERAGE STOPS

Your coverage may terminate when:

- A Covered Person stops being an Eligible Dependent, coverage stops as specified in Section IV;
- A Covered Person stops being an eligible Policyholder, all coverage stops at the end of the month in which the Policyholder became ineligible;
- The Policyholder does not pay the required contribution, all coverage stops at the end of the period for which payment was made;
- We have the right to void the coverage of any Covered Person who engages in fraudulent conduct, deception or misrepresentation relating to a Claim, Application for coverage, obtaining benefits or the use of an ID Card; or
- You have similar coverage under any group or non-group health benefits plan, or are provided similar benefits pursuant to, or in accordance with, the requirements of any state or federal law.

For individuals who are enrolled in a QHP through an Exchange, coverage may terminate when:

- The enrollee is no longer eligible for coverage through the Exchange;
- The enrollee changes from one QHP to another during the Annual Enrollment Period;
- The QHP terminates or is no longer certified; or
- Non-payment of premiums. If premiums are delinquent for an enrollee who receives Advance Premium Tax Credit, and at least one month's premium has been paid in full during the benefit year, coverage will be terminated after the exhaustion of a three (3) month grace period. Benefits will only be provided under this Policy for Covered Services received during the first month of the three (3) month grace period if payment of the appropriate premium amount by the Covered Person is not received prior to the end of the grace period. Failure of the Plan to receive Advance Payment of Premium Tax Credits shall not be grounds for termination of this Policy.

H. CONTINUATION UPON DEATH OF POLICYHOLDER OR TERMINATION OF POLICYHOLDER'S COVERAGE

Unless coverage under this Policy is provided pursuant to enrollment through the Exchange, coverage may continue under this Policy for the covered Dependents upon termination of the Policyholder's coverage under this Policy due to enrollment in a Medicare Supplemental or Medicare Advantage plan, or due to the death of the Policyholder, for any period for which premium has already been paid. The Policyholder's spouse or Domestic Partner, if covered under this Policy shall thereafter become the Policyholder upon notice to the Plan of the termination of the Policyholder's coverage or the Policyholder's death. If the Policyholder's spouse or Domestic Partner was not covered under this Policy, a Dependent child may become a Policyholder but only under his or her own Policy.

I. BENEFITS AFTER TERMINATION OF COVERAGE

If you are an Inpatient of a Hospital or Skilled Nursing Facility on the day your coverage stops, the benefits listed under the Inpatient Services Section, subsections Bed, Board and General Nursing Services and Ancillary Services only, will continue until the earliest of the following:

- We pay your maximum benefits;
- You leave the Hospital or Skilled Nursing Facility;
- The end of the Benefit Period in which your coverage stopped; or
- You have other health care coverage for the condition that requires your Inpatient Hospital or Skilled Nursing Facility care.

No other benefits will be provided once your coverage stops.

J. GUARANTEED RENEWABILITY OF COVERAGE

For individuals who are enrolled in a QHP through an Exchange, your coverage will renew or continue in force except in situations involving nonpayment of premiums, fraud, termination of the plan, enrollee's movement outside the Service Area or discontinuance of a product or all coverage.

IV. Schedule of Benefits

Subject to the exclusions, conditions, and limitations of this Agreement, a Member is entitled to the benefits described in this Section for Medically Necessary and Appropriate Services rendered by a Provider and/or Supplier.

IMPORTANT - Read this Section carefully. See Section V for a detailed description of benefits. Section IX describes Prescription Drug benefits if such are provided under this Policy.

This Section indicates the amounts for Coinsurances, Deductible, Fees, reimbursement percentages, and benefit maximums. You will receive notification if your benefits change. Please refer to www.highmarkbcbswv.com to assure you have the most current version or you may contact Member Services to request an updated Policy.

A. PROVIDER NETWORKS AND DIRECTORY

Remember, in an emergency, always go to the nearest appropriate medical Facility or call 911 for assistance.

The choice of a Network Provider is solely yours. You are not required to select a Primary Care Physician to receive covered care. Please note that while you or a family member can use the Services, including behavioral health and well-woman care, of any Network Physician or Specialist without a referral and receive coverage under your benefit plan, you are encouraged to select a personal or Primary Care Physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal Physician can help you select an appropriate Specialist and work closely with that Specialist when the need arises. In addition, Primary Care Providers or their covering Physicians are on call 24/7.

Network Services are limited to the Highmark WV PPO Network and/or the local PPO Network depending upon where you receive Services.

Examples of Providers include, but are not limited to the following: primary care Physicians; Specialists; mental health and Substance Use Disorder Providers; community and specialty Hospitals; and laboratories. You have access to care 24 hours a day/7 days a week. If you have Covered Services outside of your primary care Physician's hours, you should follow up with them after receiving care.

1. **Emergency Care Services.**

   For coverage information, please see the Emergency Services section below.

2. **Out-of-Network Provider Exception (does not include Emergency Care Services).**

   Services are covered only when they are received from a Network Provider with the exception of Emergency Care Services and approved exceptions. You may request to obtain Covered Services from an Out-of-Network Provider in the following instances:

   a. When Highmark WV does not have a type of provider available to provide a Covered Service;
   b. When Highmark WV does not have a sufficient number of Network Providers available to provide a Covered Service; or
   c. When Highmark WV does not have a Network Provider available without unreasonable travel or delay.

   To request an approved exception to obtain Covered Services from an Out-of-Network Provider, contact Member Services at the number on the back of your ID Card. If your request is approved, the benefit will be based upon the Provider's Actual Charge. If approved your deductible, coinsurance and cost-sharing will be no greater than if the provider had been In-Network and will be included in the Maximum Out-of-Pocket amount.

B. LOCATING A PROVIDER

To find a Provider near you, simply go to the Member website and click **Find a Doctor.** You can search for:

- Name and address;
- Location/Office hours/Phone numbers;
- Information on accepting new patients;
- Medical school and residency;
- Board certifications/Hospital affiliations;
- Clinical specialties;
- Patient ratings;
- Performance in 13 categories of care;
- Parking and public transit nearby;
- Professional qualifications;
- Handicap accessibility;
- Languages spoken; or
- Gender.

You can also call My Care Navigator at 1-888-258-3428 or call Member Service at the number on the back of your ID card.

C. MEDICAL COST-SHARING PROVISIONS (MEMBER LIABILITY)

The expenses you may incur include, but are not limited to, those briefly defined and described below. Further detail is provided later in this Section IV, Section V, and throughout this Policy. The Network Provider may request that you pay any applicable unmet Deductible, Coinsurance or Fee for the Covered Services at the time Covered Services are rendered.

NOTE: ***You may be responsible for a Facility fee, clinic charge, or similar fee or charge in addition to the Physician's charge if the Service is provided at a Physician's office, a Hospital, Facility Other Provider, Professional Other Provider, Retail Clinic or Urgent Care Center.***

1. Emergency Services

As a my Blue Access Member, you are covered for Emergency Care received in or outside the Provider Network. This flexibility helps accommodate your needs when you need care immediately.

NOTE: ***Please keep in mind, however, if your care is determined not to be an Emergency and you receive care at an Out-of-Network hospital you may be responsible for the costs of the services you received. You should use Emergency Services only when Medically Necessary and Appropriate.***

Claims for Emergency Services to screen and Stabilize a Member shall be covered without the need for Prior Authorization if a Prudent Layperson would have reasonably believed that an Emergency Medical Condition existed even if the Emergency Services provided on an Out-of-Network basis and shall cover Emergency Services whether the health care Provider providing the services is a Network Provider or Out-of-Network Provider.

If the Emergency Services are provided by an Out-of-Network Provider, we will not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from Network Providers. For Out-of-Network Emergency Services, any cost-sharing requirement expressed as a Copayment amount or Coinsurance rate for the Member cannot exceed those Network Services. The Member may be required to pay, in addition to the Network cost-sharing, the excess of the amount the Out-of-Network Provider charges over the amount Highmark WV is required to pay (also known as "balance billing").

For immediately required post-evaluation or post-stabilization services, Highmark WV shall provide access to a designated representative twenty-four (24) hours a day, seven (7) days a week, to facilitate review.

2. Benefit Maximums

Once the benefit maximum is met for a Covered Service(s) within the Benefit Period, any additional Charges Incurred will be your responsibility. Charges for Services above a benefit maximum will not apply to Fees, Deductibles~~,~~ Coinsurances, or other Covered Person responsibilities.

3. Network Coinsurance

Coinsurance is a percentage of the Network Plan Allowance after your Deductible has been satisfied.

Except as otherwise specified, after you have paid any applicable Deductibles or Fees, Covered Services will be paid according to the percentage noted on your Schedule of Benefits Description.

4. Out-of-Network Coinsurance and Member Liability

You will only receive benefits under your my Blue Access policy when received from a Network Provider, except for covered Emergency Care and approved exceptions. When a Member receives Covered Services that are not an approved exception from an Out-of-Network Provider, the Out-of-Network Provider may bill the Member for the difference between the billed amount and the Plan's Allowance (also known as "balance billing"). This is in addition to any Member Deductible and/or Coinsurance obligations, as Out-of-Network Providers are not required to accept the Plan's reimbursement as payment in full. If a Member receives Services which are not Covered Services under this policy, the Member is responsible for all Charges Incurred.

5. Deductible and Copayment

A specified dollar amount you must pay for Covered Services each Benefit Period before we begin to provide payment for benefits. You may be required to pay any applicable Deductible at the time you receive care from a Provider. The Copayment is typically payable at the time Covered Services are rendered.

6. Maximum Out-of-Pocket Amount

The maximum out-of-pocket amount is the maximum amount of expenses Incurred for Deductibles, Copayments and Coinsurances for Covered Services for a Benefit Period per individual or family. The Maximum Out-of-Pocket amount does not include any Out-of-Network Liability amounts in excess of the Plan Allowance unless otherwise stated.

7. Non-Covered Services

Certain Services that may be Incurred or recommended by a Provider may not be a Covered Service under your Policy. As a result, you will be responsible for the cost of such Services. These Services will not apply towards any Fees, Deductibles, and Coinsurances.

8. Office Visit Fees

An upfront charge, usually stated in dollars, for Office Visits with Physicians and Professional Other Providers. The Office Visit Fee applies to Charges for the Office Visit only. This Fee does not apply to other Services received during a Visit, except as specified. Office Visit Fees are in addition to, and do not apply toward any other Deductibles, Fees or Coinsurances. The Office Visit Fee applies per Visit and is payable at the time Covered Services are received.

9. Waivers

In some instances, a Network Provider may ask you to sign a "waiver" or other document prior to receiving care. This waiver may state that you accept responsibility for the Charges above the applicable Plan Allowance with Highmark WV or for Services deemed not Medically Necessary and Appropriate by Highmark WV. Generally, Network Providers are prohibited from this practice. See Section VIII for circumstances where you may be responsible for non-Medically Necessary and Appropriate Services.

SCHEDULE OF BENEFITS DESCRIPTIONS

The following pages provide details regarding specific benefit amounts and limits.

Benefit Provision	In-Network	Out-of-Network
General Provisions		
Effective Date	Individual effective: 01/01/2021	
Plan-Wide Provisions[1,2]		
Medical Deductible - Individual *(per benefit period)*	$2,900	N/A
Medical Deductible – Family *(per benefit period)*	$5,800	N/A
Coinsurance - Plan Payment Level	70%	N/A
Out-of-Pocket (OOP) Maximum - Individual *(Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.)*	$7,800	N/A
Out-of-Pocket (OOP) Maximum - Family *(Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.)*	$15,600	N/A
Inpatient Facility Services		
Inpatient Hospital Facility Services	70%	Not Covered
Skilled Nursing Facility	70%	Not Covered
	Benefit Limit: Must be recertified every two weeks, benefits expire when patient cannot present any significant improvement.	N/A
Maternity *(Includes Home Health Care Visit)*	70%	Not Covered
Maternity for Dependent Daughter	70%	Not Covered
Nursery Care - State Mandates	70%	Not Covered
Short Term Inpatient Rehabilitation Inpatient Occupational Therapy Inpatient Speech Therapy Inpatient Physical Medicine Inpatient Respiratory Therapy	70%	Not Covered
Outpatient Facility[6]		
Emergency Room Care (Includes Emergency medical / Emergency Accident) One copay per visit	100% after In-network deductible and $750 copay (Waived if Admitted)	
Outpatient Surgery	100% after deductible and $250 copay	Not Covered
Outpatient Diagnostic		
Advanced Imaging	70%	Not Covered
Standard Imaging	100% after $75 copay	Not Covered
Pathology/Lab	100% after $75 copay	Not Covered
Diagnostic Medical	100% after $75 copay	Not Covered
Allergy Testing	100% after $75 copay	Not Covered
Mammograms *(Medically Necessary)*	100% after $75 copay	Not Covered

Outpatient Therapy and Rehabilitation Services		
Occupational Therapy	100% after $50 copay	Not Covered
	Benefit Limit: 30 Rehabilitative and 30 Habilitative visits / benefit period for other than chronic pain **Benefit Limit:** 20 Rehabilitative and 20 Habilitative visits / event for chronic pain[5] Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Use Disorder diagnosis.	N/A
Speech Therapy	100% after $50 copay	Not Covered
Physical Medicine	100% after $50 copay	Not Covered
	Benefit Limit: 30 Rehabilitative and 30 Habilitative visits / benefit period for other than chronic pain **Benefit Limit:** 20 Rehabilitative and 20 Habilitative visits / event for chronic pain[5] Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Use Disorder diagnosis.	N/A
Respiratory Therapy	70%	Not Covered
Cardiac Rehabilitation	70%	Not Covered
Dialysis	70%	Not Covered
Chemotherapy	70%	Not Covered
Radiation Therapy	70%	Not Covered
Infusion Therapy	70%	Not Covered
Clinic	70%	N/A
Professional Services[6]		
Inpatient Medical Care *(Includes Intensive Medical Care)*	70%	Not Covered
Skilled Nursing Facility Care	70%	Not Covered
Concurrent Care	70%	Not Covered
Consultations (*Inpatient)*	70%	Not Covered
Second Surgical Opinion	70%	Not Covered
Emergency Medical/Accident	100% after in-network deductible	
Specialist Office & Virtual Visits	100% after $50 copay	Not Covered
Primary Care Provider Office & Virtual Visits	100% after $50 copay	Not Covered
Virtual Visit Origination Fee	70%	Not Covered
Telemedicine Services [3]	100% after $0 copay	Not Covered
Surgery	100% after deductible and $250 copay	Not Covered
Tubal Ligation	100% deductible does not apply	Not Covered
Vasectomy	70%	Not Covered
Sterilization Reversal	Not Covered	Not Covered
Transsexual Surgery	70%	Not Covered
Assistant at Surgery	70%	Not Covered
Anesthesia	70%	Not Covered
Outpatient Diagnostic		
Advanced Imaging	70%	Not Covered
Standard Imaging	100% after $75 copay	Not Covered
Pathology/Lab	100% after $75 copay	Not Covered
Diagnostic Medical	100% after $75 copay	Not Covered
Allergy Testing	100% after $75 copay	Not Covered
Mammograms *(Medically Necessary)*	100% after $75 copay	Not Covered

Professional Maternity Services		
Maternity	70%	Not Covered
Maternity for Dependent Daughter	70%	Not Covered
Newborn Care *State Mandated Benefits Apply*	70%	Not Covered
Professional Therapy and Rehabilitation Services		
Occupational Therapy	100% after $50 copay	Not Covered
	Benefit Limit: 30 Rehabilitative and 30 Habilitative visits / benefit period for other than chronic pain **Benefit Limit:** 20 Rehabilitative and 20 Habilitative visits / event for chronic pain[5] Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Use Disorder diagnosis.	N/A
Speech Therapy	100% after $50 copay	Not Covered
Physical Medicine	100% after $50 copay	Not Covered
	Benefit Limit: 30 Rehabilitative and 30 Habilitative visits / benefit period for other than chronic pain **Benefit Limit:** 20 Rehabilitative and 20 Habilitative visits / event for chronic pain[5] Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Use Disorder diagnosis.	N/A
Respiratory Therapy	70%	Not Covered
Cardiac Rehabilitation / Therapy	70%	Not Covered
Dialysis	70%	Not Covered
Chemotherapy	70%	Not Covered
Radiation Therapy	70%	Not Covered
Infusion Therapy	70%	Not Covered
Chiropractic/Spinal Manipulations	100% after $50 copay	Not Covered
	Benefit Limit: 30 visits / benefit period for other than chronic pain. **Benefit Limit:** 20 visits / event for chronic pain [5]	N/A
Allergy Extracts	70%	Not Covered
Allergy Injections	70%	Not Covered
Urgent Care & Retail Clinic		
Urgent Care	100% after $100 copay	100% after $100 copay
Retail Clinic and Virtual Visits	100% after $50 copay	Not Covered
Preventive Care [4,6]		
Preventive Schedule	Highmark Preventive Schedule – State and Federal Mandates Apply For number of visits for Preventive Services: See Preventive Schedule / Women's Health Schedule	
Routine Physical Exam	100% deductible does not apply	Not Covered
Routine Gynecological Exam	100% deductible does not apply	Not Covered
Routine Pap Smear	100% deductible does not apply	Not Covered
Routine Mammogram	100% deductible does not apply	Not Covered
Adult Immunizations	100% deductible does not apply	Not Covered
Travel Immunizations	Not Covered	
Pediatric Immunizations	100% deductible does not apply	Not Covered
Well Baby Care	100% deductible does not apply	Not Covered
Neonatal Circumcision	70%	Not Covered

Well Woman Care	100% deductible does not apply	Not Covered
Adult Care	100% deductible does not apply	Not Covered
Routine Foot Care	Not Covered	Not Covered
Routine Diagnostic Services and Procedures *(Highmark Preventive Schedule Only)*	100% deductible does not apply	Not Covered
Hearing Care[5]		
Hearing Care/Diagnostic Hearing Exam *(excludes coverage for hearing aid exam)*	70%	Not Covered
Routine Hearing Screening *(as part of preventive exam)*	100% deductible does not apply	Not Covered
Hearing Aid	Not Covered	Not Covered
Hearing Aid Exam	Not Covered	Not Covered
Vision Care (Medical)[6]		
Routine Vision Screening (as part of preventive exam)	100% deductible does not apply	Not Covered
Comprehensive Routine Eye Exam	Not Covered	Not Covered
Eyeglasses/Lenses After Cataract Surgery	70%	Not Covered
Eyeglasses/Contacts	Not Covered	Not Covered
Corneal Microsurgery for Vision correction / cosmetic	Not Covered	Not Covered
Other Services[6]		
Emergency Ambulance	70%	
Non-Emergency Ambulance	70%	Not Covered
Durable Medical Equipment	70%	Not Covered
Prosthetic Devices	70%	Not Covered
Orthotics	70%	Not Covered
Home Infusion Therapy	70%	Not Covered
Blood/Blood Components/Blood Derivatives	70%	Not Covered
Private Duty Nursing	70%	Not Covered
	Benefit Limit: 35 Visits/benefit period	N/A
Home Health	70%	Not Covered
	Benefit Limit: 100 visits/benefit period - aggregate with Visiting Nurse	N/A
Visiting Nurse	70%	Not Covered
	Benefit Limit: 100 visits/benefit period - aggregate with Home Health	N/A
Hospice	70%	Not Covered
	Benefit Limit: N/A	N/A
Experimental /Investigational	Not Covered	Not Covered
Nicotine Cessation Programs	100% deductible does not apply	Not Covered
Assisted Fertilization Procedures	Not Covered	Not Covered
Elective Abortion	70%	Not Covered
	Limited to those necessary to avert the death of the member or to terminate pregnancies by rape or incest	N/A
Transplant Services	70%	Not Covered
Oral Surgery	70%	Not Covered
Impacted Teeth *Services limited to third molars when partially or totally covered by bone*	70%	Not Covered
Surgery to Mouth *Services Limited to Maxillary or Mandibular Frenectomy and Mandibular Staples - when not for dentures*	70%	Not Covered

Dental Accident *Services limited to injuries of the jaw, cheeks, lips, tongue, roof and floor of mouth*	70%	Not Covered
Mastectomy and Breast Cancer Reconstruction *State Mandates Apply*	70%	Not Covered
Enteral Formulae *State Mandates Apply*	70%	Not Covered
Contraceptives	100% no deductible or copay (See Preventive Schedule/Women's Health Schedule)	Not Covered
Contraceptives - Injectable	100% no deductible or copay (See Preventive Schedule/Women's Health Schedule)	Not Covered
Contraceptives - Device/Implant	100% no deductible or copay (See Preventive Schedule/Women's Health Schedule)	Not Covered
Injections	70%	Not Covered
Acupuncture	Not Covered	Not Covered
Dean Ornish Program	Not Covered	Not Covered
Bariatric Surgery	70%	Not Covered
Conditions[b]		
Inpatient Mental Health Services	70%	Not Covered
Outpatient Mental Health Services & Virtual Behavioral Health Visits	100% after $50 copay	Not Covered
Inpatient Substance Use Disorder Rehabilitation	70%	Not Covered
Inpatient Substance Use Disorder Detoxification	70%	Not Covered
Outpatient Substance Use Disorder Services & Virtual Visits	100% after $50 copay	Not Covered
TMJ	70%	Not Covered
	Benefit Limit: Orthotics/splints/appliances limited to 1 every 36 months	N/A
Cleft Palate	70%	Not Covered
Obesity – Morbid Obesity only	70%	Not Covered
Diabetes - State Mandates Apply	70%	Not Covered
Infertility - *For the diagnosis, consultation, and/or treatment of a physical condition*	70%	Not Covered
Cosmetic Surgery - *Limited to reconstruction to restore body function or malformation caused by disease, trauma, birth defects, growth defects, prior therapeutic processes or as a result for an act of family violence.*	70%	Not Covered
Autism	70%	Not Covered

[1] BE SURE YOUR PROVIDER IS AWARE THAT HIGHMARK UTILIZATION MANAGEMENT MUST BE CONTACTED FOR AUTHORIZATION PRIOR TO A PLANNED INPATIENT ADMISSION OR WITHIN 48 HOURS OF AN EMERGENCY OR UNPLANNED INPATIENT ADMISSION. ALSO NOTE THAT CERTAIN OUTPATIENT PROCEDURES REQUIRE PRIOR AUTHORIZATION. IF AUTHORIZATION IS NOT OBTAINED AND IT IS LATER DETERMINED THAT ALL OR PART OF THE SERVICES RECEIVED WERE NOT MEDICALLY NECESSARY OR APPROPRIATE YOU WILL BE RESPONSIBLE FOR THE PAYMENT OF ANY COSTS NOT COVERED BY YOUR HEALTH PLAN.

[2] PAYMENT IS BASED ON THE PLAN ALLOWANCE. THE PLAN ALLOWANCE WILL GENERALLY BE LESS FOR SERVICES RECEIVED FROM A NON-NETWORK PROVIDER. IN ADDITION, YOU WILL BE RESPONSIBLE FOR THE NON-NETWORK LIABILITY.

[3]**TELEMEDICINE SERVICES MUST BE PERFORMED BY A HIGHMARK APPROVED TELEMEDICINE VENDOR. SERVICES PROVIDED BY AN APPROVED TELEMEDICINE VENDOR RELATING TO THE TREATMENT OF MENTAL HEALTH OR SUBSTANCE USE DISORDER ARE ELIGIBLE UNDER THE OUTPATIENT MENTAL HEALTH/SUBSTANCE USE BENEFIT.**

[4]**THE SCHEDULE OF COVERED SERVICES IS BASED UPON RECOMMENDATIONS FROM THE AMERICAN ACADEMY OF PEDIATRICS; THE AMERICAN COLLEGE OF PHYSICIANS; THE U.S. PREVENTIVE SERVICES TASK FORCE; THE INSTITUTE OF MEDICINE, AND THE AMERICAN CANCER SOCIETY AND THE BLUE CROSS BLUE SHIELD ASSOCIATION. THEREFORE, THE FREQUENCY AND ELIGIBILITY OF SERVICES IS SUBJECT TO CHANGE.**

[5]**20 VISIT MAXIMUM PER EVENT FOR COMBINED PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPINAL MANIPULATIONS.**

[6]**COVERED VIRTUAL SERVICES WILL BE PAID ACCORDING TO THE BENEFIT CATEGORY (E.G. PRIMARY CARE PROVIDER OFFICE VISIT, MATERNITY VISIT, ETC.) FOR EXAMPLE VIRTUAL VISITS RELATING TO THE TREATMENT OF MENTAL ILLNESS OR SUBSTANCE USE DISORDER ARE COVERED UNDER YOUR OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFIT AND SUBJECT TO THE COST SHARING AMOUNT IN THIS SCHEDULE OF BENEFITS**

Prescription Drug Benefits (1)				
Formulary	Essential			
Formulary Type	Closed			
Pharmacy Network	National			
Diabetic Supplies	If applicable, only one copay should apply for Needles, Syringes, and Diabetic Supplies when Dispensed within 24 hours Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply			
Member Cost Share	**Retail**			**Mail Order**
	34 Day Supply	**60 Day Supply**	**90 Day Supply**	**90 Day Supply**
Tier 1	$0 No deductible	$0 No deductible	$0 No deductible	$0 No deductible
Tier 2	$30 No deductible	$60 No deductible	$90 No deductible	$60 No deductible
Tier 3	$150 No deductible	$300 No deductible	$450 No deductible	$300 No deductible
Tier 4	50% $250 min - $1,000 Max No deductible	50% $500 min - $2,000 Max No deductible	50% $750 min - $3,000 Max No deductible	50% $500 min - $2,000 Max No deductible

Prescription benefits are provided through Medco/Express Scripts

1. Anti-cancer medications orally administered or self-injected. Deductible, Copayment and Coinsurance amounts for patient administered anti-cancer medications that are Covered Benefits are applied on no less favorable basis than for Provider injected or intravenously administered anti-cancer medications.

West Virginia– Pediatric Vision - Vision Care Plan Benefit Summary

IN-NETWORK BENEFIT	FREQUENCY
Eligible Participants	Members under 19 years of age[1]
Eye Examination (including dilation, as professionally indicated)	Once every 12 months
Eyeglass lenses	Once every 12 months
Frames	Once every 12 months
Contact lenses (in lieu of eyeglass lenses)	Once every 12 months
	MEMBER RESPONSIBILITY
EYE EXAMINATION (including dilation as professionally indicated)	Covered In Full
FRAMES	
Pediatric Frame Selection	Covered In Full
STANDARD EYEGLASS LENSES[2] (per pair)	
Single vision	Covered In Full
Bifocal	Covered In Full
Trifocal	Covered In Full
Lenticular	Covered In Full
OPTIONAL EYEGLASS LENSES/COATINGS/TREATMENTS (per pair)	**MEMBER RESPONSIBILITY**
Standard progressive lenses[3]	Covered In Full
Select progressive lenses[3]	Member pays $70
Premium progressive lenses[3]	Member pays $90
Ultra progressive lenses[3]	Member pays $195
Polycarbonate lenses	Covered In Full
Blended segment lenses	Member pays $20
Intermediate vision lenses	Member pays $30
Glass photochromic lenses	Member pays $20
Plastic photosensitive lenses	Covered In Full
High-index (thinner and lighter) lenses	Member pays $55
Polarized lenses	Member pays $75
Fashion, sun or gradient tinted plastic lenses	Covered In Full
Ultraviolet Coating	Covered In Full
Scratch-resistant coating	Covered In Full
Scratch Protection Plan Single Vision	Member pays $20
Scratch Protection Plan Multifocal	Member pays $40
Standard ARC (anti-reflective coating)	Member pays $35
Premium ARC (anti-reflective coating)	Member pays $48
Ultra ARC (anti-reflective coating)	Member pays $60
CONTACT LENSES (in lieu of eyeglass lenses—per pair or initial supply of disposable contact lenses from the Pediatric Contact Lens Selection)	
Contact lens evaluation and fitting	
Daily wear	Covered in full when the performing provider dispenses from the pediatric contact lens selection
Extended wear	Covered in full when the performing provider dispenses from the pediatric contact lens selection
	Pediatric Contact Lens Selection[4]
Standard daily wear contact lenses	Covered In Full
Specialty contact lenses	Covered In Full
Disposable contact lenses	Covered In Full
Medically necessary contact lenses (prior approval required)	Covered In Full

(1) Dependents will be terminated from the contract at the end of the month in which they turn 19 for individual contracts.
Note: Termination rules for employer groups are determined by client.
(2) Includes glass, plastic or oversized lenses.
(3) Progressive multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive lenses. However, the member's payment towards the progressive upgrade will not be refunded.
(4)Disposable contact lens wearers will receive four multi-packs of lenses. Planned replacement lens wearers will receive two multi-packs of lenses.

Vision benefits utilize the Davis Vision Network. Members must use a Davis Vision provider who participates in the Health Care Reform Vision Network There is no out-of-network coverage. Davis Vision is a separate company that administers Highmark vision benefits. Visionworks, also a separate company, is a provider within the Davis Vision Network.

Schedule of Benefits

THIS PLAN MEETS THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

THESE BENEFITS ARE ONLY AVAILABLE FOR CHILDREN THROUGH THE END OF THE CONTRACT YEAR THAT THEY TURN 19.

This Policy will pay benefits for Covered Services shown below subject to the Schedule of Exclusions and Limitations and other Policy terms. Payment is based on the Maximum Allowable Charge (MAC) for the specific Covered Service. Participating Dentists accept contracted MACs as payment in full for Covered Services. **Participating Dentists may also agree to limit their charges for any other services delivered to Insured Persons.**

Non-participating Dentists do not limit their charges and may bill you for the difference between their charge and the benefit paid by the Policy.

Contract Year Deductible per Insured Person:	$0
Annual Maximum per Insured Person:	Unlimited
Out-of-Pocket Maximum for Certificate Holders:	Combined with Medical
Network	Advantage Plus

Service Category	Waiting Period	Policy Pays at		After Deductible
		Participating Dentists	Non-Participating Dentists	
Diagnostic Services				
Oral Evaluations (Exams)	None	100%	Not Covered	N/A
Radiographs (All X-Rays)	None	100%	Not Covered	N/A
Preventive Services				
Prophylaxis (Cleanings)	None	100%	Not Covered	N/A
Fluoride Treatments	None	100%	Not Covered	N/A
Sealants	None	100%	Not Covered	N/A
Space Maintainers	None	100%	Not Covered	N/A
Restorative Services				
Basic Restoration Anterior Composite	None	50%	Not Covered	N/A
Basic Restoration Anterior Amalgam	None	50%	Not Covered	N/A
Basic Restoration Posterior Amalgam	None	50%	Not Covered	N/A
Crowns	None	50%	Not Covered	N/A
Inlays & Onlays	N/A	Not Covered	Not Covered	N/A
Crown Repair	None	50%	Not Covered	N/A
Endodontic Services				
Endodontic Therapy (Root canals, etc.)	None	50%	Not Covered	N/A
Periodontal Services				
Surgical Periodontics	None	50%	Not Covered	N/A
Non-Surgical Periodontics	None	50%	Not Covered	N/A
Periodontal Maintenance	None	Not Covered	Not Covered	N/A
Prosthodontic Services, Fixed				
Prosthodontic (Fixed Partial Dentures)	None	50%	Not Covered	N/A
Prosthodontic Services, Removable				
Prosthetics (Complete Dentures)	None	50%	Not Covered	N/A
Adjustments and Repairs of Prosthetics	None	50%	Not Covered	N/A
Implant Services				
Implant Services	N/A	Not Covered	Not Covered	N/A

Service Category	Waiting Period	Policy Pays at Participating Dentists	Policy Pays at Non-Participating Dentists	After Deductible
Maxillofacial Prosthetics Services				
Maxillofacial Prosthetics	N/A	Not Covered	Not Covered	N/A
Oral and Maxillofacial Surgical Services				
Simple Extractions	None	50%	Not Covered	N/A
Surgical Extractions	None	50%	Not Covered	N/A
Oral Surgery	None	50%	Not Covered	N/A
Apicoectomy/Periradicular Surgery	None	50%	Not Covered	N/A
Adjunctive General Services				
Consultations	None	100%	Not Covered	N/A
General Anesthesia, Nitrous Oxide and/or IV Sedation	None	50%	Not Covered	N/A
Palliative Treatment (Emergency)	None	100%	Not Covered	N/A
Orthodontic Services				
Medically Necessary Orthodontics	None	50%	Not Covered	N/A
Cosmetic Orthodontic Services	None	Not Covered	Not Covered	N/A

Medically Necessary Orthodontics Coverage:

In this section, "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician or Dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. in accordance with the generally accepted standards of medical/dental practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. not primarily for the convenience of the patient or physician/Dentist, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

As used subpart 1, above, "generally accepted standards of medical/dental practice" means:

- standards that are based on credible scientific evidence published in peer-reviewed, medical/dental literature generally recognized by the relevant professional community;
- recognized Medical/Dental and Specialty Society recommendations;
- the views of physicians/Dentists practicing in the relevant clinical area; and
- any other relevant factors.

A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

Coverage of Medically Necessary Orthodontics:

1. Orthodontic treatment must be Medically Necessary and be the only method capable of:
   a) Preventing irreversible damage to the insured person's teeth or their supporting structures and,
   b) Restoring the insured person's oral structure to health and function.

2. The insured person must have a fully erupted set of permanent teeth to be eligible for comprehensive, Medically Necessary orthodontic services for handicapping malocclusions of the adult dentition.

3. Other orthodontic Covered Services include: pre-orthodontic treatment visit for completion of HLD (NJ-Mod2) form, diagnostic photographs and panoramic radiographs; limited treatment for the primary, transitional and adult dentition; interceptive treatment for the primary transitional dentition; minor treatment to control harmful habits; continuation of transfer cases or cases started prior to the insured person's Effective Date; orthognathic surgical cases with comprehensive orthodontic treatment; placement and removal of orthodontic appliances; repairs to

orthodontic appliances; replacement of lost or broken retainer; rebonding or recementing of brackets and/or bands; and removal of appliances by a provider that did not start the case when requested by report.

4. **All Medically Necessary orthodontic services require prior approval** and a written plan of care.

*Pediatric Dental benefits utilize the United Concordia Advantage Plus Network. Members must use a United Concordia provider. There is no Out-of-Network coverage for this benefit. United Concordia is a separate company that administers Highmark dental benefits.

V. Description of Benefits

This Section describes the benefits available to you under your my Blue Access policy for Covered Services you receive from a Network Provider when such Services are determined to be Medically Necessary and Appropriate. Please refer to Section IV for specific payment details, benefit maximums and limitations.

For assistance in obtaining more specific benefit information on what procedures or tests are covered, call Member Services. **Certain Services may also require Prior Authorization. For additional information, see Section VII, visit Highmark WV's website at www.highmarkbcbswv.com or contact Member Services.**

A. ALLERGY TESTS AND TREATMENT

Allergy tests that are performed and related to a specific diagnosis are Covered Services. Desensitization treatments are also Covered Services.

B. AMBULANCE SERVICES

See also, Emergency Services Section.

1. General

Ambulance services are covered when clinical condition is such that the use of any other method of transportation would endanger the patient's medical condition. Payment will not be made for ambulance service when an ambulance was used simply for convenience or because other means of transportation was not available.

Trips must be to the closest Facility that can give Covered Services appropriate for your condition. Transportation provided by an Ambulance Service shall constitute Emergency Ambulance Service if the injury or the condition satisfies the criteria as described in the Emergency Services later in this Section.

Any vehicle used as an ambulance must be designed and equipped to respond to medical Emergencies, and, in non-Emergency situations, be capable of transporting Members with acute medical conditions. The vehicle must comply with state or local laws governing the licensing and certification of an Emergency medical transportation vehicle.

2. Air Ambulance Services

Air ambulance transportation is covered if the aircraft meets air ambulance criteria and when the Service is Medically Necessary and Appropriate. The Covered Person's medical condition must require immediate and rapid ambulance transportation that cannot be provided by land ambulance and either:

- The point of great distances or other obstacles are involved in getting the patient to the nearest Hospital with appropriate facilities capable of providing the required level and type of care to treat the Member's condition; or
- Pick-up is inaccessible by land vehicle.

Air ambulance Services are not covered for transport to a Facility that is not an acute care Hospital, such as a nursing Facility, Physician's office or a Member's home.

C. AUTISM SPECTRUM DISORDER

Treatments include those that are ordered or prescribed by a licensed Physician or licensed Psychologist in accordance with a treatment plan developed from a comprehensive evaluation by a Certified Behavior Analyst for an individual diagnosed with Autism Spectrum Disorder. See Section VII for information

regarding treatment plans. Treatment may include, but not be limited to, Applied Behavioral Analysis provided or supervised by a Certified Behavioral Analyst.

Progress reports may be required semi-annually from the Certified Behavior Analyst. In order for treatment to continue, we may require documented objective evidence or a clinically supportable statement of expectation that:

- The individual's condition is improving in response to treatment;
- maximum improvement is yet to be attained; and
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

Covered Services will be paid according to the benefit category (e.g. Speech Therapy, Office Visit, etc.)

D. BONE MARROW PROCEDURES

Benefits are provided for the following types of bone marrow transplants:

- Allogeneic;
- Autologous;
- Syngeneic; and
- Peripheral stem cell transplants.

Covered Services include the following:

- Bone marrow donation and storage;
- Pre-transplant chemotherapy and/or radiation treatment;
- Bone marrow or peripheral stem cell transplant;
- Post-transplant Outpatient care directly related to the transplant; and
- Travel Reimbursement
- For transplants that occur at a Facility that is located greater than 50 miles from the recipient's home, the following will be covered during the reimbursement period:
    - $150/day limit for reasonable lodging and meals.
    - Ground travel is reimbursed based on the mileage from the recipient's home or temporary lodging to the transplant Facility. Reimbursement is calculated using Highmark WV current mileage reimbursement rate.
    - Air travel is reimbursed at the price of the airline ticket (coach class).
    - Tolls and parking Incurred while traveling between recipient's home or temporary lodging and transplant Facility.
    - There is a $10,000 aggregate limit for all travel costs.
    - The reimbursement period begins 5 days prior to a transplant and ends 12 months after the date of transplant. Reimbursement applies to recipient (adult) and one other person. If the recipient is a minor, two adults are covered; and
- Retransplantation.

E. CLINICAL TRIALS COVERAGE

Coverage is provided for approved clinical trials if the individual's referring Provider has concluded that the Member's participation in the trial would be appropriate or the individual provides medical and scientific information establishing that participation in the trial would be appropriate. Coverage includes routine patient costs for items and Services furnished in connection with participation in the trial. Highmark WV will not discriminate against any individual participating in such trials.

An approved clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial;
- A clinical trial conducted under an FDA Investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA Investigational new drug Application.

F. COST EFFECTIVE NON-COVERED SERVICES

We may approve benefits that are not expressly Covered in this Policy in limited circumstances if we determine that any such Services present a more appropriate means of treatment is appropriate. Coverage for these Services must be approved in advance and in writing by Highmark WV.

G. DENTAL SERVICES

1. Dental Services for an Accidental Injury

Dental Services will be covered only when due to an accidental injury to the jaws, sound natural teeth, mouth or face. Such Services must be Incurred within one year from the date of the accident. Injury as a result of chewing or biting shall not be considered an accidental injury.

2. Pediatric Dental Services

Benefits are provided for Covered Persons under age nineteen (19) for the following when rendered by a Participating Dentist:

a. Full mouth x-rays:
- Intraoral series one (1) per 2 years; and
- Panoramic film one (1) per 3 years.

b. Bitewing x-rays – 1 set per 12 months (the total number of individual bitewings cannot exceed 4 per 12 months).

c. Oral Evaluations:
- Comprehensive – one (1) per 3 years. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s);
- Periodic – 1 per 6 months;
- Limited problem focused and consultations – one (1) of these services per Dentist per patient per 12 months; and
- Detailed problem focused – one (1) per Dentist per patient per 12 months per eligible diagnosis.

d. Prophylaxis – one (1) per 6 months. One (1) additional for Members under the care of a medical professional during pregnancy.

e. Fluoride treatment and Fluoride varnish – two (2) per 12 months under age nineteen (19).

f. Space maintainers – one (1) per quadrant or arch in 12 months.

g. Sealants – one (1) per tooth per 3 year(s) under age sixteen (16) on permanent first and second molars.

h. Prefabricated stainless steel crowns – one (1) per tooth per year.

i. Periodontal Services:
- Full mouth debridement – one (1) per 6 months;
- Periodontal scaling and root planing – one (1) mouth area per year; and
- Gingivectomy and osseous Surgery – one (1) mouth area per year.

j. Replacement of restorative services only when they are not, and cannot be made, serviceable:
- Basic restorations – not within 3 years of previous placement;
- Single crowns, inlays, onlays – not within five (5) years of previous placement;
- Buildups- one(1) per year;

- post and cores – one (1) per 3 years;
- Replacement of natural tooth/teeth in an arch – not within 5 year(s) of a fixed partial denture, full denture or partial removable denture;
- Denture adjustments – three (3) per year. Considered part of the denture charge if provided within 3 months of insertion by the same office; and
- Denture reline – one (1) per 2 years. Considered part of the denture charge if provided within 6 months of insertion by the same office. Denture rebase – one (1) per 5 years.

k. Root canal retreatment – one (1) per tooth per lifetime.

l. Recementation – one (1) per 12 months. Recementation during the first 12 months following insertion of any preventive, restorative, or prosthodontic service by the same Dentist is included in the preventive, restorative or prosthodontic benefit.

m. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the Dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the Dentist choose the more expensive treatment, the Member is responsible for the additional Charges beyond those allowed under this ABP.

n. General anesthesia and IV sedation: a total of 60 minutes per session.

NOTE: ***Payment for orthodontic services shall cease at the end of the month after termination by Highmark WV. Orthodontia procedures will only be approved for dentofacial abnormalities that severely compromise the Insured Person's physical health or for a serious handicapping malocclusion. Presence of a serious handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, open bite and crossbite. The determination will be made by the Dentist in accordance with guidelines established by Highmark WV. When there is a conflict of opinion between the Dentist and Highmark WV on whether or not a dental service or procedure is Medically Necessary and Appropriate, the opinion of Highmark WV will be final.***

H. DIAGNOSTIC SERVICES

Diagnostic Services include:

- Radiology, ultrasound and nuclear medicine;
- Laboratory and pathology Services;
- EKG, EEG, and other electronic diagnostic medical procedures; and
- Other forms of medical imaging.

I. EMERGENCY CARE SERVICES

Emergency Care Services, including the treatment of bodily injuries resulting from an accident, following the sudden onset of a medical condition, or following in the case of a chronic condition, a sudden and unexpected medical event that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or more of the following:

- Placing the Member's health, or with respect to a pregnant Member, the health of the Member or the unborn child in serious jeopardy;
- Causing serious impairment to bodily functions; or
- Causing serious dysfunction of any bodily organ or part, and for which care is sought as soon as possible after the medical condition becomes evident to the Member or the Member's parent or guardian.

Transportation and related Emergency Services provided by an Ambulance Service shall constitute Emergency Ambulance Service if the injury or the condition satisfies the criteria above. Use of an

Ambulance as transportation to an Emergency Room of a Facility Provider for an injury or condition that does not satisfy the criteria above will not be Covered as Emergency Ambulance Services.

Treatment for an occupational injury for which benefits are provided under any Workers' Compensation Law or any similar occupational disease law is not covered.

In the event that the Member requires Emergency Services, all benefits will be provided at the Network Services level of benefits. Once a Member is stabilized, Highmark WV reserves the right to transfer the Member's care from an Out-of-Network Provider to a Network Provider.

NOTE*: As a my Blue Access Member, if your care is determined not to be an Emergency, monitoring and stabilization Services will be covered but all other Services you receive will be your responsibility.*

Emergency care received in a Physician's office will be paid as any other Office Visit.

Remember, in an emergency, always go to the nearest appropriate medical Facility or call 911 for assistance.

J. ENTERAL FOODS

Coverage is provided for prescription Enteral Foods when administered on an Outpatient basis for the following:

- Amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorption surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state:
  - Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food proteins;
  - Severe food protein-induced enterocolitis syndrome;
  - Eosinophilic disorders as evidenced by the results of a biopsy; and
  - Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).

K. HABILITATIVE SERVICES

Medically Necessary and Appropriate Services that help a person gain, keep or improve skills for daily living.

NOTE*: For treatment of conditions that cause chronic pain you will be provided a total of twenty (20) visits per event of physical therapy, occupational therapy, osteopathetic manipulation,chronic pain management program services and chiropractic when ordered by a Health Care Provider.*

1. Occupational Therapy

The treatment by means of constructive activities designed and adapted to promote the ability to satisfactorily accomplish the ordinary tasks of daily living and those required by a particular occupational role.

2. Physical Medicine

The treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities.

3. Speech Therapy

The treatment for the correction of a speech impairment.

L. HOME HEALTH CARE SERVICES

The following are Covered Services when you are Homebound and receive them from a Hospital or a Home Health Care Agency:

- Intermittent Skilled Care rendered by a registered or licensed practical nurse or nurse-midwife;
- Physical therapy, occupational therapy or speech therapy;
- Medical and surgical supplies;
- Prescription Drugs;
- Oxygen and its administration;
- Medical social services;
- Home health aide Visits when you are also receiving Skilled Care or Therapy Services;
- Laboratory tests; and
- Home Infusion Therapy.

We do not pay Home Health Care benefits for any Services or Supplies not specifically listed above. Non-covered examples include, but are not limited to:

- Dietician Services;
- Homemaker Services;
- Food or home delivered meals;
- Custodial Care;
- Maintenance therapy;
- Routine prenatal care;
- Mental Illness or Substance Use Services;
- Private duty nursing; and.
- Personal comfort items.

M. HOME INFUSION AND SUITE INFUSION THERAPY SERVICES (INFUSION THERAPY)

Benefits will be provided when performed by a Home Infusion Therapy Provider and/or Suite Infusion Therapy Provider at an infusion suite or in a home setting. This benefit includes pharmaceuticals, pharmacy Services, intravenous solutions, medical/surgical Supplies and nursing services associated with Infusion Therapy. Specific adjunct non-intravenous Therapies are included when administered only in conjunction with Infusion Therapy. Benefits for certain Infusion Therapy Prescription Drugs as identified by Highmark WV and which are appropriate for self-administration, will be provided only when received from a Network Pharmacy Provider as set forth under the PRESCRIPTION DRUGS, Section IX.

N. HOSPICE SERVICES

Hospice care consists of health care benefits provided to a terminally ill Covered Person. Benefits will begin when the prognosis of life expectancy is estimated to be six months or less.

A treatment plan must be developed and submitted to us for our approval by the Covered Person's Physician and the Hospice Provider.

A licensed Hospice organization or a Hospice program sponsored by a Hospital or Home Health Care Agency and approved by us must provide all Covered Services. The Covered Services listed in the Home Health Care Services Section are also considered Hospice Services. In addition, your coverage includes:

- Acute Inpatient hospice care;
- Respite care;
- Dietary guidance;
- Durable medical equipment; and
- Home Health aide Visits.

Approved Prescription Drugs will be limited to a two-week Supply per Prescription Order or Refill. These Prescription Drugs must be required for palliative or supportive care.

In addition to the excluded Services listed in the Home Health Care Services Section, no Hospice Services will be provided for:

- Physician Visits;
- Volunteer Services;
- Spiritual counseling;
- Bereavement counseling for family members; or
- Chemotherapy or Radiation Therapy if other than palliative.

O. HOSPITAL SERVICES

1. INPATIENT SERVICES

a. Bed, Board and General Nursing Services

- A semiprivate room;
- A private room (a room with one bed). We will pay only the Hospital's average semiprivate room rate; or
- A bed in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for the intensive care of critically ill patients.

b. Ancillary Services

- Operating, delivery, treatment rooms, and equipment;
- Prescription Drugs;
- Whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing;
- Anesthesia, anesthesia Supplies and Services given by an employee of Hospital or Facility Other Provider;
- Oxygen and other gasses;
- Medical and surgical dressing, Supplies, casts, and splints;
- Diagnostic Services, and
- Therapy Services.

c. Medical Care Visits

The personal examination given to you by your Physician or Professional Other Provider. Consultations are not a part of this benefit. Benefits are provided for one Visit for each day you are an Inpatient.

d. Intensive Medical Care

Constant attendance and treatment when your condition requires it.

e. Concurrent Care

Care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Concurrent Care is also care by two or more Physicians during one Hospital stay for two or more unrelated conditions.

f. Diagnostic Surgical Procedures

Surgical procedures to diagnose your condition while you are in the Hospital.

g. Substance Use Disorder

Please refer to MENTAL ILLNESS AND SUBSTANCE USE DISORDER COVERAGE in this section for coverage information.

h. Inpatient Consultation

A personal bedside examination by another Physician or Professional Other Provider, performing within the scope of their license, when requested by your Physician. The Physician or Professional Other Provider rendering the consulting Service must be board-eligible, if applicable, and possess the knowledge, training, and skill needed to provide this Service. Consultation Services are not covered if the consultant subsequently takes charge of the patient. At that point, we will consider him the treating Physician. We will not provide coverage for both the treating Physician and initial treating Physician for Services rendered during the same time period. Staff consultations required by Hospital rules are not covered.

i. Newborns

- **Inpatient Newborn Care**. Routine care of a newborn while the mother remains an Inpatient for the maternity admission, or if the newborn is added to your Policy within the time limit specified in Section III. Cost-sharing will be applied to neonatal circumcision. Coverage must be in effect for the newborn care to be a Covered Service. **Each new Dependent must be added to your Policy within 60 days of acquiring the new Dependent, regardless of the type of coverage in effect at the time you acquire the new Dependent.** Refer to the Section III for information on how to apply for the necessary coverage.
- **Newborn Hearing Impairment Testing.** In West Virginia, health care Providers present at or immediately after childbirth are required to perform a test for hearing loss on the infant unless the infant's parents refuse. If delivery takes place in a non-covered Facility including home birth, a West Virginia health care Provider shall inform the parents of the need to obtain this Service within the first month of life. The newborn testing shall be a covered benefit.
- **Detection and Control of Diseases in Newborns.** West Virginia law requires the Hospital or Birthing Center in which the infant is born, the parents or legal guardians, the Physician attending the newborn child, or any person attending the newborn child not under the care of a Physician, to ensure that the newborn be tested for diseases specified by the state Public Health Commissioner and set forth in West Virginia code §16-22-3.

2. OUTPATIENT SERVICES

a. Ancillary Services

Hospital services and supplies including, but not limited to:

- Use of operating and treatment rooms and equipment;
- Drugs and medicines provided to a Member when you are an outpatient in a Facility Provider. However, certain therapeutic injectables and infusion therapy Services as identified by Highmark WV and which are appropriate for self-administration will be covered only when received from a Network Pharmacy Provider as set forth in Section. IX. PRESCRIPTION DRUGS (OUTPATIENT).
- Whole blood, administration of blood, blood processing, and blood derivatives;
- Anesthesia, Anesthesia supplies and Services rendered in a Facility Provider by an employee of the Facility Provider, including the administration of Anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery;
- Medical and surgical dressings, supplies, casts, and splints;
- Diagnostic Services;
- Habilitative and Rehabilitative Services; and
- Therapy Services

b. Pre-Admission Testing

Tests and studies when such Services are required in connection with the Member's admission and are rendered or accepted by a Hospital on an Outpatient basis prior to a scheduled admission to the Hospital as an Inpatient.

c. Substance Use Disorder

Please refer to MENTAL ILLNESS AND SUBSTANCE USE DISORDER COVERAGE in this Section for coverage information.

d. Surgery

Hospital services and supplies for Outpatient Surgery including removal of sutures, Anesthesia, Anesthesia supplies and Services rendered by an employee of the Facility Provider other than the surgeon or assistant at Surgery.

P. INFUSION THERAPY SERVICES

Benefits will be provided when Covered Services are performed by a Provider on an Outpatient basis of if the components are furnished and billed by a Provider. Certain infusion drugs may require Prior Authorization. Covered Services include pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with Infusion Therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with Infusion Therapy. However, benefits for certain therapeutic injectable and Infusion Therapy Services as identified by Highmark WV and which are appropriate for self-administration will be covered only when received from a Network Pharmacy Provider as set for the under Section IX. Prescription Drugs (Outpatient). Contact Utilization Management for additional information. Their phone number is located on the back of your ID Card.

Q. INJECTABLE DRUGS

Certain injectable drugs may require Authorization. Contact Utilization Management for additional information. Their phone number is located on the back of your ID Card.

R. MATERNITY SERVICES

Hospital, medical and surgical Services for a normal pregnancy and complications of pregnancy, miscarriage, and non-elective abortions are Covered Services. Coverage excludes procedures, equipment, Services, Supplies, or Charges for abortions for which Federal funding is prohibited. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed. These are Covered Services for the Policyholder and all Eligible Dependents. These are not Covered Services if the Policyholder or Eligible Dependent has become pregnant to serve in the capacity of a Surrogate Mother or of a Surrogate Parent.

We will not restrict maternity benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a Provider obtain Authorization from us for prescribing lengths of stay in excess of the above periods. Precertification is required only when the Inpatient stay exceeds 48 hours and 96 hours respectively.

S. MEDICAL SUPPLIES AND EQUIPMENT

1. Medical and Surgical Supplies

These Supplies include syringes, needles, oxygen, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use such as elastic bandages or thermometers.

2. Durable Medical Equipment

Durable medical equipment must be prescribed by a Physician or Professional Other Provider acting within the scope of their license. It must serve only a medical purpose and must be able to withstand repeated use. You may rent or purchase the equipment; however, we will not pay more in total rental costs than the customary purchase price, as determined by us.

3. Orthotic Devices

Rigid or semi-rigid supportive devices that limit or stop the motion of a weak or diseased body part.

4. Prosthetic Appliances

The purchase, fitting, adjustments, repairs and replacements of prosthetic devices that are artificial substitutes and necessary supplies that:

- replace all or part of a missing body organ and its adjoining tissues; or
- replace all or part of the function of a permanently useless or malfunctioning body organ.

Excluded are:

- Dental appliances;
- Replacement of cataract lenses unless needed because of a lens prescription change;
- Elastic bandages;
- Garter belts or similar devices; and
- Orthopedic shoes that are not attached to braces.

T. MENTAL ILLNESS AND SUBSTANCE USE DISORDER COVERAGE

For purposes of Mental Health Parity, "Serious Mental Illness" means an illness included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, under the diagnostic categories or subclassifications of: (A) Schizophrenia and other psychotic disorders; (B) bipolar disorders; (C) depressive disorders; (D) Substance Use Disorders with the exception of caffeine-related disorders and nicotine-related disorders; (E) anxiety disorders; and (F) anorexia and bulimia. For purposes of coverage the terms “Mental Illness” is defined as schizophrenia and other psychotic disorders, bipolar disorders, depressive disorders, anxiety disorders, anorexia and bulimia.

1. Mental Illness Care

Covered Services for the treatment of Mental Illness include:

- Individual psychotherapy;
- Group psychotherapy;
- Family counseling; counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Policy. Charges will be applied to the Covered Person who is receiving family counseling Services, not necessarily the patient;
- Electroshock Therapy or convulsive drug Therapy and related anesthesia only if given in a Hospital or Psychiatric Hospital;
- Psychological testing;
- Intensive Outpatient Services (IOP);

- Partial Hospital (PH). Mental Health Care Services provided on a Partial Hospitalization basis shall be deemed an Outpatient care Visit subject to Outpatient care cost-sharing amounts; and
- Psychiatric Inpatient hospitalization.

2. Substance Use Disorder Services

Covered Services for the Treatment of Substance Use Disorder include:

- Individual counseling and psychotherapy;
- Group counseling and psychotherapy;
- Family counseling; counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Contract. Charges will be applied to the Covered Person who is receiving family counseling Services, not necessarily the patient;
- Psychological testing;
- Intensive Outpatient Services (IOP);Partial Hospital (PH). Substance Use Disorder Services provided on a Partial Hospitalization basis shall be deemed an Outpatient care Visit subject to Outpatient care cost-sharing amounts;
- Covered Services also include Inpatient and Outpatient detoxification Services; and
- Medically Necessary and Appropriate Inpatient and Outpatient treatment.

U. ORGAN TRANSPLANT SERVICES

The following human organ transplants are Covered Services:

- Heart;
- Heart / lung;
- Lung (single or double);
- Liver; and
- Pancreas.

NOTE: *Kidney transplants are covered under Surgical Services, Special Surgery.*

Benefits will be provided for:

- Expenses of the recipient directly related to the transplant procedure. This includes pre-operative care and post-operative care, and immunosuppressant drugs;
- Expenses for the acquisition, transportation, and storage costs directly related to the donation of a human organ to be used in a covered organ transplant procedure;
- Retransplantation; and
- Travel Reimbursement. For transplants that occur at a facility that is located greater than 50 miles from the recipient's home, the following will be covered during the reimbursement period:
  - $150/day limit for reasonable lodging and meals;
  - Ground travel is reimbursed based on the mileage from the recipient's home or temporary lodging to the transplant Facility. Reimbursement is calculated using Highmark WV's current mileage reimbursement rate;
  - Air travel is reimbursed at the price of the airline ticket (coach class);
  - Tolls and parking Incurred while traveling between recipient's home or temporary lodging and transplant Facility;
  - There is a $10,000 aggregate limit for all travel costs; and
  - The reimbursement period begins 5 days prior to a transplant and ends 12 months after the date of transplant. Reimbursement applies to recipient (adult) and one other person. If the recipient is a minor, two adults are covered.

The Policy providing coverage for the recipient in a transplant operation shall also provide for the reimbursement of any medical expenses of a live donor to the extent benefits remain and are available under the recipient's Policy, after benefits for the recipient's own expenses have been paid. Such benefits may be limited to those expenses directly relating to the organ donation.

V. OUTPATIENT MEDICAL CARE SERVICES

Medical care rendered by a Professional Provider to a Member who is an Outpatient for a condition not related to Surgery, Maternity, Mental Illness, or Substance Use Disorder, except as specifically provided, including allergy extracts, allergy injections, medical care Visits, Telehealth Services, therapeutic injections and consultations for the examination, diagnosis and treatment of an injury or illness, and Covered Services provided by Professional Providers at a Retail Clinic or Urgent Care Center. However, benefits for certain therapeutic injectables as identified by the Policy and which are appropriate for self-administration, will be provided only when received from a Network Pharmacy Provider as set for the under Section IX. Prescription Drug Benefits. For coverage information relating to Surgery, Maternity, Mental Illness, or Substance Use Disorder please refer to those benefit categories within the Description of Benefits Section.

Benefits for Outpatient Medical Care Services will be provided in the amounts specified, and are subject to additional limitations in the Schedule of Benefits.

W. PRESCRIPTION DRUG CLAIMS

Your Policy includes a Prescription Drug benefit offered by Highmark WV; you can fill a prescription through a Network of Participating Pharmacies or a Mail Order Pharmacy Service. Please refer to Section IX for details of your Prescription Drug Benefits.

X. PREVENTIVE CARE SERVICES

NOTE: ***In addition to the Covered Services listed below, there are other routine screening, immunization and Diagnostic Services covered as afforded by the Patient Protection and Affordable Care Act (PPACA). Highmark WV periodically reviews the schedule of covered services and certain prevention programs based on the requirements of the Patient Protection and Affordability Care Act of 2010, the U.S. Preventive Task Force, the Blue Cross Blue Shield Association and medical consultants. Therefore, the frequency and eligibility of services and programs are subject to change. For a current schedule of covered services, log onto your Highmark WV Member website, at www.highmarkbcbswv.com, or call Member Service at the toll-free number listed on the back of your ID Card.***

1. Routine Adult Physical Exams

Benefits are provided for routine physical examinations when performed by a Primary Care Provider regardless of Medical Necessity and Appropriateness. The routine physical examination includes a complete medical history, and other items and Services.

2. Adult Immunizations

Benefits are provided for adult immunizations, including the immunizing agent, required for the prevention of disease. Adult immunizations required by an employer are subject to all Deductibles.

3. Colorectal Cancer Screening

- Benefits are provided for the following tests and procedures when ordered by a physician for the purpose of early detection of colorectal cancer: Basic Diagnostic laboratory and pathology screening services such as a fecal occult blood or fecal immunochemical test;
- Basic diagnostic standard imaging screening services such as barium enema;
- Surgical screening services such as flexible sigmoidoscopy and colonoscopy and Hospital Services related to such surgical screening services; and
- Such other basic diagnostic laboratory and pathology, basic diagnostic standard imaging, surgical screening tests, basic diagnostic medical and advanced imaging screening services consistent with approved medical standards and practices for detection of colon cancer

Benefits are provided for Members 50 years of age or older as follows, or more frequently regardless of age when prescribed by a physician:

- An annual fecal occult blood test or fecal immunochemical test;
- A sigmoidoscopy every 5 years;
- A screening barium enema or test consistent with approved medical standards and practices to detect colon cancer every 5 years; and
- A colonoscopy every 10 years.

If you are determined to be at a high or increased risk, regardless of age, benefits are provided for a colonoscopy or any other combination of covered services related to a colorectal cancer screening when prescribed by a Physician and in accordance with the American Cancer Society guidelines on screening for colorectal cancer as of January 1, 2008.

Colorectal cancer screenings which are otherwise not described herein and are prescribed by a Physician for a symptomatic Member are not considered Preventive Care Services. The payment for these services will be consistent with similar Medically Necessary and Appropriate Covered Services.

4. Routine Gynecological Examination and Papanicolaou Smear

Benefits are provided for one (1) routine gynecological examination, including a pelvic examination and clinical breast examination and one (1) routine Papanicolaou smear per year for all Members.

NOTE: ***As required by law, Members have direct access to a women's health care Provider of their choice.***

5. Well Woman Care Services

Benefits are provided for women for items and services, including but not limited to, an initial physical examination for pregnant women to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling and breastfeeding support and counseling.

6. Mammographic Screenings

Benefits are provided for the following Covered Services in amounts specified in SECTION IV Schedule of Benefits of this Certificate Book:

- One (1) annual routine mammographic screening for all Members forty (40) years of age or older; and
- Mammographic screenings for all asymptomatic Members, regardless of age, when such Services are prescribed by a Physician.

Mammographic screenings which are otherwise not described in this Mammographic Screening Paragraph and are prescribed by a Physician for a symptomatic Member are not considered Preventive Services. These Services, however, may be eligible for payment under other provisions of this Certificate Book.

7. Diabetes Prevention Program

Benefits ae provided for those Members meeting certain medical criteria of having a high risk of developing type 2 diabetes when enrolled in a Diabetes Prevention Program that is offered through a Network Diabetes Prevention Provider. Coverage is limited to one (1) enrollment in a Diabetes Prevention Program per year, regardless of whether the Member completes the Diabetes Prevention Program.

8. Diagnostic Services and Procedures

Benefits are provided for eligible routine Diagnostic Services and procedures regardless of Medical Necessity and Appropriateness.

9 Routine Pediatric Physical Exams

Benefits are provided for routine physical examinations regardless of Medical Necessity and Appropriateness.

10. Pediatric Immunizations

Benefits are provided to Members under twenty-one (21) years of age as defined in SECTION III. Schedule of Eligibility of this Policy and the Highmark WV Preventive Schedule, for those pediatric immunizations, including the immunizing agents which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, and the U. S. Department of Health and Human Services.

11. Pediatric Diagnostic Services and Procedures

Benefits are provided for eligible routine Diagnostic Services and procedures regardless of Medical Necessity and Appropriateness.

Y. PRIVATE DUTY NURSING SERVICES

Skilled Care rendered by a registered, licensed vocational or licensed practical nurse when ordered by a Physician. Care that is primarily non-medical or Custodial Care is not covered. Such Services must be certified initially and every 30 days by your Physician. Inpatient Services are Services that we decide are of such a nature or degree of complexity that the Provider's regular nursing staff cannot give them.

Z. REHABILITATION SERVICES

Diagnostic tests, assessment, monitoring or treatments which are designed to remediate a patient's condition or to restore the patient to his or her optimal physical, medical, psychological, social, emotional, vocational and economic status.

NOTE: ***For treatment of conditions that cause chronic pain you will be provided a total of twenty (20) visits per event of physical therapy, occupational therapy, osteopathic manipulation, chronic pain management program and chiropractic services when ordered by a Health Care Provider.***

1. Occupational Therapy

The Treatment by means of constructive activities designed and adapted to promote the ability to satisfactorily accomplish the ordinary tasks of daily living and those required by a particular occupational role. In order to be considered a Covered Service, this therapy must be expected to improve the level of functioning within a reasonable period of time.

2. Physical Medicine

The Treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities.

3. Chiropractic/Spinal Manipulation

The Treatment by means of manual manipulation of the spine.

4. Speech Therapy

The treatment for the correction of a speech impairment. In order to be considered a Covered Service, this therapy must be expected to improve the level of functioning within a reasonable period of time.

5. Cardiac Rehabilitation

The physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

Rehabilitative services includes care rendered by the following:

- A Hospital duly licensed by the state of West Virginia that meets the requirements for rehabilitation;
- Hospitals as described in the Medicare Provider Reimbursement Manual, Part 1;
- A distinct part rehabilitation unit in a Hospital duly licensed by the state of West Virginia;
- A Hospital duly licensed by the state of West Virginia that meets the requirements for cardiac rehabilitation; or
- Similar facilities located outside of the state.

NOTE: Rehabilitation Services do not include Services for mental health, chemical dependency, Vocational Rehabilitation, long-term maintenance or custodial Services.

Your Physician must certify that there is reasonable likelihood that Rehabilitation Services will correct or restore you to your optimal physical, medical, psychological, social, emotional, vocational and economic status.

AA. SKILLED NURSING FACILITY SERVICES

Benefits for the same Services available to an Inpatient of a Hospital are also covered for an Inpatient of a Skilled Nursing Facility. Such Services must be Skilled Care and authorized and provided pursuant to your Physician's Plan of Treatment. Your Physician must certify initially and every two weeks that you are receiving Skilled Care and not merely Custodial Care.

No benefits are payable:

- Once a patient can no longer significantly improve from treatment for the current condition as determined by us;
- For Custodial Care; or
- Solely for the treatment of Mental Illness, Substance Use, or pulmonary tuberculosis.

BB. SPECIAL SERVICES

1. Pre-Admission Testing

Outpatient tests and studies required for your scheduled Hospital admission as an Inpatient, which would have been covered as an Inpatient.

2. Diabetic Services

Services provided or performed for the treatment of both insulin dependent and non-insulin dependent diabetes includes:

- Blood glucose monitors and monitor supplies (paid under your durable medical equipment (DME) benefits);

- Insulin infusion devices (paid under your DME benefits);
- Insulin;(Cost-sharing for Prescription Insulin Drugs are paid under your Precription Drug benefits and will not exceed $100 for a 30 day supply);
- Syringes and insulin injection aids or devices; (paid under your Prescription Drug benefits);
- Pharmacological agents for controlling blood sugar (paid under your Prescription Drug benefits);
- Urine ketone testing strips;
- Urine micro albumin test;
- Blood pressure monitoring device;
- Podiatric appliances and therapeutic footwear;
- Foot Orthotics; and
- Orthopedic appliances including canes, crutches and walkers, and other items as may be Medically Necessary and Appropriate.

NOTE: ***You may directly access any Network Provider for one annual diabetic retinal exam.***

Diabetes self-management education to ensure the proper self-management and treatment, including diet education, is a Covered Service. However, this education is limited to:

- Visits upon diagnosis of diabetes;
- Visits necessitated by a significant change in the patient's symptoms or conditions resulting in a change in the patient's self-management; and
- When a new medicine or therapeutic process relating to treatment or management of the patient's condition has been identified as Medically Necessary and Appropriate.

Education services may be provided by:

- A licensed pharmacist when providing instruction on the proper use of equipment covered by this Policy or supplies and medication prescribed by a licensed Physician;
- A diabetes educator certified by a national diabetes educator certification program; or
- A registered dietitian registered by a nationally recognized professional association of dieticians.

National diabetes education certification or any professional association of dietitians must be certified to the Insurance Commissioner by the West Virginia Health Department.

3. Dental Anesthesia Services

General anesthesia for dental procedures and associated Outpatient Hospital or Ambulatory Facility Charges provided by appropriately licensed health care individuals in conjunction with dental care is covered if the Member is:

- Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the enrollee or insured and for whom a superior result can be expected from dental care provided under general anesthesia; or
- A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

Prior authorization is required for general anesthesia and associated Outpatient Hospital or Ambulatory Facility Charges for dental care and must be provided by:

- A fully accredited specialist in pediatric dentistry;
- A fully accredited specialist in oral and maxillofacial Surgery; or
- A Dentist to whom Hospital privileges have been granted.

This section applies only to general anesthesia, not the dental care for which the general anesthesia is provided nor does it apply to dental care rendered for temporomandibular joint disorders.

CC. SURGICAL SERVICES

1. Surgery

This must be done by a Physician or Professional Other Provider performing within the scope of their license. Benefits include Medical Care Visits before and after Surgery.

2. Special Surgery

a. Sterilization.
b. Removal of impacted teeth. Partial and Full-bony impacted teeth are covered under your medical benefits; all soft tissue impactions would be covered under your Dental benefits, if applicable.
c. Mandibular staple implant, due to trauma and/or accidental injury.
d. Maxillary or mandibular frenectomy.
e. Kidney transplants.
f. Mastectomy and Breast Cancer Reconstruction.
g. Benefits are provided for a mastectomy performed on an Inpatient or Outpatient basis and for the following:
   - Reconstruction of breast on which the mastectomy was performed;
   - Reconstructive Surgery of the other breast to present symmetrical appearance;
   - Prostheses and coverage for physical complications at all stages of the mastectomy procedures including pymphedemas in a manner determinedin consultation with the attending Physician and the patient;
   - Minimum stay of 24 hours of Inpatietn care following a total mastectomy or partial with lymph node dissection for treatment of breast cancer.
   - Minimum stay of 48 hours of Inpatient care for a radical or modified mastectomy.

NOTE: ***Coverage for the above will be provided in a manner determined in consultation with the attending Physician and the patient and subject to the terms and conditions of your Policy including any applicable Deductible and Coinsurance limitations consistent with those established for other benefits under this Policy.***

3. Multiple Surgical Procedures

When more than one surgical procedure is performed through the same body opening during one operation, you are covered for the most complex procedure. When more than one surgical procedure is performed through more than one body opening during one operation, you are covered for the most complex procedure and for one-half of the benefit for additional procedures.

4. Assistant at Surgery

A Physician's help to your surgeon in performing covered Surgery when no qualified house staff member, intern, or resident exists.

5. Anesthesia

Administration of anesthesia, done in connection with a Covered Service, by a Physician or certified registered nurse anesthetist who is not the surgeon or the assistant at Surgery. This benefit includes care before and after the administration. The Services of a standby anesthesiologist are covered during coronary angioplasty Surgery.

6. Second Surgical Opinion

A second Physician's opinion and related Diagnostic Services to help determine the need for elective covered Surgery Services recommended by your first Physician is a Covered Service. The second opinion must be provided by someone other than the first Physician who recommended the Surgery. This benefit is not payable while you are an Inpatient of a Hospital. We cover a third opinion if the first two opinions conflict. The Surgery is a Covered Service even if the Physicians' opinions conflict.

DD. TELEHEALTH SERVICES

1. Telemedicine Services

Benefits will be provided for Covered Services provided by our approved telemedicine vendors via real-time interactive audio and video telecommunications technology. These approved vendors provide access to a national network of board-certified physicians to a Member with twenty-four hour, seven days a week availability. For a current list of approved telemedicine vendors contact Member Services. Their phone number is located on the back of your ID card.

2. Virtual Services (Specialist, Primary Care Provider, Retail Clinic, and other Virtual Visits)

Benefits will be provided for Covered Services provided by a Network Provider via real-time interactive audio and video telecommunications technology. A Member can participate in a virtual visit with a Network Provider from the privacy of their own home, office, or other private setting. If a Member receives Virtual Services at an Originating Site, the Member will be responsible for the Originating Site Fee Coinsurance amount specified in the Schedule of Benefits. Please verify that your Provider has the required telecommunications technology to support Virtual Services.

Covered Virtual Services will be paid according to the benefit category (e.g. Primary Care Provider Office Visit, Maternity Visit, etc.) For example Virtual Visits relating to the treatment of Mental Illness or Substance Use Disorder are covered under your Outpatient Mental Health and Substance Use Disorder benefit and subject to the cost sharing amount in your Schedule of Benefits.

EE. TEMPOROMANDIBULAR JOINT DISORDERS (TMD) / CRANIOMANDIBULAR DISORDERS (CMD)

Benefits will be provided for the following procedures for the Treatment of TMD or CMD:

- Health history;
- Clinical examination;
- Diagnostic imaging procedures;
- Conventional diagnostic and therapeutic injections;
- Limited orthotics; splints or appliances are limited to one every three years. All adjustments to the appliance performed during the first six months of installation are considered part of the total appliance fee;
- Surgery, including arthrotomy and diagnostic arthroscopy; and
- Physical medicine and physiotherapy; which shall include:
  - Ultrasound;
  - Diathermy;
  - High Voltage Galvanic Stimulation; and
  - Transcutaneous Nerve Stimulation.

FF. THERAPEUTIC INJECTIONS

Therapeutic injections required in the diagnosis, prevention and treatment of an injury or illness. However, certain therapeutic injectables as identified by Highmark WV and which are appropriate for self-administration will be covered only when received from a Network Pharmacy Provider as set forth under Section IX. PRESCRIPTION DRUGS.

GG. THERAPY SERVICES

Services or supplies used to promote the recovery from an illness or injury include:

- Radiation Therapy;
- Chemotherapy;
- Dialysis Treatments;
- Respiratory Therapy;
- Hyperbaric and Pulmonary Therapy;
- Speech Therapy
- Occupational therapy
- Cardiac Rehabilitation
- Physical Therapy; and
- Infusion Therapy.

Benefits will be provided when Covered Services are performed by a Provider or if the components are furnished and billed by a Provider. Covered Services include pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with Infusion Therapy. Specific adjunct non-intrvenous therapies are included when administered only in conjunction with Infusion Therapy. Benefits for certain Infusion Therapy Prescription Drugs as identified by Highmark WV and which are appropriate for self-administered, will be provided only when received from a Network Pharmacy Provider as set forth under the Prescription Drugs (Outpatient) section.

Certain infusion drugs may require Authorization. Contact Utilization Management for additional information. Their phone number is located on the back of your ID Card.

HH. VISION CARE SERVICES

1. PEDIATRIC VISION

Benefits are provided for Covered Persons under age nineteen (19) every twelve (12) consecutive months for the following when rendered by a Participating Vision Provider:

- one (1) comprehensive eye examination (including dilation as professionally indicated);
- one (1) pair of single vision, bifocal, trifocal or lenticular lenses (including glass, plastic or oversized lenses); and
- one (1) pair of frames from a selection designated by Highmark WV.

II. WELLNESS PROGRAMS

The Plan may offer Members the opportunity to participate in programs of health promotion and/or disease prevention. When offered, these programs will be available to Members without regard to health status. Whether or not Members decide to participate in such programs will not affect their continued eligibility, benefits, premiums, or cost-sharing obligations under this Policy.

At times, this Policy may offer rewards for Member participation in certain of these programs. Any reward provided by the Plan in connection with these programs will not be offered or conditioned upon the Member satisfying a standard that is based on a health related factor.

VI. Coordination of Benefits, Right of Recovery, Right of Reimbursement/Subrogation and Work Related Injuries or Illnesses

A. DOUBLE COVERAGE

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "Coordination of Benefits (COB)" to determine how much each should pay when you have a Claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

COB is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, contact your Member services or your state insurance department.

B. PRIMARY OR SECONDARY?

You will be asked to complete questionnaires from time to time to identify all the plans that cover Members of your family. We need this information to determine whether Highmark WV is the "primary" or "secondary" benefit payer. To avoid possible Claim denials you need to complete and return the questionnaires promptly. Also, please notify us timely with any changes to the other health care coverage.

C. ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

  Except: 1) a plan that does not contain a coordination of benefits that is consistent with this rule is always primary unless the provisions of both plans state that the complying plan is primary; or 2) coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverage that are written in connection with a closed panel plan to provide Out-of-Network benefits.

- A plan may consider the benefits paid or provided by another plan in calculation payment of its benefits only when it is secondary to that other plan.
- Each plan determines its order of benefits using the first of the following rules that apply:
  - **Non-Dependent/Dependent**
    The plan which covers the person other than as a Dependent, for example as an employee, Member, Policyholder or retiree is the primary plan and the plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (e.g. a retired employee); then the order

of benefits between the two plans is reversed so that the plan covering the person as an employee, Member, Policyholder or retiree is the secondary plan and the other plan is the primary plan.

- **Dependent Child Covered Under More Than One Plan**
  Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan the order of benefits is determined as follows:
  - For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    i. plan of the parent whose birthday falls earlier in a calendar year is the primary plan; or
    ii. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
  - For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    i. If there is no court decree allocating responsibility for the Dependent child's health care coverage, the order of benefits for the child are as follows:
      - The plan of the parent with custody of the child;
      - The plan of the spouse/Domestic Partner of the parent with the custody of the child;
      - The plan of the parent not having custody of the child; and
      - The plan of the spouse/Domestic Partner of the parent not having custody of the child;
  - If the specific terms of a court decree state that one of the parents is responsible for the health care coverage of the Dependent child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
  - If a court decree states that both parents are responsible for the Dependent child's health care coverage, the provisions of (i) above shall determine the order of benefits.
  - If the court decree states that the parents have joint equal custody, without stating that one of the parents is responsible for the health care coverages of the Dependent child, the provisions of (i) above shall determine the order of benefits.
  - For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.
- **Active Employees or Retired or Laid-Off Employee**
  The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree this rule is ignored. This rule does not apply if the rule labeled 3(a) of this section can determine the order of benefits.
- **COBRA or State Continuation Coverage**
  If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, Member, Policyholder or retiree or covering the person as a Dependent of an employee Member, Policyholder or retiree is the primary plan and the COBRA, state or other federal continuation coverage is the secondary plan. If the other plans do not have this rule, and as a result, the plans do not agree on the order of benefits this rule is ignored. This rule does not apply if the rule labeled 3(a) of this section can determine the order of benefits.
- **Length of Coverage**
  The plan that has covered a person as an employee, Member, Policyholder or retiree the longest shall be the primary plan and the plan that covered that person for the shorter period of time shall be secondary to the Primary plan.
- **If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Policy will not pay more than it would have paid had it been the primary plan.**

EXCEPT: ***A plan that does not contain a Coordination of Benefits that is consistent with this rule is always primary unless the provisions of both plans state that the complying plan is primary; or 2)***

coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverage that is written in connection with a closed panel plan to provider Out-of-Network benefits.

D. HOW WE PAY CLAIMS WHEN WE ARE PRIMARY

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.

E. HOW WE PAY CLAIMS WHEN WE ARE SECONDARY

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay

part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense covered by one of the plans, including Copayments, Coinsurance and Deductibles.

We will determine our payment by calculating what we would have paid as the primary payer and then compare that amount to the Member Liability from the primary plan and pay the lesser amount. Highmark WV should never pay more than what we would have paid as primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your Claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan Deductible.

If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

F. FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Policy. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Policy.

G. RIGHT OF RECOVERY

If the amount of the payments made by Highmark WV is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

H. RIGHT OF REIMBURSEMENT AND SUBROGATION

To the extent we pay any medical or other expenses, we shall have the right to be reimbursed in full for those expenses from any recovery that you may have obtained from the Responsible Party. This is known as our Right of Reimbursement.

If you or your Eligible Dependents fail or refuse to make or pursue a Claim against any Responsible Party, then we shall have the right to make and/or pursue such Claim against the Responsible Party. This right exists to the extent that we have paid any medical or other expenses for you or any Eligible Dependents under this Policy. This is known as our Right of Subrogation.

Under our Right of Subrogation, we may, at our discretion:

- Assert a Claim on behalf of you or your Eligible Dependents against any Responsible Party (including bringing suit in your or your Eligible Dependents name); or
- Intervene in any lawsuit or Claim that you or your Eligible Dependents has filed or made against any Responsible Party.

Our Right of Reimbursement, as well as our Right of Subrogation, is hereinafter referred to as Right of Reimbursement.

Our Right of Reimbursement shall constitute a lien against the proceeds of any:

- Settlement or compromise between you or your Eligible Dependents and any Responsible Party;
- Judgment or award obtained by you or your Eligible Dependents against a Responsible Party; or
- Third party reimbursement or proceeds.

The types of proceeds described above are hereinafter referred to as Subrogated Recovery. Our Right of Reimbursement shall exist notwithstanding any allocation or apportionment of any Subrogated Recovery that purports to limit or eliminate our Right of Reimbursement. All recoveries that you or your Eligible Dependents or your representative obtain (whether by lawsuit, settlement, insurance or benefit program Claims, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Any Subrogated Recovery that excludes or limits, or attempts to exclude or limit, the cost of medical Services or care shall not preclude us from enforcing our Right of Reimbursement. Our Right of Reimbursement shall not be eliminated or limited in any way because the Subrogated Recovery fails to fully compensate or "make whole" you or your Eligible Dependent on his or her total Claim against any Responsible Party. Similarly, our Right of Recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.

A Covered Person agrees not to do anything to prejudice our rights and agrees to cooperate fully with us. The Covered Person must notify our Third Party Recoveries Department, in writing, of the existence of any Responsible Party. You should contact Member Services at the number on the back of your Identification Card to get the contact information. If a Covered Person retains legal counsel to recover from any Responsible Party, the Covered Person must immediately notify legal counsel of our Right of Reimbursement. In addition, the Covered Person must immediately notify our Third Party Recoveries Department, in writing, that legal counsel has been retained. The Covered Person must also provide us with prompt notice of any Subrogated Recovery.

A Covered Person further agrees to notify us of any facts that may impact our Right of Reimbursement, including but not limited to:

- Filing of a lawsuit;
- Making a Claim against any third party, for Worker's Compensation benefits, or against any other potential source of recovery;
- Timely advance notification of settlement negotiations; and
- Timely advance notification of the intent of a third party to make payment of any kind for the benefit of or on behalf of the Covered Person that is in any manner related to the condition giving rise to our Right of Reimbursement.

A Covered Person and/or his or her legal counsel may be required to execute and deliver to us written confirmation of our Right of Reimbursement. In addition, a Covered Person may be required to execute and deliver to us other documents that may be necessary to secure and protect our Right of Reimbursement. Our failure to request such written confirmation or other documents shall not be considered to be a waiver by us of our Right of Reimbursement. Failure to provide such written confirmation or other documents

upon request, or failure to cooperate with us in the protection of our Right of Reimbursement, may result in:

- Cancellation of benefits; and/or
- Denial of the Claim upon which our Right of Reimbursement is based.

Any such cancellation or denial shall not affect our Right of Reimbursement to the extent of any medical expenses actually paid by us.

A Covered Person agrees to keep in a segregated account that portion of any Subrogated Recovery that is equal to any benefits we have paid for the Covered Person's injuries, until our Right of Reimbursement has been satisfied. A Covered Person and/or his or her legal counsel shall promptly pay us all amounts recovered as a result of any Subrogated Recovery to the extent we have paid any medical or other expenses for that Covered Person. We have no duty or obligation to pay any legal fees or expenses Incurred by such Covered Person in obtaining a Subrogated Recovery.

Should we be required to take any action to enforce our Right of Reimbursement, including, but not limited to, the filing of a civil action, we shall be entitled to recover all costs associated with such enforcement efforts. These costs include, but are not limited to, all attorney's fees and expenses Incurred by us.

If necessary, we shall have the right to seek appropriate equitable relief to redress any violation of this provision by a Covered Person. Recoveries under this provision will be applied to your Claim history, less any Charges or Fees Incurred in obtaining the recoveries.

If we are unable to recover our benefits notwithstanding a Covered Person's recovery from a Responsible Party, and if the Covered Person thereafter Incurs health care expenses for any reason, we may exclude benefits for otherwise covered expenses until the total amount of those health care expenses exceeds the recovery from the Responsible Party.

You may contact Highmark WV's Third Party Recoveries Department.

I. WORK RELATED INJURY AND ILLNESS

This Policy does not provide benefits for a work-related injury or illness when covered under a Workers' Compensation Program. **It is your <u>responsibility</u> to inform the Provider of the work-related nature of the injury or illness and where appropriate, to seek benefits under any applicable Workers' Compensation Program.** If the Provider was not properly informed, or if Highmark WV paid Claims more appropriately paid by Workers' Compensation, you must notify Highmark WV's Third Party Recoveries Department by contacting Member Services.

Highmark WV reserves the right to conduct an investigation of *any* illness or injury it has *any* reason to believe may be work-related, and to do so *before or after* Claims are paid. In these situations, failure to respond to a Highmark WV inquiry or failure to otherwise cooperate with Highmark WV's investigation may result in the denial or adjustment of all affiliated Claims. Highmark WV may, in its sole discretion, withhold payment unless or until the Member produces a written denial of workers' compensation coverage.

If you enter into a settlement giving up your right to recover future medical benefits under a Workers' Compensation benefit, medical benefits that would have been compensable except for the settlement will not be Covered Services.

VII. General Provisions

A. WHAT IS A CLAIM AND HOW TO APPLY FOR BENEFITS

1. Claim

A Claim is a request made by or on behalf of a Member for Precertification or prior approval of a Service, as required under this Policy, or for the payment or reimbursement associated with a Service that has been received by a Member. Claims for benefits provided under this Policy include the following types.

a. Pre-Service Claim
A Pre-Service Claim is a Claim for Services that has not yet been rendered and for which you are required to contact us in advance.

b. Urgent Care Claim
An Urgent Care Claim is any Claim for Medical Care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the Claim.

c. Concurrent Care Claim
A Concurrent Care Claim is a Claim required for an ongoing course of treatment that requires approval from us after a specified period of time or number of treatments.

d. Post-Service Claim
A Post-Service Claim is a Claim for Services that already have been rendered.

Designation of a Claim or an Appeal of a denied Claim as a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim will be determined at the time the Claim or Appeal is filed with Highmark WV in accordance with its procedures for filing Claims and Appeals.

This Policy will not cover Claims when premiums are not timely paid. Claims filed in the event of fraud or non-payment of premiums are not considered Claims since there are no benefits payable under this Policy in such circumstances.

2. Filing Claims

A Claim must be filed for you to receive benefits. Network Providers will submit a Claim for you. A Claim must contain certain minimum information in order to qualify. If certain minimum information is not included, it will be returned to the person who submitted it.

3. Notice of Claim and Proof of Loss (Applies to Post-Service Claims Only)

a. Network Providers

Network Providers have entered into an agreement with Highmark WV for the provision of Covered Services rendered to a Member. When a Member receives Services from a Network Provider, it is the responsibility of the Network Provider to submit its Claim to Highmark WV in accordance with the terms of its agreement with Highmark WV. Should the Network Provider fail to submit its Claim in a timely manner or otherwise satisfy Highmark WV's requirements as they relate to the filing of Claims, the Member will not be liable and the

Network Provider shall hold the Member harmless relative to payment of Covered Services received by the Member.

b. Out-of-Network Providers

This Policy will only cover Out-of-Network Services in specific circumstances. Out-of-Network Providers are not obligated to bill Highmark WV directly. As a result, it will be your responsibility to submit to Highmark WV the completed Claim form. If the Provider does not have the forms, we will send you one. In such instances, the Member must submit the Claim in accordance with the following procedures:

- Claim Forms
  Proof of loss for benefits under the Policy must be submitted to Highmark WV on the appropriate Claim form. Highmark WV, upon receipt of a request for a Claim form will, within fifteen (15) days will furnish to the Member Claim forms for filing proofs of loss.
- Notice of Claim
  Highmark WV will not be liable for any Claims unless proper notice is furnished to Highmark WV that Covered Services have been rendered to a Member. Notice given by or on behalf of the Member to Highmark WV that includes information sufficient to identify the Member that received the Covered Services shall constitute sufficient notice of a Claim to Highmark WV. A Charge shall be considered Incurred on the date a Member receives the Service or Supply for which the Charge is made.
- Proof of Loss and Timely Filing
  Claims cannot be paid until a written proof of loss is submitted to Highmark WV. Proof of loss must include all required information necessary for Highmark WV to determine benefits and be given to us within one (1) year of you receiving Covered Services or the date another payor, primary to Highmark WV, processes the Claim (pays or denies). We may require medical records or other supporting documents before a proof of loss is considered sufficient to determine benefits.
- Submission of Claim Forms
  The completed Claim form must be forwarded to Highmark WV at the address appearing on the Member's Identification Card in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under the Policy. To avoid delay in handling Member-submitted Claims, answers to all questions on the Claim form must be complete and correct.

Highmark WV reserves the right to require additional information and documents as needed to support a Claim that a Covered Service has been rendered.

4. Explanation of Benefits (EOB's)

You will receive a paper EOB for Claims for which you owe additional money, other than a Copayment, and for Claims you file yourself. In most cases, the EOB or other notice will be issued directly to the Policyholder. Policyholders may view EOB's at www.highmarkbcbswv.com. You may also request a copy of a particular EOB or you may request to continue to receive paper EOBs through Member Services.

In some limited circumstances, Highmark WV may permit an alternative recipient for the EOB if specifically requested. EOB's are available for Custodial and Non-Custodial parents/guardians of Eligible Dependents. See Section III for additional information regarding custodial parents.

B. PRE-SERVICE CLAIM CONDITIONS

1. Authorizations

An "Authorization" is a determination by Highmark WV that Services a Provider proposed for a Member is Medically Necessary and Appropriate. Authorization may also be called

"Precertification," "Pre-authorization," "Prior Authorization," "Prospective Review," "Pre-Service Review," "Prior Approval" or other similar terms. If a Service requires Authorization, then the Provider or Member must contact Highmark WV to request the Medical Necessity and Appropriateness review.

NOTE: ***An Authorization is a determination of Medical Necessity and Appropriateness only and does not guarantee coverage or payment.***

If you have a Prior Authorization that was approved under your previous coverage, that authorization may apply under this Plan for up to 3 months from your Effective Date of Coverage. Services must be covered under your Plan, and be provided within West Virginia. You must notify us of your request to continue these Services as soon as possible or you may be required to request a new Prior Authorization.

2. Responsibility for Requesting Authorizations

Precertification may be required to determine the Medical Necessity and Appropriateness of certain procedures or Covered Services (including Covered Medications) as determined by us prior to the receipt of services.

a. In-Area Network Services

A Network Provider within your Service Area ("In-Area-Network") is responsible for the Precertification of such procedure or Covered Service. You will not be financially responsible whenever Precertification for such procedure or Covered Service is not obtained by the Network Provider. If the procedure or Covered Service is deemed not to be Medically Necessary and Appropriate, you will not be financially responsible, except when we provide prior written notice your or your Provider that charges for the procedure or Covered Service will not be covered. In such case, you will be financially responsible for such procedure or Covered Service.

b. Out-of-Area Network Services

Whenever you utilize an Out-of-Area Network Provider, it is your the responsibility to first contact us to confirm the Medical Necessity and Appropriateness of such procedures or Covered Services.

If you DO NOT CONTACT us for Precertification those procedures or Covered Services may be reviewed after they are received to determine Medical Necessity and Appropriateness.

If the procedure or Covered Service is determined to be Medically Necessary and Appropriate, benefits will be paid in accordance with this Policy. If the procedure or Covered Service is determined not to be Medically Necessary and Appropriate, no benefits will be provided. You will be financially responsible for the full amount of the Out-of-Area Network Provider's charge.

c. Out-of-Network Services

You will only receive benefits under your my Blue Access Policy when received from a Network Provider, except for covered emergency care and approved exceptions.

If you are admitted to an Out-of-Network Facility for an Emergency Medical Condition, for maternity related care, or for Substance Use Disorder, you must call Utilization Management; the number is on the back of your ID card, within forty-eight (48) hours after admission. If you do not call to authorize an Out-of-Network admission, Utilization Management will review your care after you receive services to determine if your care was Medically Necessary

and Appropriate. If Utilization Management determines that it was not, you will be responsible for all hospital charges. Out-of-Network Providers also do not have to contact Utilization Management. If they do, they do not have to accept Utilization Management's decision. As a result, you may receive Out-of-Network Provider Services that are not considered Medically Necessary and Appropriate under your Policy. You could be responsible for all costs.

3. Exceptions to the Responsibility for Requesting Authorizations

a Substance Use Disorders

The benefits for the first five (5) days of intensive outpatient or partial hospitalization Services shall be provided without Prior Authorization. Benefits beginning day six (6) and every six (6) days thereafter of intensive outpatient or partial hospitalization Services are subject to a Concurrent review for Medical Necessity and Appropriateness.

Facility shall notify us of both the admission and the initial treatment plan within forty-eight (48) hours of the admission or initiation of treatment. If there is no Network Facility immediately available, we will provide an exception to our Network to ensure admission in a treatment facility within seventy-two (72) hours. If you are being treated at an Out-of-Network Facility and a Network Facility becomes available during the course of your treatment plan, you may be required to transfer to a Network Facility.

If we determine that continued Inpatient care in a Facility is no longer Medically Necessary and Appropriate, we shall, within seventy-two (72) hours, provide written notice to you and the your Provider of our decision and the right to file for an expedited review.

NOTE: ***Prior Authorization and concurrent review are not required for In-Area Network or Out-of-Area Network Partial Hospitalization or Intensive Outpatient for Substance Use Disorder Services.***

b. Emergency Medical Condition and Child Birth Admissions

For an admission for an Emergency Medical Condition or an admission related to childbirth Services, you or your Physician must contact us within forty-eight (48) hours of the admission for an Emergency Medical Condition or for lengths of stay beyond forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery. Prior to each admission which is not an Emergency Medical Condition or an admission related to childbirth, you or your Physician must contact us at least two (2) weeks prior to the date of admission, when possible. Otherwise, you or your Physician must contact us as soon as your intended admission is known.

4. Services Requiring Prior Authorization

Highmark WV requires Prior Authorization for all Inpatient admissions and selected Outpatient Services, drugs and equipment.

The following Services are representative of those that require Prior Authorization **(this is not an all-inclusive list).** A current listing is published at www.highmarkbcbswv.com. After you log in go to Your Coverage Tab, Useful Coverge Information, and then Procedures That Require Authorization.

a. Behavioral health Intensive Outpatient and Partial Hospitalization.
b. Substance Use Disorder Intensive Outpatient and Partial Hospitalization.
c. Certain non-emergency Outpatient imaging Services.
d. Clinical trials.

e. Durable medical equipment listed on the Highmark WV website and any non-standard issue (i.e. deluxe) DME.
f. Home Health Care.
g. Hospice.
h. Hospital admissions for childbirth if the Inpatient stay extends beyond 48 hours after a vaginal delivery or 96 hours after a cesarean section delivery.
i. Injectable drugs listed on the Highmark WV website.
j. Inpatient admissions (e.g. Skilled Nursing Facility, rehabilitation, behavioral health, long term acute).
k. Outpatient procedures listed on the Highmark WV website.
l. Outpatient therapies (physical, occupational, speech, chiropractic) after a specified number of Visits or Treatments.
m. Potentially Experimental, Investigational or cosmetic Services.
n. Pulmonary rehabilitation.
o. Transplant Services.

C. CLAIMS PROCESS FOR INITIAL CLAIMS FOR BENEFITS

1. Pre-Service Claims

a. Pre-Service Claims Submitted Electronically

If your Pre-Service Claim is improperly filed, you and/or your Provider will be notified within two (2) business days of receipt of your Claim. If your Pre-Service Claim is properly filed, we will notify you and/or your Provider of our decision within a reasonable time appropriate to the medical circumstances, but no later than seven (7) days from the receipt of the Claim. If additional information is needed to perfect or process the Claim, the Provider shall provide the additional information requested within three (3) business days from the time the return request is received by the Provider or the Pre-Service Claim is deemed denied and a new request must be submitted.

b. Pre-Service Claims Submitted by Telephone, Mail, or Fax.

If your Pre-Service Claim is improperly filed, you and/or your Provider will be notified within five (5) days of receipt of your Claim. If your Pre-Service Claim is properly filed, we will notify you and/or your Provider of our decision within a reasonable time appropriate to the medical circumstances, but no later than fifteen (15) days from the receipt of the Claim. We may extend this period for another fifteen (15) days if we determine it to be necessary because of matters beyond our control. In the event that this extension is necessary, you and/or your Provider will be notified prior to the expiration of the initial fifteen (15) day period as to the reasons for the extension. If additional information is needed to perfect or process the Claim, we will provide you and/or your Provider with at least forty-five (45) days from receipt of the notice to provide the specified information. If we are not provided the additional requested information within the designated time, we will complete our review based on the information we have been provided. Once we have made a decision on Services requiring prior contact, you and/or your Provider will receive notification of the decision.

2. Urgent Care Claims

a. Urgent Claims Submitted Electronically

If the Pre-Service Claim request is for medical care or other Service for a condition that could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or that in the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request, we will respond within two (2) days.

b. Urgent Claims Submitted by Telephone, Mail, or Fax.

For Urgent Care Claims, we will notify you and/or your Provider of our decision as soon as possible but not later than seventy-two (72) hours after the receipt of the Claim by us. We may notify you of an Adverse Determination orally, in writing or electronically. If notice is provided orally, we will provide written or electronic notice of the Adverse Determination within seventy-two (72) hours following the oral notification.

If we have not been provided with sufficient information to determine if the benefits are covered or payable, we will notify you and/or your Provider as soon as possible, but not later than twenty-four (24) hours after receipt of the Claim of the specific information necessary to complete the Claim. You and/or your Provider shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours to provide the specified information.

3. Concurrent Care Claims

If we have approved an ongoing course of Treatment to be provided over a period of time or number of Treatments and then determine a reduction or termination of such course of Treatment is appropriate, we shall notify you and/or your Provider before the end of such period of time or number of Treatments that this is an Adverse Benefit Determination. Our notification will allow you and/or your Provider to request an Appeal of the Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a claimant to extend the course of Treatment beyond the period of time or number of Treatments that is a Claim involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies, and we shall notify you of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the Claim provided that any such Claim is made to us at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of Treatments.

4. Post-Service Claims

Post-Service Claims filed as described in this Section VII will be processed within a reasonable time, but no later than thirty (30) days of receipt of the Claim. We may extend the initial period for fifteen (15) days if we determine it to be necessary because of matters beyond our control. In the event that we utilize this extension, you and/or your Provider will be notified prior to the expiration of the initial thirty (30) day period as to the reasons for the extension. If additional information is needed to perfect or process the Claim, we will notify you within five (5) days of receipt of the Claim and will provide you and/or your Provider with at least forty-five (45) days from receipt of the notice to provide the specified information. If we are not provided the additional requested information within the designated time, we will complete our review based on the information we have been provided.

We may deny a Claim for benefits if information needed to fully consider the Claim is not provided. The denial will describe the additional information needed to process the Claim. You or your Provider furnishing the specified additional information may Appeal the Claim.

5. Emergency Services- Prudent Layperson

In some instances, a Claim filed for emergency services may lack sufficient information or documentation to be processed. In that event, you will receive an EOB instructing you to provide additional information or documentation within forty-five (45) days from the receipt of the EOB so that we can review the Claim. If we do not receive any additional information the Claim will be processed based on the information we have in our files.

The documentation/medical records that would assist us in reviewing a Claim should provide a description of acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health, or, with respect to a pregnant women, the health of the unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

If you have additional records, materials, or other information that you would like to be considered, please provide the additional information to Highmark West Virginia, PO Box 7026, Wheeling, WV 26003, or you may contact Member Services at the number on the back of your ID card.

If a Claim you previously submitted for emergency services was denied in whole or in part based on lack of sufficient information, you may submit an appeal as described in the Grievance and Appeals Procedures for Adverse Benefits Determinations section below.

D. NOTICE OF ADVERSE CLAIM/APPEAL DECISIONS

If the Adverse Determination is a denied Claim, in whole or in part, you will receive written notice with the following information:

- Information sufficient to identify the benefit request or Claim involved, including any applicable dates of service, health care Provider and Claim amount, if applicable;
- The specific reason or reasons for the decision;
- The diagnosis code and procedure code, as well as descriptions of each, will be provided free of charge upon request (a request for diagnosis shall not, in itself, be deemed a request to file a Grievance for review of an adverse determination);
- Reference to the plan provision that supports the decision;
- Descriptions of any further information required to complete the Claim, and an explanation of why further information needs to be submitted;
- A description of Appeal procedures and relevant time limits;
- A Member's right to file a civil suit in a court of competent jurisdiction;
- A statement that Highmark WV will provide, free of charge upon request, a copy of any internal rule, guideline or protocol used to make the decision;
- A declaration that any scientific or clinical judgment involved in the decision and applied in the circumstances, if applicable (i.e. Medical Necessity and Appropriateness, Experimental or Investigational treatment, etc.), will be provided free of charge upon request; and
- A statement that the Member can contact the Commissioner's office for further assistance.

If the Adverse Determination is a Rescission, Highmark WV shall provide at least thirty (30) calendar days' notice to the Member before coverage may be Rescinded, regardless of whether the Rescission applies to an individual only, to an entire group, or to individuals in a group. The notice shall include:

- Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;
- An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;
- Notice that the Member or Group may, prior to the date the advance notice of the proposed Rescission ends, immediately file a Grievance to request a review of the Adverse Determination to rescind coverage;
- A description of Highmark WV's Grievance and Appeal Procedures established, including any time limits applicable to those products; and
- The date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.

At any time the Member has the right to contact the Commissioner for assistance at:
Offices of the WV Insurance Commissioner
PO Box 50540, Charleston, WV 25301
1-304-558-3386.

NOTE: ***If Services are approved after Appeal, payment of Claims will be dependent upon all provisions, limitations, and conditions of this Policy. For instance, all Deductibles, Co-Insurance, Co-Pays and other limitations still apply.***

E. GRIEVANCE AND APPEAL PROCEDURES FOR ADVERSE BENEFIT DETERMINATIONS

1. Internal Grievance and Appeal Procedures

Highmark WV maintains a Grievance and Appeal Process ("Appeal Process") involving one (1) level of review.

The Member may file a Grievance to appeal determinations made by Highmark WV for reasons including, but not limited to, a rescission of a Member's coverage, a denial of an enrollment request of an individual who Highmark WV has determined is ineligible for coverage under this Policy, a denial of a Member's request for an approved exception to obtain Covered Services from an Out-of-Network Provider, urgent care requests, a determination regarding the availability, delivery or quality of Health Care Services, or matters pertaining to the contractual relationship between the Member and Highmark WV. If a Member has received notification that a Claim has been denied by Highmark WV, in whole or in part, the Member may Appeal the decision. . The Member must file a Grievance or Appeal within one hundred eighty (180) days from the receipt of notice of an adverse decision.

At any time during the Appeal process, a Member may choose to designate an authorized representative to participate in the Appeal process on his/her behalf. The Member or the Member's authorized representative shall notify Highmark WV, in writing, of the designation. For purposes of the Appeal process, Member includes designees, legal representatives and, in the case of a minor, parents of a Member entitled or authorized to act on the Member's behalf. Highmark WV reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member. Such procedures as adopted by Highmark WV shall, in the case of an Urgent Care Claim, permit a Professional Provider or Professional Other Provider with knowledge of the Member's medical condition to act as the Member's authorized representative.

At any time during the Appeal process, a Member may contact the Member Service Department at the toll-free telephone number listed on his / her Identification Card to inquire about the filing or status of a Grievance or Appeal.

The Member, upon request to Highmark WV, may review all documents, records and other information relevant to the review or relied upon in making the benefit decision, was submitted or generated in the course of making the adverse determination. The Member shall have the right to submit or present additional evidence or testimony which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of the Grievance or Appeal. Prior to issuing a decision the Member will be provided any new or additional evidence, relied upon or generated by Highmark WV, in advance of the date the decision is required to be provided to permit the Member a reasonable opportunity to respond prior to that date.

The reviewer shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the Claim or matter which is the subject of the Member's Grievance or Appeal. In rendering a decision on the Grievance or Appeal, the reviewer will take into account all evidence, comments, testimony, documents, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by Highmark WV. The reviewer will perform a new review and will not assume the correctness of the original determination. For Appeals of Adverse Benefit Determinations which were based on medical judgment, including Medical Necessity and Appropriateness or Experimental treatment, we will consult with a Physician or other health

professional that holds an unrestricted license and has appropriate training and experience in the field of medicine involved in the medical judgment, medical condition, procedures, or treatment under review.

If additional information is needed to perfect or process the Claim, we will request the specific information from you and/or your Provider. If we are not provided the additional requested information we will complete our review based on the information we have in our files. Each Grievance or Appeal will be promptly investigated and Highmark WV will provide written notification of its decision within the following time frames:

- When the matter involves a non-Urgent care Pre-Service Claim, within a reasonable period of time appropriate to the medical circumstances involved not to exceed thirty (30) days following receipt of the Appeal;
- When the matter involves a concurrent review Urgent Care request involving an admission, availability of care, continued stay or Health Care Service for a Member who has received Emergency Services, but has not been discharged from a Facility, the decision shall be made expeditiously as the Member's medical condition requires, but no more than seventy-two (72) hours. If the decision is an Adverse Determination, the Service shall be continued without liability to the Covered Person until the Covered Person has been notified of the determination;
- When the matter involves an Urgent Care Claim, the review and the decision will be made expeditiously taking into account the medical exigencies involved but not later than seventy-two (72) hours following receipt of the Grievance; or
- When the Grievance or Appeal involves a Post-Service Claim or a decision by Highmark WV to rescind coverage or deny an enrollment request because the individual is not eligible for coverage, within a reasonable period of time not to exceed sixty (60) days following receipt of the Grievance or Appeal.

If Highmark WV fails to provide notice of its decision within the above-stated time frames or otherwise fails to strictly adhere to these Grievance and Appeal Procedures, the Member shall be permitted to request an external review.

Notification of the decision to the Member shall be made electronically or in writing and shall include:

- The titles and qualifying credentials of the person or persons participating in the review process;
- Claim information at issue;
- The availability, upon request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The reviewers' understanding of the Grievance;
- The decision in clear terms and the contract basis or medical rationale;
- The availability, upon request and free of charge, the evidence or documentation, internal rule, guideline, protocol, explanation of the scientific or clinical judgment in the case of medical necessity and Appropriateness, Experimental or Investigational treatment, or similar criterion relied upon in making the decision;
- Reference to specific plan provision on which the determination was made;
- Entitlement to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other relevant information relied upon in making the decision;
- A description of the procedures for obtaining independent external review;
- The specific reason or reasons for the Final Adverse Determination, including the denial code and its corresponding meaning; as well as a description of Highmark WV's standard, if any, that was used in reaching the denial;
- A statement that the Member has a right to bring a civil action in a court of competent jurisdiction; and

- A statement that the Member has the right to contact the West Virginia Office of the Commissioner's office at PO Box 50540, Charleston, WV 25301 or call 1 (304) 558-3386 for assistance at any time.

2. Expedited Internal Grievance and Appeal Procedures

You may file a request for an expedited external Appeal with the West Virginia Office of the Insurance Commissioner ("Commissioner") at the same time that you file for an expedited internal Appeal with us. It may be determined that you will need to complete the expedited internal Appeal process before the expedited external Appeal is started.

A request for an expedited internal Appeal related to Concurrent Care involving an admission, availability of care, continued stay, or where you have received Emergency Services but have not been discharged from a Facility may be made orally or in writing. A clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed will be appointed to do the review. The clinical peer or peers shall not have been involved in making the initial Adverse Determination.

All information necessary, including Highmark WV's decision, shall be transmitted in the most expeditious method available.

If the expedited review involves an Adverse Determination with respect to a Concurrent Care, the Service shall be continued without liability to the Member until the Member has been notified of the determination.

The review will be handled as expeditiously as the Member's medical condition requires, but in not more than seventy-two (72) hours after the receipt of the request.

The decision notification shall include:
- The titles and qualifying credentials of the person or persons participating in the review process;
- Claim information at issue;
- The availability, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The reviewers' understanding of the Grievance;
- The decision in clear terms and the contract basis or medical rationale;
- Reference to the evidence or documentation used as the basis for the decision; and
- If the decision involves a Final Adverse Determination, the notice may be provided orally. If the notice is provided orally, a written or electronic notice will be provided within three (3) days following the oral notification.

The Final Adverse Determination notice will contain the following information;
- The specific reason or reasons for the final determination, including the denial code and its corresponding meaning, as well as any description on Highmark WV's standard, if any was used in reaching the denial;
- Reference to specific plan provision on which the determination was made;
- A description of any additional material or information necessary for the Member to complete the request, including an explanation of why the material or information is necessary to complete the request;
- Entitlement to receive upon request, free of charge, any internal rule, guideline, protocol, specific rule, or other similar criterion was relied on in making the Adverse Determination shall be supplied;
- If the final decision determination is based on Medical Necessity and Appropriateness, Experimental or Investigational Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the

health benefit plan to the Covered Person's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;
- A description of the procedures for obtaining an independent external review;
- A statement that the Member has the right to bring a civil action in a court of competent jurisdiction, and
- A statement that the Member has a right to contact the Commissioner's office at PO Box 50540, Charleston, WV 25301 or call 1 (304) 558-3386 for assistance at any time.

3. Internal Grievance and Appeal Procedures Involving Non-Adverse Benefit Determinations

The Member will be informed within three (3) working days, after receiving the request for an Appeal of a non-Adverse Determination, that they are entitled to submit written material for consideration**.**

Upon receipt of the request for Appeal, Highmark WV will designate a person or persons to conduct the review.

The Member shall be provided the name, address and telephone number of the person or organization unit designated to coordinate the review on behalf of Highmark WV.

The reviewer shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the Claim or matter which is the subject of the Member's Appeal.

The Member will be notified of the decision within twenty (20) working days after the receipt of the Appeal request. You will be notified in writing of the need and the reason for an additional extension of ten (10) working days if necessary.

Written notification of the decision to the Member shall include:
- The titles and qualifying credentials of the person or persons participating in the review process;
- The reviewers' understanding of the Appeal;
- The decision in clear terms and the contract basis or medical rationale;
- A reference to the evidence or documentation used as the basis for the decision; and
- The Member's right to contact the Commissioner's office at PO Box 50540, Charleston, WV 25301 or call 1 (304) 558-3386 for assistance at any time.

4. Standard External Grievance and Appeal Procedures

An issuer or Member adversely affected by a final decision rendered by an Internal Review Organization (IRO) is entitled to judicial review. A petition for judicial review must be filed within sixty (60) days after the receipt of the notice from the IRO of the final decision. The petitioner shall send a copy of the petition by registered or certified mail to the IRO and all other parties.

Except for a request for an expedited external review, all requests for external review shall be made in writing to the Commissioner in a form and manner approved by the Commissioner.

Within four (4) months of receipt of a notice of an Adverse Determination or Final Adverse Determination, a Member may file a request for an external review with the Commissioner and, within two (2) business days of receipt of such a request, the Commissioner shall forward a copy to Highmark WV.

Within five (5) business days following receipt of the notice of the request for external review from the Commissioner, Highmark WV will send to the Commissioner and the Member its

determination whether the request is complete and if it is eligible for an external review. This determination will be based on the following:

- If the individual is or was a Covered Person at the time the Health Care Service was requested or, in the case of retrospective review, was a Covered Person in the health plan at the time the Health Care Service was provided;
- Is the Health Care Service a Covered Service but for a determination by Highmark WV that the Service is not covered because it does not meet Highmark WV's requirements for Medical Necessity and Appropriateness, health care setting, level of care or effectiveness;
- If the internal Appeal process has been exhausted; and
- And if all information and forms required has been received.

If the request is not complete, you and the Commissioner will be informed in writing of what information or materials is needed to make the request complete. If the request is not eligible for an external review it will state the reason and that it may be appealed to the Commissioner. The Commissioner shall make the final decision.

Within two (2) business days after receipt of notice of eligibility for an external review from Highmark WV, the Commissioner will assign an IRO. The Member and Highmark WV will be notified of the assignment. The assignment shall be done on a random basis, based on the nature of the Health Care Service that is the subject of the Adverse Determination and on other circumstances, including conflict of interest concerns.

Within five (5) business days after receipt of the notice, Highmark WV shall provide to the IRO all documents and any information considered in making the Adverse Determination.

Within five (5) business days the Member may also submit additional information to the IRO for consideration when conducting the external review. Within two (2) business days of receipt of the additional information, the IRO will forward a copy of the additional information to Highmark WV.

Within forty-five (45) days after receipt of the request for an external review, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination to the Member, Highmark WV and the Commissioner. The notice of the decision shall include:

- General description of the reason for the request;
- The date the IRO received the assignment from the Commissioner;
- When the external review was conducted;
- The principal reason or reasons for its decision, including, if any, evidence-based standards that were the basis of its decision;
- The rationale for its decision; and
- References to the evidence or documentation, including the evidence-based standards.

5. Expedited Standard External Grievance and Appeal Procedures

You may file a request for an expedited external review with the Commissioner at the same time that you file for an expedited internal review. It may be determined that you will need to complete the expedited internal review process before the expedited external review is started.

Except for a retrospective Adverse Determination, a request to the Commissioner for an expedited external review may be requested in writing to the Commissioner. To be eligible for an expedited external review, the Member must have a medical condition where the time-frame for a standard external review would seriously jeopardize his or her life, health or ability to regain maximum function.

The Commissioner shall immediately send a copy of the request for an expedited external review to Highmark WV who shall immediately make an initial determination whether the request meets

the requirements for an expedited external review. If Highmark WV's determination that it does not meet the requirements for an expedited external review, you may Appeal to the Commissioner. Then the Commissioner will make the final decision.

Within one (1) business day after the Commissioner receives the notice that the request is eligible for an expedited external review, the Commissioner will assign an IRO. The Commissioner will notify the Member and Highmark WV of the assignment. Highmark WV will forward to the IRO all documents and information considered in making the Adverse Determination immediately by any available expeditious method.

As expeditiously as the Member's medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the eligibility for an expedited review, the IRO shall notify the Member, Highmark WV and the Commissioner of its decision by any available expeditious method. Written confirmation will be provided within forty-eight (48) hours if not already provided. The notice of the decision will include:

- General description of the reason for the request;
- The date the IRO received the assignment from the Commissioner;
- When the external review was conducted;
- The principal reason or reasons for its decision, including, if any, evidence-based standards that were the basis of its decision;
- The rationale for its decision; and
- References to the evidence or documentation, including the evidence-based standards.

6. External Grievance and Appeal Procedures for Experimental or Investigational Treatment Adverse Determinations

Within four (4) months of receipt of a notice of an Adverse Determination or Final Adverse Determination that involves a denial of coverage based on a determination that the Health Care Service or treatment recommended or requested is Experimental or Investigational, a Member may file a request for an external review with the Commissioner. You may make an oral request for an expedited external review if the treating Physician certifies, in writing, that the recommended or requested Health Care Service or treatment would be significantly less effective if not promptly initiated. Please see Expedited Standard External Grievance Appeal Review section above.

Except for a request for an expedited external review, the Commissioner shall notify Highmark WV within one (1) business day after the date of receipt of such request.

Within six (6) business days following receipt of the notice of the request for external review from the Commissioner, Highmark WV will send to the Commissioner and the Member its determination whether the request is complete and if it is eligible for an external review. This determination will be based on the following:

- Individual is or was a Covered Person at the time the Health Care Service was requested or, in the case of retrospective review, was a Covered Person in the health plan at the time the Health Care Service was provided;
- Is the Health Care Service a Covered Service except for Highmark WV's determination that the service or treatment is Experimental or Investigational for a particular medical condition;
- The Health Care Service is not explicitly listed as an excluded benefit under your health benefit plan;
- The treating Physician, licensed, board certified or board eligible qualified to practice in the area of medicine appropriate to treat the Member's condition, has certified that one of the following situations is applicable:
    - Standard Health Care Services or treatments have not been effective in improving the condition.
    - Standard Health Care Services or treatments are not medically appropriate.

- There is no available standard Health Care Service or treatment covered by Highmark WV that is more beneficial than the recommended or requested Health Care Service or treatment.
- Valid scientific studies using accepted protocols demonstrate that the Health Care Service or treatment requested is likely to be more beneficial.

- If the Internal Grievance Process has been exhausted; and
- If all information and forms required has been received.

Within two (2) business day after receipt of notice of eligibility for an external review from Highmark WV, the Commissioner will assign an IRO. The Member and Highmark WV will be notified of the assignment. The assignment shall be done on a random basis, based on the nature of the Health Care Service that is the subject of the Adverse Determination and on other circumstances, including conflict of interest concerns.

Within one (1) business day after the IRO receives notice of the assignment, the IRO will select one or more reviewers to conduct the external review. Within five (5) business days after receipt of the notice, Highmark WV shall provide to the IRO all documents and any information considered in making the Adverse Determination.

Within five (5) business days the Member may also submit additional information to the IRO for consideration when conducting the external review.

Within one (1) business day of receipt of the additional information from the Member, the IRO will forward a copy to Highmark WV. Highmark WV may reconsider its Adverse Determination at this time.

Within twenty (20) days after being selected, each reviewer shall provide an opinion in writing to the IRO on whether the recommended or requested Health Care Service or treatment should be covered.

Within twenty (20) days after receipt of the reviewer(s) opinions the IRO shall make a decision and provide notice orally or written to the Member, Highmark WV and the Commissioner. If the notice was provided orally a written confirmation of the decision will be provided within forty-eight (48) hours.

For an expedited review, within forty-eight (48) hours after the IRO receives each reviewer's opinion, the IRO shall make a decision and provide notice of the decision orally or in writing to the Member, Highmark WV and the Commissioner. If the notice was provided orally a written confirmation of the decision will be provided within forty-eight (48) hours.

The written notice of the decision shall include:

- General description of the reason for the request;
- The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested Health Care Service or treatment should be covered and the rationale for the reviewer's recommendation;
- The date the IRO received the assignment from the Commissioner;
- The date the external review was conducted;
- The date of its decision;
- The principal reason or reasons for its decision; and
- The rationale for its decision.

7. **Member Assistance Services**

Members may obtain assistance with Highmark WV's internal appeal and external review procedures set forth in this Subsection by contacting the Employee Benefit Security

Administration (EBSA) at 1-866-444-EBSA (3272) or such other applicable Office of Health Insurance Consumer assistance or ombudsman.

F. INFORMAL DISSATISFACTION RESOLUTION

In the event that you are dissatisfied with other aspects of your program, such as, benefits, a Participating Provider, coverage or management policies, please contact Member Services at the toll-free number located on the back of your ID Card or submit in writing to Highmark Blue Cross Blue Shield West Virginia, Attn; Member Services, PO Box 7026, Wheeling, WV, 26003. You will need to include your ID number and group number from your ID card. The appropriate representative will review, research, and respond to your inquiry as quickly as possible.

G. DESIGNATING AN AUTHORIZED REPRESENTATIVE

You have the right to designate an authorized representative to act on your or the patient's behalf in pursuing a Claim or an Appeal of an Adverse Benefit Determination. This designation may be granted for a particular event or date of Service after which time the designation approval is revoked, or may be granted for any present or future Claim for health care benefits you may have. You are free to designate any person to act as your authorized representative. However, in general, designations of authorized representative status for any present or future Claims for health care benefits are more appropriately made to family members and other trusted persons whom you may wish to authorize to assist you in the future with health care Claim matters. To initiate the designation process, contact Member Services.

H. TREATMENT PLANS

Certain Covered Services provide benefits only when you receive care as part of a treatment plan approved by us. In order to maximize your benefits, your Provider must submit a treatment plan, as specified in Section VII. If approved, additional Treatments or Services will be authorized. The Services or number of additional Treatments authorized will depend upon the treatment plan. We may need to request updated treatment plans as you progresses. If a required treatment plan is not submitted or approved, Services will be denied as not Medically Necessary and Appropriate. If you change Providers, we may require submission of a new treatment plan. A treatment plan typically involves a written course of Services and sufficient information to evaluate Medical Necessity and Appropriateness. A Treatment Plan is required for Hospice Care Services.

I. OUR RIGHT TO REVIEW CLAIMS

When a Claim is submitted, we may review it to ensure the Service was Medically Necessary and Appropriate and all other conditions for coverage are satisfied. We will determine Medical Necessity. Highmark WV determines Medical Necessity and Appropriateness through qualified individuals.

J. PROVIDER SERVICES

1. Assignment of Benefits

a. You authorize us to make payments directly to Providers who have performed Covered Services for you. Except as otherwise provided for in this Section, you may not assign your right to receive payment for benefits to anyone or any Out-of-Network Provider. We reserve the right to make payment of any Claim directly to you regardless of whether you assign your right to receive payment for benefits to a Provider. We are discharged from liability to the extent of such amounts paid to you for Covered Services. It is then your responsibility to pay the Provider.

b. Dental Benefits

You are permitted to assign your right to receive payment for dental benefits to your dental provider or dental corporation. The assignment must be in writing.-You may revoke a written assignment by notifying us in writing. Upon receipt, we will provide a copy of the revocation notice to the provider. The revocation will be effective when both Highmark WV and the provider have received a copy of the revocation and is only effective for charges incurred after both parties received the revocation notice.

2. Choice of Provider

The choice of a Provider is solely yours. Once a Provider performs a Service, we will not honor your request for us to withhold payment .

3. Provider Status (Network or Out-of-Network)

Providers are designated as Network or Out-of-Network . **You will only receive benefits under your my Blue Access policy when received from a Network Provider, except for covered Emergency Care and approved exceptions.**

We have agreed to make payment directly to Network Providers for Covered Services. Therefore, you should not be required to pay for Covered Services at the time they are rendered by Network Providers other than any Deductibles, Coinsurances or Fees. Network Providers have the right to request proof that any required Deductible or other Member cost sharing has been met before filing your Claim with Highmark WV. See Section IV for how to verify a Provider's status.

4. Nondiscrimination – Providers

Highmark WV will not discriminate with respect to participation in coverage against any health care Provider acting within the scope of his or her license or certification under state law.

K. PROVIDER PAYMENT AND MEMBER COST SHARING

You are responsible for payment of any Deductibles, Fees, and Coinsurances required under the Policy for Covered Services received from a Provider. See Section IV for specific additional details.

This coverage shares the cost of your medical expenses with you. Each Benefit Period there is a specific amount you must pay for Covered Services before Highmark WV begins to provide payment for Services provided by a Network Provider, as specified in Section IV. This front-end payment is your Deductible. Our records must show that you have met this Deductible. In addition to Claims for Covered Services that Network Providers submit directly to Highmark WV, you may Incur Out-of-Pocket costs that will count toward your Deductible. To ensure that all Incurred expenses are accurately applied to your Deductible, you must submit copies of your bills for such Covered Services, even though they would have applied to the Deductible and your Policy would not have covered any portion of those Services because your Deductible was not yet met.

After the amount of Covered Services exceeds your Deductible; we pay a portion of the remaining balance of Covered Services during that Benefit Period. The portion that you are responsible for will be the Coinsurance. The Deductible and Out-of-Pocket amounts will renew each Benefit Period. Some of the benefits of this Policy have a maximum amount payable each Benefit Period.

Providers must bill you for all Network Coinsurances specified in this Policy. If a Provider does not bill you for, or waives a Network Coinsurance, the Claim for Covered Services will be reduced by the amount that was not billed or was waived. Benefits will also be reduced by the amount that was not billed or was waived, minus the Coinsurance. Many times, Claims for Services are not received in the same order you

received the Services. The Network Deductible and Coinsurances will be applied in the sequence that Claims are received and processed by us.

1. Out-of-Network Liability

Your policy will generally not reimburse for Services performed by an Out-of-Network Provider except for Emergency Care and approved exceptions.

2. Plan Allowance

The amount used to determine reimbursement by Highmark WV for Covered Services provided on behalf of a Member is based on the type of Provider who renders such Services or as required by law. The Plan Allowance is used to calculate Highmark WV's payment and to determine Member Liability.

In the case of a Network Provider, Participating Dentist or Participating Vision Provider, the Plan Allowance is the contractual allowance for Covered Services rendered by a Network Provider in a specific geographic region. A Network Provider, Participating Dentist or Participating Vision Provider will accept the Plan Allowance, plus any Member liability, as payment-in-full for Covered Services.

The Plan Allowance for Out-of-Network Providers is different than the Plan Allowance for Network Providers as follows:

Out-of-Network Providers Located in the Service Area
In the case of an Out-of-Network Provider in the Service Area, the Plan Allowance shall be based on an adjusted contractual allowance for like Services rendered by a Network Provider in the same geographic region. The Member will be responsible for any difference between the Provider's Actual Charges in excess of Highmark WV's Plan Allowance for the Out-of-Network Provider's Services, as well as any applicable Deductible, Coinsurance or Fees.

Out-of-Area Providers
In the case of an Out-Of-Area Provider, whether or not such Out-of-Area Provider has an agreement with the local licensee of the Blue Cross Blue Shield Association, the Plan Allowance shall be determined, for other than Pediatric Dental and Vision Care Covered Services, based on prices received from local licensee pursuant to Highmark WV's participation in the BlueCard® Program, as set forth in this section.

The Plan Allowance is determined by Highmark WV in its sole discretion and in most circumstances unrelated to Actual Charges. Any waiver of a Member's cost sharing obligations by a Provider will be deemed an equivalent reduction of the Plan Allowance. The Plan Allowance may exceed Actual Charges in some circumstances.

3. Out-of-Area Services

a. Overview

Highmark WV has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area Highmark WV serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Highmark WV's Service Area, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating" Providers") don't contract with the Host Blue. Highmark WV explains below how we pay both kinds of Providers.

All Claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical Claims/benefits, and those Prescription Drug Benefits or Vision Care benefits that may be administered by a third party contracted by us to provide the specific Service or Services.

b. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Highmark WV will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When you receive Covered Services outside Highmark WV's Service Area and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed Charges for your Covered Services;
- The negotiated price that the Host Blue makes available to Highmark WV.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments and/or other credits or Charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over-or-underestimation of past pricing of Claims, as noted above. However, such adjustments will not affect the price Highmark WV has used for your Claim because they will not be applied after a Claim has already been paid.

c. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these Fees to Highmark WV through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If Highmark WV has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to your employer on your behalf, Highmark WV will follow the same procedures for Value- Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

d. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, Highmark WV will include any such surcharge, tax or other fee as part of the Claim charge passed on to you.

e. Non-Participating Providers Outside Highmark WV's Service Area

- **Member Liability Calculation**
  You will only receive benefits under your my Blue Access policy when received from a Network Provider, except for covered Emergency Care and approved exceptions. However, when eligible Covered Services are provided outside of Highmark WV's Service Area by non-Participating Providers, the amount you pay for such services will normally be based on either the Host Blue's non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the non-Participating Provider bills and the payment Highmark WV will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for Out-of-Network Emergency Services.

- **Exceptions**
  In certain situations, Highmark WV may use other payment methods, such as billed Charges for Covered Services, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment to determine the amount we will pay for services provided by non-Participating Providers. In these situations, you may be liable for the difference between the amount that the non-Participating Provider bills and the payment Highmark WV will make for the Covered Services as set forth in this paragraph.

f. Blue Cross Blue Shield Global Core

If you are outside the United States, (hereinafter "BlueCard Service Area"), you may be able to take advantage of the BCBS Global Core when accessing Covered Services. The BCBS Global Core is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although the BCBS Global Core assists you with accessing a Network of Inpatient, Outpatient and professional Providers, the Network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard Service Area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard Service Area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or Hospital, if necessary.

- **Inpatient Services**
  In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your cost-share amounts (Deductibles, Coinsurance, etc.). In such cases, the Hospital will submit your claims to the service center to begin Claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services. ***You must contact Highmark WV to obtain Precertification for non-emergency Inpatient Services.***

- **Outpatient Services**
  Physicians, Urgent Care Centers and other Outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

- **Submitting a BCBS Global Core Claim**
  When you pay for Covered Services outside the BlueCard Service Area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a BCBS Global Core Claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from Highmark WV, the BlueCard Worldwide Service Center or online at www.bcbsglobalcore.com. If you need assistance with your Claim submission, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, and seven days a week.

g. Common Accident Deductible

Only one Member's Deductible is required when two or more Members in a Policyholder's family are injured in the same accident. Initial Covered Services must be Incurred within 90 days of the accident during the same Benefit Period.

L. HOW TO REPORT FRAUD

Fraud increases the cost of health care for everyone and increases your Policy premium. Highmark WV's Financial Investigations and Provider Review (FIPR) Unit investigates allegations of fraud, waste, and abuse. Here are some things you can do to prevent fraud:

1. Don't give your Policy identification number over the telephone or to people you do not know, except for your health care Provider or us;
2. Let only the appropriate medical professionals review your medical record or recommend Services;
3. Avoid using Providers who say that an item or Service is not usually covered, but they know how to bill us to get it paid;
4. Carefully review EOBs that you receive from us;
5. Do not ask your Provider to make false entries on certificates, bills, or records in order to get us to pay for an item or Service; and
6. If you suspect that a Provider has charged you for Services that you did not receive, billed you twice for the same Service, or misrepresented any information, do the following:
   - Call the Provider and ask for an explanation. There may be an error; and
   - If the Provider does not resolve the matter, call us at 800-788-5661 and explain the situation. All reports to this number are confidential and you can remain anonymous.
7. Do not maintain as a family member on your Policy:
   - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
   - Your child over the age specified in Section I (unless he/she is disabled and incapable of self-support).

If you have questions about the eligibility of a Dependent, call Member Services.

NOTE: ***You can be prosecuted for fraud if you falsify a Claim to obtain benefits or try to obtain Services for someone who is not eligible or is no longer enrolled in the Policy.***

M. LIMITATION OF ACTIONS AND VENUE

No legal action may be taken to recover benefits within 90 days after a Claim has been submitted. No legal action related to this Policy may be taken before the Grievance and Appeal Process has been exhausted. In no event can legal action be brought against Highmark WV later than two (2) years after the time within which a Claim is required to be submitted. Exclusive venue for any action shall be before the courts of Wood County, West Virginia.

N. NON-WAIVER PROVISION

Any failure of Highmark WV to enforce any term or condition of this Policy shall not constitute a waiver in the future of any term or condition of this Policy. Highmark WV may choose not to enforce any term or condition of this Policy. Such choice shall not constitute a waiver in the future of any such term or condition.

O. SEVERABILITY

If any portion of this Policy shall be held invalid, illegal, or unenforceable for any reason, the remainder shall continue to be effective.

P. GOVERNING LAW

This Policy shall be governed and construed in accordance with the laws of the State of West Virginia, unless preempted by federal law.

VIII. Exclusions/What Is Not Covered

We do not provide benefits for the following Services, Supplies, or Charges and as a result, you may be responsible for the related Charges.

1. For otherwise Covered Services ordered by a court or other tribunal unless Medically Necessary and Appropriate or if the reimbursement of such Services is required by law.

2. Not prescribed by or performed by or under the direction of a Physician or Professional Other Provider.

3. Not performed within the scope of the Provider's license.

4. Services or Treatments received from other than a Provider.

5. Experimental or Investigational.

6. Not Medically Necessary and Appropriate. (See the Important Information About this Coverage Section for information on your liability for not Medically Necessary and Appropriate Services.)

7. Services outside generally accepted medical standards and practices.

8. To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.

9. Injuries, conditions, diseases, disorder, or illnesses that occur as a result of any act of war.

10. Where you have no legal obligation to pay in the absence of this or like coverage.

11. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.

12. Received from a member of your Immediate Family.

13. Incurred before your Effective Date.

14. Incurred after you stop being a Covered Person, except as specified in Section III.

15. The following physical examinations or Services:
    - Solely required by an insurance company to obtain insurance;
    - Solely required by a governmental agency such as the FAA, DOT, etc.;
    - Solely required by an employer in order to begin or to continue working;
    - Premarital examinations;
    - Screening examinations, except as specified;
    - Medical imaging examinations made without documented image; or
    - Routine or annual physical or vision examinations, except as specified.

16. A Diabetic Prevention Program offered by other than a Network Diabetes Prevention Provider.

17. For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.

18. Received in a military Facility for a military service related injury, ailment, condition, disease, disorder, or illness for which Governmental benefits are available.

19. Surgery and other Services or devices primarily to improve appearance and any complications incident to such services. Exceptions include: (a) only those that restore a body function or which were caused by disease, trauma, birth defects, growth defects, prior therapeutic processes; or (b) reconstructive Surgery following Covered Services for a mastectomy, including reconstruction of the other breast for the purpose of restoring symmetry; or (c) reconstructive or cosmetic Surgery necessary as a result of an act of family violence. There are no benefits for wigs and hair prostheses.

20. Inpatient admissions primarily for Diagnostic Services, physical therapy or occupational therapy, when these Services could have been performed on an Outpatient basis and it was not Medically Necessary and Appropriate that you be an Inpatient to receive them.

21. Custodial Care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care.

22. Primarily for educational, vocational or training purposes, including speech therapy for language and/or developmental delay, stuttering and articulation errors, except as specified.

23. Conditions related to Autism Spectrum Disorders, learning disabilities or intellectual disability which extends beyond traditional medical management or for Inpatient confinement for environmental change, except as specified herein.

24. Topical anesthetics or stand-by anesthesia, except as specified.

25. Arch supports, molded removable foot orthotics, and other foot care or foot support devices only to improve comfort or appearance such as care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses, ingrown toenails and similar foot conditions, including Visits Incurred specifically to prepare or fit for such devices.

26. The treatment for obesity, including dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss. The only exception to this exclusion would be if Surgery is determined to be Medically Necessary and Appropriate.

27. Marital counseling or any Service for marital maladjustments. Specific non-covered therapies are: marital therapy or sexual therapy, or any therapy which is not specifically listed as a Covered Service.

28. Massage therapy, pet therapy, dance therapy, art therapy, nature therapy or any therapy which is not specifically listed as a Covered Service.

29. The treatment of sexual problems not caused by organic disease or physical trauma.

30. Reversal of sterilization.

31. In Vitro fertilization, gamete intra-fallopian transfer and other ova transfer procedures.

32. The Treatment of cysts or abscesses associated with the teeth, dental X-rays, dentistry or any other dental processes, except as specified.

33. Appliances designed for orthodontic purposes such as braces, bionators, functional regulators, Frankel, and similar devices.

34. Personal hygiene and convenience items. Examples include diapers, cervical pillows, lift chairs, jacuzzis, exercise equipment and special linens, pillows, and air filters for allergy conditions.

35. Unless otherwise stated, eyeglasses, contact lenses, or examinations for prescribing or the fitting of them, excluding those for aphakic patients and soft lenses or sclera sheets for use as corneal bandages.

36. Hearing aids.

37. Hypnosis, acupuncture and massage therapy.

38. Telephone consultations, missed appointments, or completion of a Claim form.

39. Human organ transplant services, other than as listed in this Policy.
40. Rehabilitation Services for Vocational Rehabilitation, long-term maintenance, or Custodial Care.
41. Fraudulent or misrepresented Claims.
42. Routine immunizations, except as specified.
43. Illness or injury arising in the course of employment or care received without cost under the laws of the federal or any state government or any political subdivision thereof, including any Workers' Compensation program or any employer self-funded Workers' Compensation plan .
44. Prescription Drugs, except as specified. Prescription Drugs purchased from a Pharmacy on an Outpatient basis are payable under Prescription Drug Benefits.
45. Unless otherwise stated, the treatment of Temporomandibular Joint Syndrome with intraoral prosthetic devices or by any other method to alter vertical dimension; for the treatment of Temporomandibular Joint Dysfunction not caused by documented organic disease or physical trauma.
46. Services excluded elsewhere in this Policy.
47. Any Service or Supply that can be purchased without a Prescription Order. Examples include nutritional supplements, Ensure, Pediasure or baby formula, batteries, earplugs and any over the counter item.
48. Injuries sustained while committing an illegal act or as a result of action on the part of any civil authority.
49. Cloning or any services related to cloning.
50. Cleft Palate Orthodontic treatment.
51. Maternity services for a Covered Person who is pregnant for the purpose of serving as a Surrogate Parent.
52. Abortions, except where pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a Physician, places the woman in danger of death unless an abortion is performed.
53. Partial birth abortion.
54. Defective Services or Supplies.
55. Services or Supplies in excess of any maximum limits or benefits.

DENTAL EXCLUSIONS

1. Services started prior to the Member's Effective Date or after the Termination Date of coverage of the Policy (e.g. multi-Visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. House or Hospital calls for dental services and for hospitalization costs (e.g. Facility-use Fees).
3. Claims for Services that are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance Policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.
4. Prescription and non-prescription drugs, vitamins or dietary supplements.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.
6. Services and Treatments deemed to be cosmetic in nature as determined by the Company (e.g. bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
7. Elective procedures (e.g. the prophylactic extraction of third molars).

8. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).
9. Dental implants and any related Surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under this Policy.
10. Diagnostic Services and treatment of jaw joint problems by any method unless specifically covered under this Policy. Examples of these jaw joint problems are Temporomandibular Joint Disorders (TMD) and Craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
11. Treatment of fractures and dislocations of the jaw.
12. Treatment of malignancies or neoplasms.
13. Services and/or appliances that alter the vertical dimension (e.g. full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
15. Preventive restorations.
16. Periodontal splinting of teeth by any method.
17. Periodontal maintenance following active periodontal therapy.
18. Duplicate dentures, prosthetic devices or any other duplicative device.
19. Services and Treatments which is in the absence of insurance the Member would Incur no charge.
20. Services and Treatments for plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
21. Services and Treatment for any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
22. Treatment and appliances for bruxism (e.g. night grinding of teeth).
23. Any Claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.
24. Incomplete treatment (e.g. patient does not return to complete treatment) and temporary services (e.g. temporary restorations).
25. Procedures that are:
    - part of a service but are reported as separate services;
    - reported in a treatment sequence that is not appropriate; and
    - misreported or that represent a procedure other than the one reported.
26. Specialized procedures and techniques (e.g. precision attachments, copings and intentional root canal treatment).
27. Fees for broken appointments.
28. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.
29. Guided tissue regeneration.
30. Pulpal Therapy.
31. Orthodontic treatment is not a Covered Service unless deemed Medically Necessary and Appropriate and a written Treatment Plan is approved by Us.
32. Orthodontic services for the following are excluded:
    - Treatments that are primarily for Cosmetic reasons;

- Treatments for congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic Surgery including orthodontic treatment); or
- Diagnostic Services and treatment of jaw joint problems by any method unless specifically covered under the Schedule of Benefits. Examples of these jaw joint problems are Temporomandibular Joint Disorders (TMD) and Craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

IX. Prescription Drug Benefits

Generally, all terms and conditions of Sections I through IX shall apply to this Section IX. In the event of a conflict involving Prescription Drug benefits, this Section IX shall control. If you need more information on specific Prescription Drug coverage under your Policy, please contact Highmark WV at the phone number or the internet address shown on your ID Card.

A. PRESCRIPTION DRUG BENEFITS

See Section V for specifics or exceptions to the following.

1. Prescription Drug Coinsurance

You must pay a certain percentage or dollar amount for each Medically Necessary and Appropriate Prescription Order or Refill. This payment is referred to as your Prescription Drug Coinsurance. The Prescription Drug Coinsurance for Prescription Drugs received from Network Pharmacies and Mail Order Prescription Drugs are indicated in Section V.

2. Network Pharmacies

Under this Prescription Drug Program, **you must utilize Network Pharmacies to receive benefits.** If a Medically Necessary and Appropriate Prescription Drug is filled through a Network Pharmacy, you simply present your ID Card to the Pharmacy and pay only the Prescription Drug Coinsurance. You may review the Network Pharmacy List by contacting Highmark WV.

3. Prescription Requirements

All Prescription Drugs must be prescribed by a Physician or Professional Other Provider and dispensed for your use as an Outpatient.

4. Brand Name Prescription Drugs

Except as indicated in Section IV, **if you request** a Brand Name Prescription Drug when a Generic Prescription Drug is available, you will be required to pay the difference between the Prescription Drug Allowance for the Generic Prescription Drug and the Prescription Drug Allowance for the Brand Name Prescription Drug in addition to the Prescription Drug Coinsurance. You will have to pay the difference if no Generic Prescription Drug exists or if your Physician or Professional Other Provider states 'Brand Necessary' (Dispense as written, DAW) on the Prescription Order.

5. Disputes

You may dispute a decision made by a Pharmacy concerning coverage and amount of payment by filing a Claim for benefits with Highmark WV (or its designee). Such Claims are subject to the procedures for initial Claims for benefits and appeals described in Section VII.

6. Prescription Drugs and Refills received from a Network Retail Pharmacy.

If you receive medications from a Network Pharmacy and present your ID Card, you will not have to file a Claim. If you forget your ID Card when you go to a Network Pharmacy, the Pharmacy may ask you to pay in full for the prescription.

The procedure is simple. Just take the following steps:

a. **Know Your Benefits.** Review this information to see if the Services you received are eligible under your prescription program.
b. **Get an Itemized *Bill*.** Itemized bills must include:
   - The name and address of the Pharmacy Provider;
   - The patient's full name;
   - The date of Service or Supply or purchase;
   - A description of the Service or medication/Supply;
   - The amount charged;
   - Drug and medicine bills must show the prescription name and number and the prescribing Provider's name.

If you've already made payment for the Services you received, you must also submit proof of payment (receipt from the Provider) with your Claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

a. ***Copy Itemized Bills.*** You must submit originals, so you may want to make copies for your records. Once your Claim is received, itemized bills cannot be returned.
b. ***Complete a Claim Form.*** Make sure all information is completed properly and then sign and date the form. To Get a Claim Form call Member Services at the number on the back of your Identification Card.
c. ***Attach Itemized Bills to the Claim Form and Mail.*** After you complete the above steps, attach all itemized bills to the Claim form and mail everything to the address on the back of your ID Card.

NOTE: ***Multiple Services or medications for the same family Member can be filed with one Claim form. However, a separate Claim form must be completed for each Member.***

7. Prescription Drugs and Refills received from an Out-of-Network Retail Pharmacy

No coverage is provided when Prescription Drugs are filled through an Out-of-Network Pharmacy. You are responsible for paying the Out-of-Network Pharmacy the full cost of the Prescription Drugs.

8. Home Delivery (Mail Order) Prescription Drug Benefits

a. **Using the Mail Order Service for the first time**
You may request a new prescription by mail, fax, or through the internet.

- Requests for New Prescriptions by mail.
  Ask your Physician or Professional Other Provider to write a new prescription for the maximum Supply allowed by your Health Plan, plus refills (if appropriate) for up to one (1) year. Mail the new prescription(s), along with the form provided in your mail order packet to the address provided on the form.
- Requests for New Prescriptions by fax.
  If you decide to order by fax, ask your Physician or Professional Other Provider to write a new prescription for the maximum Supply allowed by your Health Plan, plus Refills (if appropriate) for up to one (1) year. Give your Physician or Professional Other Provider your Member ID number from your ID Card. Please ask your Physician or Professional Other Provider to call the phone number listed on your ID Card.

Your medication will generally be delivered to your home within 7 to 11 days ***after*** you mail your order. Orders placed through the internet, telephone or fax may be received faster. Standard shipping is free.

b. Refilling your Prescription

To make sure that you don't run out of your medication, remember to reorder 14 days before your medication runs out. You can find the Refill date on the Refill slip that comes with every order.
You may use the Refill and order forms that will accompany your initial order. Mail the form also with your Prescription Drug Coinsurance in the return envelope. You may also phone and use the automated refill system. Should you choose to call, have your Member identification number (which is on your ID Card), the prescription number and your credit card number available.

You may also request Refills online. Refer to your packet for the internet address and how to Refill your order.

c. Prescription Drugs (Outpatient)

Benefits are provided for covered medications when prescribed by a Professional Provider in connection with a Covered Service, when purchased at a Network Pharmacy upon presentation of a valid Identification Card and when dispensed on or after the Member's Effective Date. Benefits for covered medications are provided in the amounts specified in the Schedule of Benefits.

Coverage is provided for:

- Prescription Drugs, including Specialty Prescription Drugs obtained from a retail Network Pharmacy Provider or through a mail order Pharmacy Provider for up to a 90-day supply; and
- Benefits are provided for continuous glucose monitoring devices when prescribed by a Professional Provider in connection with a Covered Service, when purchased at a Network Pharmacy Provider upon presentation of a valid Identification Card and when dispensed on or after your Effective Date for Outpatient use; and
- Selected Prescription Drugs are covered medications when dispensed through an Exclusive Pharmacy Provider for, but not limited to, the following drug classifications:
    - Oncology related therapies;
    - Interferons;
    - Agents for multiple sclerosis and neurological related therapies;
    - Antiarthritic therapies;
    - Anticoagulants;
    - Hematinic agents;
    - Immunomodulators;
    - Growth hormones; and
    - Hemophilia related therapies.

These selected Prescription Drugs may be ordered by a Physician or other health care Provider on behalf of the Member, or the Member may submit the Prescription Order directly to the Exclusive Pharmacy Provider. In either situation, the Exclusive Pharmacy Provider will deliver the Prescription Drug to the Member.

d. Manufacturers Rebates

We may receive financial credits, rebates, discounts or other payments from Prescription Drug manufacturers. We retain these amounts for our use. We are not required to pass on to you and we do not pass on to you any such credits, rebates, discounts or any other such payments. These amounts are not considered in determining the Prescription Drug Allowance, the Prescription Drug Coinsurances or any other cost sharing amounts that you are required to pay.

B. COVERED DRUGS

Your Prescription Drug benefits includes a Formulary which is a list of Prescription Drugs that are preferred by your Plan. This list includes a wide selection of medications and is preferred because it offers you choice while helping keep the cost of your Prescription Drug benefits affordable. Every Prescription Drug on the Formulary is Food and Drug Administration (FDA) approved and reviewed by an independent group of doctors and pharmacists for safety and efficacy. We may remind your Physician or Professional Other Provider when a Formulary medication is available for a medication that is not on your Formulary. This may result in a change in your Prescription. However, your Physician or Professional Other Provider will always make the final decision on your medication.

The Formulary is subject to change periodically (at least twice a year). If such a change affects you, your Physician or Professional Other Provider will always make the final decision on your medication. You may access the most up-to-date Formulary by calling or through our website. This information is located on your ID Card.

Covered drugs include: Those which, under federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription";

- Legend drugs under applicable state law and dispensed by a licensed pharmacist;
- Prescription Drugs listed in your program's Prescription Drug Formulary;
- Prescribed insulin;
- Diabetic supplies, including needles and syringes; and
- Long-term antibiotic therapy for Lyme disease.

1. Quantity Level Limits

Quantity level limits may be imposed on certain Prescription Drugs by Highmark WV. Such limits are based on the manufacturer's recommended daily dosage, state law, or as determined by Highmark WV. Quantity level limits control the quantity covered each time a new Prescription order or refill is dispensed for selected Prescription Drugs. Each time a Prescription order or refill is dispensed, the Participating Pharmacy may limit the amount dispensed.

2. Precertification

Certain Covered Medications, as designed by the Plan, may require Precertification to ensure the Medical Necessity and Appropriateness of the Prescription order. The Member's Physician must obtain certification from Highmark WV prior to the dispensing of the drug at a Participating Provider or through mail-order, if applicable. If it is determined by Highmark WV that the Covered Medication is Medically Necessary and Appropriate, the Covered Medication will them be dispensed by the Network Pharmacy Provider or through mail order, if applicable.

Your prescription drug program follows a select drug list, which is referred to as a "closed formulary." As long as a medication is on the formulary, the drug will be a covered drug, subject to any applicable limitations such as fill restrictions and/or Step Therapy. The formulary is an extensive list of Food & Drug Administration (FDA)-approved prescription drugs and selected over-the-counter drugs. It includes products in every major therapeutic category.

To obtain prescription medication that is not included in the formulary, or to request Prior Authorization for a managed care prescription drug, your Provider must complete the "Prescription Drug Medication Request Form" and return it to the Clinical Pharmacy Services Department for clinical review. The Clinical Pharmacy Services Department will mail a decision letter to you and your Provider when a decision has been made. To print a copy of the "Prescription Drug Medication Request Form" for your Physician to complete, log onto our website at www.highmarkbcbswv.com, click on the "Coverage" tab, click "Prescriptions Summary," and then click on the "Prescription drug medication request" link. Once you are at the form, click the "print" icon.

You may also initiate this process yourself by following these steps: Log onto our website at www.highmarkbcbswv.com, click on the "Coverage" tab, then click "Prescriptions Summary," and then click on "Medications exception request link". Complete the on-line form and click "Submit".

C. RETAIL AND MAIL ORDER PRESCRIPTION DRUG MANAGEMENT

1. Preauthorization

The prescribing Physician must obtain Authorization from us prior to prescribing certain Prescription Drugs. This includes Prescription Drugs that are subject to a Step Therapy Program. Step Therapy is trying other medications first before "stepping up" to other Prescription Drugs to help make sure you have the most safe, effective and reasonably priced drug. The specific drugs or drug classifications which require Preauthorization may be obtained by calling the toll-free Member Service telephone number or accessing the internet address appearing on your ID Card.

You and/or your Provider may access the exception form on the Member portal or the Provider portal. You may also contact Member Service for assistance. Their phone number is on the back of your ID Card. The Prescription Drug being used will be covered while the Step Therapy exception determination is made.

A prescription written for an Inpatient at the time of discharge requiring a Prior Authorization shall not be subject to Prior Authorization requirements and shall be immediately approved for not less than three days. Provided, that the cost of the medication does not exceed $5,000 per day and the Physician shall note on the prescription or notify the Pharmacy that the prescription is being provided at discharge. After the three (3) day time frame, a Prior Authorization must be obtained.

2. Managed Prescription Drug Coverage

A Prescription Order or Refill which may exceed the manufacturer's recommended dosage over a specified period of time may be denied when presented to the Pharmacy Provider. The managed Prescription Drug coverage (MRxC) program also consists of online edits that encourage the safe and effective use of targeted medications.

We may contact the prescribing Physician to determine if the Prescription Drug is Medically Necessary and Appropriate. If it is determined by us that the prescription is Medically Necessary and Appropriate, the Prescription Drug will be dispensed.

D. EXCLUSIONS AND LIMITATIONS SPECIFIC TO PRESCRIPTION DRUGS

In addition to the exclusions in Section VIII, we do not provide benefits for the following Services, Supplies, or Charges:

1. Therapeutic devices or for artificial appliances;
2. Prescription Drugs that are received as an Inpatient or administered by a Physician or Professional Other Provider;
3. Hypodermic needles, syringes or comparable devices, unless stated as Covered Services;
4. Fees for administering or injecting Prescription Drugs;
5. More than a ninety 90-day Supply of a Prescription Drug, except for a tweleve (12) month refill of contraceptive drugs obtained at one time after the initial supply of the drugs;
6. Any Prescription Refill dispensed more than one year after the date of the original Prescription Order;
7. A Prescription Drug which is entirely consumed or administered at the time and place where the Prescription Order is issued;
8. Drugs and Supplies you can buy without a Prescription Order, including but not limited to blood glucose monitors and injection aids, unless specifically described as provided;
9. Continuous glucose monitoring devices are available from a retail Network Pharmacy Provider or a Designated Mail-Order Pharmacy Provider. Receiver kits are limited to one (1) per Benefit Period.

Sensor kits are limited to one (1) refill every thirty (30) days. Transmitter kits are limited to one (1) refill every ninety (90) days;

10. Over the counter medications other than certain preventive drugs described in SECTION V. DESCRIPTION OF BENEFITS, PREVENTIVE CARE SERVICES Subsection and only if prescribed in accordance with any state or federal mandates;
11. Prescription Drugs dispensed for cosmetic purposes that are used solely for beautifying or altering one's appearance in the absence of any underlying injury, ailment, condition, disease, disorder or illness;
12. More than the number of Prescription Refills specified by a Physician or Professional Other Provider; Prescription Drugs for the Treatment of obesity or for weight reduction;
13. Prescription Drugs that are Experimental or Investigational for a given Treatment, as determined by us;
14. Prescription Drugs that are part of an approved Clinical Trial may be covered;
15. Prescription Drugs not specified as Covered Services or which are specifically excluded in the text;
16. Prescription Drugs that are determined to be not Medically Necessary and Appropriate;
17. Prescription Drugs that are not FDA approved, such as compound medications;
18. Prescription Drugs and over the counter drugs not listed in the formulary applicable to your program; and
19. Food Supplements.

E. PRESCRIPTION DRUG CLAIM APPEALS

CLOSED FORMULARY: You may dispute a Prescription Drug benefit decision by filing an Appeal with Highmark WV (or its designee). Such Claims are subject to the procedures for initial Claims for benefits Appeals described previously.

F. HOW TO INITIATE AN EXTERNAL REVIEW OF A FORMULARY EXCEPTION REQUEST DENIAL

You or your authorized Representative has the option of an external review of a formulary exception request denial with an Independent Review Organization (IRO). Please send your written request, along with any additional evidence related to your inquiry, **within four (4) months** after receiving the denial to:

Highmark Blue Shield
P.O. Box 535095
Pittsburgh, PA 15230
Attn: Review Committee

You or your duly authorized Representative may submit in writing any issues, comments, documents, records and other information relevant to the denied Service for consideration in your external review. In addition, you or your duly authorized Representative have the right to request copies of any documents, records or other information relevant to the decision to deny coverage for the item or Service that was requested. This includes, but is not limited to, copies of any plan rule, guideline or protocol used in making the decision to deny coverage. These materials will be provided free of charge.

If your internal exception request was a standard exception request, your request for an external exception review will be treated as a standard external exception review. If your internal exception request was based on exigent circumstances, your request for external exception review will be treated as an exigent external exception review request.

If your request is for an external review of an expedited exception denial, you will be notified of the decision on your external review decision as soon as possible but no later than 24 hours from the time your external review request was received. If your request is for an external review of a standard exception denial, you will be notified of the decision on your external review as soon as possible but no later than 72 hours from the time your external review request was received.

You also have the option of a **voluntary** level of Appeal regarding this decision, in writing to the West Virginia Offices of the Insurance Commissioner. Please send your request to:

West Virginia Office of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305

1. If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your Representative. If you want someone else to act for you, please call Member Services at the telephone number on your Identification Card to learn how to name your Representative. TTY users call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us.

2. Questions

If you have any questions about your right to request an external review or how to file a request for external review, please call Member Services at the telephone number on your Identification Card. TTY users please call 711.

DEFINITIONS

Brand Name Prescription Drug. A Prescription Drug that has been patented and is only produced by one manufacturer.

Closed Formulary. A Prescription Drug program, which covers only specific Brand Name Prescription Drugs on the Closed Formulary list.

Contracting Mail Order Pharmacy. A Pharmacy which dispenses Prescription Drugs through the mail and which has a direct contractual obligation with us or our designee to provide these Services.

Exclusive Pharmacy Provider - a Pharmacy Provider performing within the scope of its license that has an agreement, either directly or indirectly, with Highmark WV pertaining to the payment and exclusive dispensing of selected Prescription Drugs as set forth in this Policy, provided to a Member.

Formulary. A list of Prescription Drugs that are Preferred Drugs.

Generic Prescription Drug. A Prescription Drug that is produced by more than one manufacturer. It is chemically the same and generally costs less than a Brand Name Prescription Drug.

Maintenance Prescription Drug. A Prescription Drug prescribed for the control of a chronic disease or illness or to alleviate the pain and discomfort associated with chronic disease or illness.

Network Pharmacy. A Network Pharmacy is a Pharmacy that has an agreement with us or our designee to provide the Covered Services and to collect from the Covered Person, only the Prescription Drug Coinsurance amount indicated in Section IV. To the extent permitted by state and federal law, Network Pharmacy Providers with the capability to provide certain immunizations as specified by Highmark WV, may also receive payment under the agreement for such immunizations and for the administration thereof, provided to you. Contact Member Services for additional information. Their phone number is located on the back of your ID Card.

Out-of-Network Pharmacy. Any Pharmacy that is not a Network Pharmacy.

Pharmacy. A licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable law.

Preferred Drug. A Prescription Drug that has been determined to be safe, effective and most cost effective in relation to its clinically equivalent counterparts.

Prescription Drug. Subject to your Policy's exclusions and limitations, a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is a Medically Necessary and Appropriate Covered Service. Prescription Drugs include a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Prescription Drug Allowance. An amount that we consider to be reasonable payment for a Prescription Drug considered to be a Covered Service. The Prescription Drug Allowance for Prescription Drugs from Network Pharmacies or Mail Order pharmacies is the amount charged to you by the Network Pharmacy or the Mail Order pharmacy .

Prescription Drug Coinsurance. The percentage of the Prescription Drug Allowance for a Prescription Order or Refill or fixed dollar amount listed in Section IV, which you must pay for each Prescription Order or Refill.

Prescription Mail Order Coinsurance. A certain percentage or dollar amount you are required to pay for each Medically Necessary and Appropriate Prescription Order or Refill.

Prescription Order or Refill. The directive to dispense a Prescription Drug issued by a Physician or Professional Other Provider whose scope of practice permits issuing such a directive.

Refill. See Prescription Order.

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