HEALTH CARE BENEFITS

FOR

Monongalia Health System

Premium High Deductible Health Plan Option

Administered By:

An Independent Licensee of the Blue Cross and Blue Shield Association

YOUR HEALTH CARE BENEFITS
AND
HOW TO USE THEM

Super Blue Plus[sm]
Comprehensive Major Medical
Health Care Benefit Booklet
with
Prescription Drug

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I. Super Blue Plus Qualified Health Deductible Health Plan Health Care Benefit Booklet

A. GROUP CONTRACT AND BENEFIT BOOKLET

This Group Health Plan is a High Deductible Health Plan of Inpatient and Outpatient benefits, most of which are provided at both Network and Out-of-Network benefit levels. Health care coverage is based on guidelines from the U.S. Treasury Department. These guidelines require: 1) a minimum Deductible amount; 2) a maximum Out-of-Pocket amount; 3) all medical and drug Services, with the exception of Preventive Care, must be applied toward the Deductible; and 4) all medical and drug Services must be applied toward the Out-of-Pocket amount. You must be enrolled in a Qualified Health Plan to establish and contribute to a Health Savings Account.

This Benefit Booklet describes the health care benefits available to you as part of a Group Contract (or "Contract"). It is part of and subject to the terms and conditions of the Group Contract.

The actual Group Contract is between Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield West Virginia ("Highmark WV") and the employer or organization that pays or forwards the premiums and any administrative costs for your coverage with Highmark WV. 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. Highmark WV may be referred to throughout this Benefit Booklet as **we**, **us**, **or our**. The employer or organization will be called the **Group, Plan Sponsor, or Plan Administrator**. All persons who meet eligibility criteria in this Benefit Booklet are eligible for coverage under the Group Contract. They are referred to as **Covered Persons, Member, you or your**. They must:

- Apply for coverage under the Group Contract;
- Pay a portion of the premium if necessary;
- Satisfy the conditions specified in Section III; and
- Be approved by us.

Certain words used in this Benefit Booklet have special meaning. They will be capitalized throughout the text so that you will pay special attention to them. They are either defined in Section II, or where used in the text.

The Group shall have the right to return the Contract within 10 days of its delivery and to have the premium refunded if, after examination of the Contract, the Group is not satisfied for any reason. In the event the Group exercises this right, Highmark WV shall not be obligated to pay any benefits under the Group Health plan for Claims submitted to Highmark WV during such 10-day period.

B. FINANCING ARRANGEMENT

Your Group is responsible for the financing of benefits under the plan. Highmark WV, through a Contract with your Group, serves as a third-party administrator. The role of Highmark WV is limited to those administrative functions related to the payment and processing of claims and Network access only. No network access is available outside the Highmark WV service area other than through the BlueCard® Program described in Section VIII. Highmark WV acts solely as a third party administrator and does not underwrite or insure these benefits and does not assume any financial risk or obligation with respect to claims.

C. HOW TO USE YOUR BENEFIT BOOKLET

This Benefit Booklet gives you the details you need in order to understand your health care benefits. We have tried to write it in simple terms that are easy to understand. Please read this Benefit Booklet carefully and completely to understand the benefit coverage. It is important that you keep a copy of this Benefit Booklet 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 Benefit Booklet sent to you.

D. 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.

1. **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, and 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.

2. **Precertification Review.** This Benefit Booklet contains a Precertification Review limitation. It is described in Sections III Precertification Review is limited solely to determining Medical Necessity and Appropriateness. It is not a guarantee of coverage or payment. **Remember, in an emergency, always go to the nearest appropriate medical Facility.**

3. **Mastectomy Benefits.** This Group Health Plan provides certain reconstructive Services for mastectomy benefits. See Section V for more information.

4. **Medical Necessity and Appropriateness Requirement and Member Liability**

   All Services must be Medically Necessary and Appropriate unless otherwise specified. Medical Necessity and Appropriateness 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 long with estimated Charges. You must also agree in writing to proceed with such Services or 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 Benefit Booklet and the Member will be responsible for all Charges Incurred.

5. **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.

6. **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 Coverage Information, and then Procedures That Require Authorization.

7. **Duties of Highmark WV**

   Highmark WV's obligations and services as Claims Administrator for this Group Health Plan are expressly limited and include: (1) Claim processing and payment of benefits; and (2) certain general administrative services and consulting services as set forth in its Contract with the Plan Sponsor/Administrator. All services to be provided by Highmark WV as Claims Administrator shall be performed pursuant to the direction of the Plan Sponsor/Administrator and in accordance

with the Contract. Highmark WV, as Claims Administrator, is to adhere to the specific directions of the Plan Sponsor/Administrator in the processing of particular Claims.

Highmark WV, as Claims Administrator, shall administer and determine initial Claims for benefits and related appeals in accordance with: (a) the U.S. Department of Labor Claims Procedure Rule [29 CFR 2560.503-1 et. Seq.]; (b) the Benefits Booklet; (c) Claims Administrator's administrative policies, practices, and Network rules; and (d) Highmark WV's Contract with the Plan Sponsor/Administrator. The Plan Sponsor/Administrator shall be responsible for clarifying Group Health Plan provisions when appropriate in accordance with a reasonable interpretation of the Group Health Plan.

8. Blue Cross and Blue Shield Association

The Group, on behalf of itself and all Eligible Employees, hereby expressly acknowledges its understanding that this agreement constitutes a Contract solely between the Group and Highmark WV, which is an independent corporation operating under a license from the Blue Cross and 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 Washington County, OH, and that Highmark WV is not contracting as the agent of the Association.

The Group, on behalf of itself and its Eligible Employees, further acknowledges and agrees that it 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 Group for any of Highmark WV's obligations to the Group 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.

9. Address

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

10. Member Services

If you have questions about your coverage or are directed to contact 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.

11. 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.

12. Member Rights and Responsibilities

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.
- 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 West Virginia Members' Rights and Responsibilities policies.

You have a responsibility to:

- Supply to the extent possible, information that the group 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 doctor based on trust and cooperation.

E. 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 doctor 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.

F. 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 Contract.

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.

Adverse Benefit Determination/Adverse 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; and
- 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 Contract.

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.

Benefit Booklet. This document, including all Riders.

Benefit Period. The period of time specified in Section III that Deductible, Fees and Coinsurances apply for which benefits will be paid for Covered Services.

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.

Care Coordination. Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's health care needs across the continuum of care,

Care Coordinator Fee. A fixed amount paid by a Blue Cross Blue Shield licensee to Providers periodically for Care Coordination under a Value-Based Program.

Charges. See Actual Charge.

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 Benefit Booklet, 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 Contract.

Coinsurance. This is 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.

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.

Contract (or Group Contract)**.** The agreement (including the Group Application, individual Applications of the Eligible Employees, this Benefit Booklet, Schedule of Benefits and any Riders) between your Group and us.

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 Eligible Employee and, if other than individual coverage is selected, the Eligible Dependents of the Benefit Booklet Holder.

Covered Service. A Provider's Service or Supply, that is eligible as described in this Benefit Booklet, 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 intellectual disability 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.

Designated Agent. An entity that has contracted, either directly or indirectly, with Highmark WV to perform a function and/or servie in the administration of this Agreement. 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 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/onset 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 Benefit Booklet.

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

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

Eligible Dependent. (also noted as Dependent) A Covered Person other than the Eligible Employee, as shown in the Schedule of Eligibility Section of this Benefit Booklet.

Eligible Employee. An Eligible Employee of the Group who has been approved for coverage under the terms and conditions of the Group Contract.

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.

Enrollment Date. The date when you enroll for benefits which may precede your Effective Date in the event there is a Waiting Period but in no event it may precede the Group's Effective Date.

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.

Experimental or 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/Investigative in nature. An intervention is considered to be Experimental/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/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/Investigative treatment. If you have a concern that a Service you will receive may be Experimental/Investigational, you or the Hospital and/or Professional Provider may contact Highmark'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:

- Alcoholism Treatment Center
- Ambulatory Medical Facility
- Ambulatory Surgical Facility
- Birthing Center
- Day/Night Psychiatric Facility
- Dialysis Facility
- Substance Use Disorder Treatment Facility
- 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/Final Adverse 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.

Group Contract. See Contract.

Habilitative 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.

Health Savings Account. A tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a High Deductible Health Plan (HDHP). The funds contributed to an account are not subject to federal income tax at the time of deposit.

High Deductible Health Plan. A plan with a higher deductible than a traditional Policy. The monthly premium is usually lower, but you pay more health care costs yourself before the Policy starts to pay its share (your deductible). A high deductible health plan (HDHP) can be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from federal taxes.

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.

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, of 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.

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

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.

Late Entrant. Enrollment in the Group Health Plan that is other than on the earliest date on which coverage can become effective under the terms of the Benefit Booklet or a Special Enrollment date for the person.

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 Contract.

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.

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 Benefit Booklet. 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 product.

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 and the treating Specialist communicate via interactive audio and streaming video telecommunications. This includes a Physician office, the Outpatient department of a Hospital or freestanding Surgery Facility or a Retail Clinic.

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

Out-of-Network. A Hospital, Facility Other Provider, Physician, or Professional Other Provider, which does not meet the definition of a Network Provider.

Out-of-Network Coinsurance. A percentage of the Plan Allowance or Actual Charges for Covered Services for which you are responsible when the Covered Services are received from an Out-of-Network Provider, after the Deductible has been met and benefits for Covered Services have been paid by us.

Out-of-Network Liability. The amount of Actual Charges in excess of the Plan Allowance that you are responsible for when Covered Services are received from an Out-of-Network Provider. The Out-of-Network Liability is in addition to the Out-of-Network Coinsurance and any other Deductible or Fees for which you are responsible for under this Benefit Booklet. It will not be applied to any limits applicable to your Deductible, Network or Out-of-Network Coinsurance.

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 Provider. A provider who, under a contract with Highmark WV or with its Designated Agent, 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.

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 greater benefits when Services are received from a Network Provider. 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 Covered Person 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 Section VII. When Highmark WV does not receive pricing from a local licensee, the Plan Allowance is determined by Highmark WV in its sole discretion and in most circumstances unrelated to Actual Charges.

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.

Pre-Certification. See Prior Authorization.

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.

Rehabilitation Hospital. A Facility, which, for compensation from its patients, is primarily engaged in providing Rehabilitation Services on an Inpatient basis. Services must be provided by, or under, the supervision of a Physician, with continuous nursing Services provided under the supervision of a registered nurse.

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, which for compensation by its patients, is 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 the 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 sub-classifications of: (A) Schizophrenia and other psychotic disorders; (B) bipolar disorders; (C) depressive disorders; (D) Substance Use Disorder-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; (E) anxiety disorders; and (F) anorexia and bulimia.

Service or Supply ("Service"). 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.

Special Enrollment Period. The period during which an Eligible Person who experience(s) certain qualifying events may enroll for coverage provided under this Contract outside of the Open Enrollment Period.

Special Enrollment Rights. An Eligible Person is entitled to enroll for coverage under this benefit program during a Special Enrollment Period pursuant to Special Enrollment Rights as defined under applicable federal or state law. Requests for special enrollment must be made during the applicable Special Enrollment Period. Coverage shall become effective on the date specified or required under applicable federal or state law.

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

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 the 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 Benefit Booklet 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. A 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 through Friday and 8 hours each on Saturday and Sunday, no appointment required, outside of a Hospital-based emergency room. 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**.**

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 Benefit Booklet 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.

Waiting Period. The period that must pass before an individual is eligible to enroll under the terms of the group health plan.

III. Schedule of Eligibility

A. APPLYING FOR COVERAGE

When you apply for coverage, you will be asked to select one of the following types of coverage:

- Employee only;
- Employee and child;
- Employee and spouse;
- Employee and children;
- Family.

An Application must be completed in all instances. In reviewing 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.

B. ELIGIBLE EMPLOYEES AND PREMIUM COST SHARING

See your Plan Administrator for specific employee eligibility and any employee premium cost sharing requirements.

C. ELIGIBLE DEPENDENTS

1. **Eligible Dependent:**

An Eligible Dependent is an individual identified by the Eligible Employee through the appropriate enrollment process or on an Application form accepted by the Plan who is

- **Spouse**
  The Eligible Employee's spouse under a legally valid existing marriage between persons of the opposite sex or between persons of the same sex when entered into within a state that sanctions such marriages by law and that is valid pursuant to such law at the time of the marriage.

- **Dependent Children:**
  - The Eligible Employee or spouse's children and stepchildren;
  - Adopted children or children placed for adoption with the Eligible Employee or Eligible Employee's spouse.
  - Any Dependent children which by court order must be provided health care coverage by the Eligible Employee or the Eligible Employee spouse.
  - Children for whom either the Eligible Employee or the Eligible Employee Spouse is the legal guardian. We will require court or government approval of guardianship.

2. **Dependent Age Limits and Disabled Children**

Eligible Dependent age limit is twenty-six (26). Coverage stops at the end of the month of the 26th birthday for qualified Eligible Dependents. The age limits for all Eligible Dependent children are specified in Section IV. Coverage for Eligible Dependents will continue past the age limit for Eligible Dependents who cannot work to support themselves due to a physical or mental disability. The disability must have started before the age limit was attained and must be medically certified by a Physician. Following the Eligible Dependent reaching the age limit, we may annually require further proof of the continuance of such incapacity and dependency.

3. **Adopted Children**

Any child under the age of 18 who is adopted by you, including a child who is legally placed with you for adoption, will be eligible for Dependent insurance upon the date of placement with you. A child will be considered placed for adoption when the natural parents (or legal guardian) legally consent to the adoption process under applicable state law and you come legally obligated to support that child, totally or partially, prior to that child's adoption. You may be required to provide documentation evidencing the consent. See the Special Enrolment Procedures.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends.

4. **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 Group Health Plan.

5. **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 Group Health Plan with respect to the covered child's Claims.

D. ENROLLMENT UPON INITIAL ELIGIBILITY

1. **Time for Applying**.

An Eligible Employee has until the first of the month beginning after the date of becoming an Eligible Employee to enroll by submitting an Application for participation on such form(s) as may be prescribed from time to time by the Group Health Plan and by providing the Group Health Plan with such other information as may be requested.

2. **Required Information**.

Participation by the Eligible Employee and, if applicable, his Eligible Dependent(s) shall be contingent upon receipt by the Group Health Plan of a completed Application form and any other

information requested by the Group Health Plan or us and, if applicable, payment of any required employee contribution.

3. **Effective Date**.

If an Eligible Employee enrolls in the Group Health Plan pursuant to this section, the Eligible Employee and, if applicable, his or her Eligible Dependent(s), shall become Covered Person(s) effective the first day of the month after he or she first becomes an Eligible Employee (the Covered Person's "Enrollment Date"). If the Eligible Employee and, if applicable, his or her Eligible Dependent(s), fail to enroll in the Group Health Plan by the first day of the month after becoming eligible, the Eligible Employee and, if applicable, his or her Eligible Dependents must wait for the Group Health Plan's next open enrollment period to enroll in the Group Health Plan unless they are eligible to enroll under a Special Enrollment procedure or a Qualified Medical Child Support Order described elsewhere within this Section III.

E. ELIGIBILITY CHANGES AND SPECIAL ENROLLMENT PROCEDURES

For Highmark WV to administer consistent coverage for you and your Dependents, you must inform the Group immediately of any changes in eligibility (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

1. **Dependent Additions and Special Enrollment Available for New Dependents**
Special Enrollment is available if you marry or acquire a child through birth, adoption or placement for adoption. You must timely notify your Plan Administrator and submit an Application to us to add a newly acquired Eligible Dependent.

NOTE: ***You must submit all necessary forms within sixty (60) days of the event to add a newly acquired Dependent.***

2. **Special Enrollment Rights for Loss of Other Coverage**
Special Enrollment is available for individuals, provided:
- They remain eligible under the Group Health Plan terms; and
- They originally declined this coverage because of the other coverage;
- If the other coverage was COBRA, it has since exhausted;
- If the other coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated; or
- They are no longer eligible for coverage under title XIX of the Social Security Act (Medicaid) or a state children's health plan under title XXI of the Social Security Act (CHIP).

3. **Changes in Eligibility**
You must immediately notify your Group of any changes in eligibility (e.g., divorce) or when a Covered Person under your Benefit Booklet becomes eligible for Medicare or becomes covered under another health insurance policy. When you or a Dependent becomes ineligible, you and your Dependents may be eligible for continuation coverage described in this Section V. COBRA continuation coverage allows individuals 60 days to notify their Group of such ineligibility from the date they become ineligible. It is important to notify the Group as soon as possible to avoid loss of guaranteed availability rights for other coverage.

4. **Nondiscrimination**
Subject to all limitations within this Contract, individuals may not be excluded from coverage under the terms of the Contract, 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, or sex.

F. OPEN ENROLLMENT

During the Group Health Plan's open enrollment period, an Eligible Employee may elect to participate in the Group Health Plan, singly or with his Eligible Dependents, or to add, modify, or eliminate coverage under the Group Health Plan. Any changes elected during the Group Health Plan's open enrollment period shall be effective as of the first day of the Benefit Period immediately following the close of the open enrollment period.

G. EFFECTIVE DATE

Coverage starts on the Effective Date:

- As agreed upon by the Plan Administrator and Highmark WV; and
- Upon acceptance by us of your Application.

No benefits will be provided for Charges Incurred prior to your Effective Date. Coverage will not be delayed or denied due to confinement in a Hospital or other health care institution on your Effective Date.

H. IDENTIFICATION CARDS (ID CARDS)

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.

I. MEDICARE ELIGIBILITY

Upon becoming eligible for Medicare, coverage may be continued in any of several ways. Your Plan Administrator can tell you if any of the following options are available to you.

1. **Active Employees**
   If you are still actively employed, you may be allowed to continue your coverage through your Group on the same basis as prior to your becoming Medicare-eligible.
2. **Retirees**
   If you have retired and coverage is provided to you under your former employer's Group Contract, you may be allowed to participate on the same basis as above. You may be required to pay part of the premium in accordance with your Group Contract. The Group must collect from you your portion of the premium.

   If your former Group does not provide retiree benefits, coverage may be available with Highmark WV. To be considered for coverage, you **must** apply for and enroll in Medicare Part A and Part B.

   Highmark WV is not permitted to offer a Direct Pay (non-group) policy to a Medicare-eligible person. You may obtain a Medicare Supplemental or Medicare Advantage policy, however if you are a Medicare eligible resident of West Virginia, you are not eligible for Traditional Medicare Supplemental coverage if you are presently enrolled in a Group Medicare Advantage product.

J. NON-MEDICARE RETIREES

If you have retired and coverage is <u>not</u> continued under your former employer's Group Contract and you are <u>not</u> eligible for Medicare, you may be eligible for coverage under our individual conversion product.

Coverage under the conversion coverage Contract may be different. Additional information is provided in this Section III, Subsection P.

K. HOW AND WHEN YOUR BENEFITS MAY CHANGE

The benefits provided by this Benefit Booklet may be changed or revised at any time by amendment to the Group Contract and if applicable, by approval of the West Virginia Offices of the Insurance Commissioner. If the benefits are changed or revised, the Plan Administrator will be given notice prior to the changes becoming effective. It is the Plan Administrator's responsibility to notify you of these changes and when they become effective. If you are receiving Covered Services at the time your new benefits become effective, we will only pay for such Services to the extent they continue to be Covered Services under the new benefits.

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.

L. HOW AND WHEN YOUR COVERAGE STOPS

1. When a Covered Person stops being an Eligible Dependent, coverage stops as specified in this Benefit Booklet or Group Contract.

2. When a Covered Person stops being an Eligible Employee, all coverage stops according to the terms of the Group Contract.

3. Termination of the Group Contract by the Plan Administrator automatically ends all of your coverage. It is the responsibility of the Plan Administrator to tell you of such termination.

4. If Highmark WV terminates the Contract, you and the Plan Administrator will be notified 60 days in advance of the coverage termination date. You may be eligible for conversion coverage as indicated in this Section IV.

5. We have the right to void coverage of any Covered Person who engages in fraud or an intentional misrepresentation of a material fact.

6. When a Group or Covered Person fails to make a required premium payment, coverage stops at the end of the month of the last fully paid premium payment.

M. CONTINUATION COVERAGE – COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended)

Your Group Administrator can tell you if your Group Health Plan is subject to the following COBRA regulations and, if so, how these benefits are administered. **Your employer is required to provide you with notice of your COBRA rights if your Group Health Plan is subject to COBRA.**

A federal law (Public Law 99-272, Title X) known as COBRA was enacted requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Group Health Plan would otherwise end. This Section is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your covered spouse, if applicable, should take the time to read this Section and the notices provided by your employer carefully and refer to them in the event that any action is required on your part.

1. **Employee**

   If you are an employee covered by this Group Health Plan, you may have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

2. **Employee's Spouse**

   If you are the covered spouse of an Eligible Employee, you may have the right to choose continuation coverage for yourself if you lose Group Health Plan coverage for any of the following four (4) reasons:
   - The death of the employee;
   - The termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment;
   - Divorce or legal separation from the employee; or
   - The employee becomes entitled to Medicare.

3. **Employee's Child**

   In the case of a covered Eligible Dependent child of an employee (including a child of a covered employee born or adopted during the period of COBRA continuation), he / she has the right to continuation coverage if Group Health Plan coverage is lost for any of the following five (5) reasons:
   - Death of the employee;
   - The termination of the employee's employment (for reasons other than gross misconduct) or reduction in employee's hours of employment;
   - Parent's divorce or legal separation;
   - Employee becomes entitled to Medicare; or
   - The Dependent ceases to be an Eligible "Dependent child" under the terms of the Group Health Plan.

You also have a right to elect continuation coverage if you are covered under the Group Health Plan as a retiree, spouse or child of a retiree, and lose coverage within one year before or after the employer's commencement of proceedings under Title 11 (bankruptcy), United States Code.

The Eligible Employee or family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing Dependent status within 60 days of the date of the qualifying event which would cause a loss of coverage. The notice must be in writing, and should be sent to the Plan Administrator. When the employer is notified that one of these events has happened, you will in turn be notified that you and your Eligible Dependents have the right to choose continuation coverage. Under the law, you and your Eligible Dependents have 60 days from the later of the date you would lose coverage or from the date of the notice to elect continuation coverage. If and when you and your Eligible Dependents make this election, coverage will become effective on the day after coverage would otherwise be terminated.

If you do not choose continuation coverage, your coverage under the Group Health Plan will end in accordance with the provisions outlined in this Benefit Booklet.

If you choose continuation coverage, the Plan Administrator is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Group Health Plan to similarly situated employees or Eligible Dependents. If coverage for similarly situated employees and Eligible Dependents is modified after you elect continuation coverage, your coverage will be modified accordingly.

The required continuation coverage for employee and Eligible Dependents is up to 18 months for employee's termination or reduction in hours of employment. An extension from 18 months up to 29

months is available under certain circumstances to disabled employees (*) who have been determined by the Social Security Administration (SSA) to have a disability onset date either before the COBRA event or within the first 60 days of COBRA continuation coverage. The required continuation coverage is up to 36 months for Eligible Dependents in the following situations:

- The employee is entitled to Medicare;
- Divorce or legal separation;
- Death of employee; and
- Cessation of Dependent child status.

However, the law also provides that your continuation coverage may be terminated for any of the following reasons:

- The employer no longer provides Group Health Plan coverage to any of its employees;
- You do not pay the premium for your continuation coverage in a timely manner;
- You first become covered, after electing COBRA continuation coverage, under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation which would apply to the COBRA covered individual with respect to any Preexisting Condition; or
- You first become entitled to Medicare, after electing COBRA continuation coverage.

You do not have to show that you are insurable to choose continuation coverage. However, **you will have to pay the Group rate premium plus a 2% administrative fee for your continuation coverage.** At the end of the 18-month, 29-month, or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under the current group health plan, if the plan provides a conversion privilege. In addition, under the Health Insurance Portability & Accountability Act (HIPAA, 1996), in certain circumstances, such as when you exhaust COBRA coverage, you may have the right to buy individual health coverage.

If you have any questions about COBRA, please contact your Plan Administrator. In addition, if you have changed your marital status or you, your spouse, or any eligible covered Dependent have changed address; please notify your Plan Administrator in writing. If any covered child is at a different address, please notify your Plan Administrator in writing so that a separate notice may be sent.

NOTE: ***A qualified beneficiary, who is determined under Title II or XVI of the Social Security Act to have been disabled as of the date of the COBRA event or within 60 days of COBRA coverage, may be eligible to continue coverage for an additional 11 months (29 months total). You must notify the employer within 60 days of the determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. You must provide a copy of the SSA determination of disability. The employer can charge up to 150% of the applicable premium during the 11-month extension. The disabled individual must notify the employer within 30 days of any final determination that he or she is no longer disabled. If the coverage is extended to a total of 29 months, extended coverage will cease upon a final determination that the qualified beneficiary is no longer disabled.***

N. MILITARY SERVICE

If you are called up for active military service, commissioned corps of the Public Health Service and certain non-military emergency responders, you may be entitled to military coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA). USERRA may also entitle you reenrollment upon returning from active military service without any Waiting Periods or a significant break in coverage.

O. INPATIENT BENEFITS INCURRED BEFORE TERMINATION AND EXCEEDING THE TERM OF CONTRACT

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 group 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.

P. CONVERSION PRIVILEGE

If either you or a Dependent stop being a Covered Person, you and your Dependents may be eligible for conversion to a non-group policy of your choice offered by Highmark WV if there was continual coverage under this Group Health Plan for three months immediately prior to the termination. You are eligible for conversion coverage if the Group coverage is terminated (including discontinuance of the group policy in its entirety), with the exception of the following reasons:

- You fail to pay any required contribution for your group health care coverage;
- You obtain other group health insurance coverage within 31 days of termination of coverage under the Group Contract;
- You become covered under Medicare; 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.

The conversion coverage and rates may be different than the coverage provided under this Contract. However, we will not require evidence of insurability for eligibility under the conversion coverage. You must apply in writing and make the first premium payment to us for such coverage no later than 31 days after your coverage under this Contract ends.

Payment for coverage under the conversion policy must be made from the date you or your Dependent ceases to be a Member under this Group Contract. The conversion policy will be effective on the date of termination of your or your Dependent's coverage under this Contract. The amount of the first premium payment will also include the premium for the following full month of coverage.

IV. Super Blue Plus High Deductible Health Plan Schedule of Benefits

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 Benefit Booklet.

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. You may contact Member Services to request an updated Benefit Booklet.

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 Provider is solely yours. Your PPO plan gives you freedom of choice. 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 the maximum 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 is on call 24/7.

All Providers are designated as either Network or Out-of-Network. **The amount of benefits that you will receive for Covered Services will vary depending upon whether the Provider is in the Network or not.** Your financial responsibility will also vary between these Provider designations.

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.

You will receive greater benefits by seeking Covered Services from Network Providers. This section tells you how much we will pay for Covered Services at Network and Out-of-Network Providers.

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
- 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.

B. 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 Benefit Booklet. 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 or Facility Other Provider, Professional, Professional Other Provider, Retail Clinic or Urgent Care Center.***

1. Emergency Services

Emergency Accident Care and/or Emergency Medical Care Provided in the Emergency Room

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. Emergency Services will be covered whether the health care Provider furnishing the services is a Network Provider or a Out-of-Network Provider.

If a Member seeks treatment at a Hospital emergency room and receives Services that are not Medically Necessary and Appropriate, this Benefit Booklet will not reimburse the cost of such Services, other than a Medical Screening Exam to determine if an Emergency Medical condition exist or, if based on retrospective review, a Prudent Layperson would have believed an Emergency Medical Condition exists (in any case, less any applicable Coinsurance and Deductible).

If the Emergency Services are provided Out-of-Network, 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 cost sharing requirements for In-Network Services. The Member may be required to pay, in addition to the In-Network cost-sharing, the excess of the amount the Out-of-Network Provider Charges over the amount Highmark WV is required to pay.

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;

Treatment for any occupational injury for which benefits are provided under any Worker's Compensation Law or any similar Occupational Disease Law is not covered.

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

Emergency Ambulance Services

Emergency Ambulance Services will be covered at the In-Network Plan Allowance regardless of whether the Provider is in the Network.

We reserve the right to make the payment of any Emergency Ambulance Service Claim directly to you as the Member.

2. Benefit Maximums.

Benefit Maximums may be noted in the Schedule of Benefits. 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, Network and Out-of-Network Coinsurances, or other Covered Person responsibilities. In some circumstances, the Benefit Maximums are combined for Network and Out-of-Network Services.

3. Coinsurance.

This is a percentage of the Plan Allowance after your Deductible has been satisfied. **Network Coinsurance** percentages generally are less than **Out-of-Network Coinsurance**. Normally you receive greater benefits from Network Providers. There are separate limits for Network Coinsurance and Out-of-Network Coinsurance. Network and Out-of-Network Coinsurance dollars do not cross apply. Family Coinsurance and Out-of-Pocket Limits may be met collectively.

Except as otherwise specified, after you have paid any applicable Deductibles or Fees, Covered Services will be paid at the percentage applicable to the Provider Network status

4. Coinsurance and Liability Limits.

Once your Network Coinsurance Limit is satisfied, benefits for Covered Services provided by a Network Provider are payable by Highmark WV at 100% of the Plan Allowance, unless otherwise stated.

After your Out-of-Network Out-of-Pocket Limit is satisfied, benefits for Covered Services are payable by an Out-of-Network Provider are payable by Highmark WV at 100% of the Plan Allowance, unless otherwise stated. You are responsible for payment of some or all of the Provider Charges in excess of the Plan Allowance for Covered Services received from an Out-of-Network Provider (Out-of-Network Liability) (also known as "balance billing").

Also, Out-of-Network Liability amounts will not be applied toward satisfying either your Network or Out-of-Network Coinsurance Limits.

5. 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 this section or on your ID Card. The Copayment is typically payable at the time Covered Services are rendered.

6. Deductible.

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.

7. Total Maximum Out-of-Pocket.

The maximum amount of expenses Incurred for Deductibles, Coinsurance and Copayments, prescription drug cost sharing and other qualifying medical expenses (for Network only) is satisfied; Covered Services for a Benefit Period are payable by Highmark WV at 100% of the Plan Allowance, unless otherwise stated, for the rest of the Benefit Period per individual or family. The Maximum Out-of-Pocket does not include Out-of-Network Liability.

8. Non-Covered Services.

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

9. Out-of-Network Liability.

In addition to any Deductible and Out-of-Network Coinsurance, you may be responsible for some, or all, of the amount of Actual Charges in excess of our agreed Plan Allowance, when you obtain Services from Out-of-Network Providers.

10. 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.

11. 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 IV. for circumstances where you may be responsible for non-Medically Necessary and Appropriate Services.

C. SCHEDULE OF BENEFITS DESCRIPTIONS The following pages provide details regarding specific benefit amounts and limits.

SuperBlue Plus QHDHP

III. SUMMARY OF BENEFITS INSERT [1]

IMPORTANT: PLEASE READ THE SUMMARY OF BENEFITS SECTION OF YOUR CERTIFICATE BOOK. THIS INSERT IS PART OF YOUR CERTIFICATE AND SUBJECT TO CHANGE. FOR FURTHER EXPLANATION REFER TO YOUR CERTIFICATE BOOK.

Covered services performed at Mon Health Medical Center, Preston Memorial Hospital and Stonewall Jackson Memorial Hospital by a network provider are payable at Tier 1. Covered services performed at Mon Health Center for Outpatient Surgery, Surgical Eye Center of Morgantown, Minnie Hamilton Health Systems and Grafton City Hospital are payable at Tier 2.

Effective Date	July 1, 2021		
Benefit Period (used for Deductible and Coinsurance limits)[2]	July 1 through June 30 (Contract Year)		
If you are enrolled as a "Family Plan", the "Family Plan" deductible and "Family Plan" coinsurance limit apply. However, no eligible family member will have to satisfy more than $4,000 for covered expenses, regardless of whether the Family TMOOP has been satisfied. If you are enrolled as an "Employee Only Plan" you will pay no more than the "Employee Only Plan" Deductible plus the "Employee Only Plan" Coinsurance Limit.			
	Tier 1	**Tier 2**	**Tier 3**
Deductible (Applies to Medical and Prescription Drug benefits. Tiers 1 & 2 dollars cross apply.)	**MHS Network – Mon Health Medical Center, Preston Memorial Hospital, and Stonewall Jackson Memorial Hospital**	**BCBS PPO Network Providers When Services are NOT Available within MHS Network**	**All Non-Network Services & Any BCBS PPO Network Providers When Services ARE Available within MHS Network**
Employee Only Plan Family Plan **Note: All services are subject to the Deductible unless otherwise specified.**	$1,500 $3,000	$2,000 $4,000	$4,000 $8,000
Carry-Over Deductible Period	NO BENEFITS		
Coinsurance Limit (Applies to Medical and Prescription Drug benefits. Tiers 1 & 2 dollars cross apply.) Employee Only Plan Family Plan	$2,500 $5,000	$2,000 $4,000	$4,000 $8,000
Total Maximum Out of Pocket[4] (Includes Medical and Drug Deductible and Coinsurance per Benefit Period. **Network only**) Employee Only Plan Family Plan	$4,000 $8,000		Not Applicable Not Applicable
Non-Network Liability	UNLIMITED		
Lifetime Maximum Benefit for all covered services	UNLIMITED		

BENEFIT HIGHLIGHTS

	Tier 1	Tier 2	Tier 3
	MHS Network – Mon Health Medical Center, Preston Memorial Hospital, and Stonewall Jackson Memorial Hospital	**BCBS PPO Network Providers When Services are NOT Available within MHS Network**	**All Non-Network Services & Any BCBS PPO Network Providers When Services ARE Available within MHS Network**
Primary Care Medical Office Visit / Office Consultation	80%	60%	40%
Specialist Medical Office Visit / Office Consultation(Includes Specialist Virtual Visits)	80%	60%	40%
Virtual Visit Originating Site	80%	60%	40%
Emergency Accident Care and/or Emergency Medical Care provided in the ER	80%	80%	80%
Retail Clinic (Fast Care) Visit	NO BENEFITS	NO BENEFITS	NO BENEFITS
Urgent Care Visit	80% for Services Provided at MedExpress Urgent Care / Wedgewood Urgent Care / Preston Memorial Hospital Urgent Care	60%	40%

PRESCRIPTION DRUGS[5]			
Group Numbers 098014-05, 06, 07, 08, 09, 10	**Mon Health Pharmacy**	**Network**	**Non-Network**
Prescription drugs are subject to the tier 2 deductible. Copays will be assessed once the tier 2 deductible has been met.			
Prescription Drugs are provided through a Retail Pharmacy Network[5] If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, even if the physician writes "Dispense As Written" (DAW) on the prescription, unless no generic equivalent exists. Maximum 30 day supply. **Note**: Prescription Copayments apply toward the Total Maximum Out-of-Pocket	Generic - $5 Co-Pay; Preferred Brand $40 Co-Pay; Non-Preferred Brand $75 Co-Pay	Generic - $20 Co-Pay; Preferred Brand $60 Co-Pay; Non-Preferred Brand $100 Co-Pay	NO BENEFITS
Prescription Drugs are provided through a Retail Pharmacy Network[5] If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, even if the physician writes "Dispense As Written" (DAW) on the prescription, unless no generic equivalent exists. Maximum 31-90 day supply. **Note**: Prescription Copayments apply toward the Total Maximum Out-of-Pocket	Generic - $12.50 Co-Pay; Preferred Brand $100 Co-Pay; Non-Preferred Brand $187.50 Co-Pay	NO BENEFITS	NO BENEFITS
Specialty Drug Program[5]- Specialty drugs must be obtained directly from Mon Health Pharmacy or Walgreens Specialty Pharmacy. For additional information please contact Customer Service. Maximum 30 day supply. Note: Prescription Copayments apply toward the Total Maximum Out-of-Pocket.	$100	$150 Co-Pay	NO BENEFITS
Maintenance Drugs Members who take maintenance drugs (those prescription drugs used to treat long-term conditions on a regular basis are required to purchase those drugs through Mon Health Pharmacy or Mail Order Service after three (3) fills at a retail pharmacy.			
Mail Order Drugs[5] If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, even if the physician writes "Dispense As Written" (DAW) on the prescription, unless no generic equivalent exists. Maximum 90 day supply. **Note**: Prescription Copayments apply toward the Total Maximum Out-of-Pocket	Maintenance Drugs can be obtained from Mon Health Pharmacy. See Retail Pharmacy Network section above for Co-Pays	Generic - $50 Co-Pay; Preferred Brand $150 Co-Pay; Non-Preferred Brand $250 Co-Pay Specialty drugs – Not covered	NO BENEFITS
Additional Preventive Prescription Benefits [3] (Retail or Mail Order) **-** Guidelines as determined by certain Governmental Agencies. You may access this information at www.healthcare.gov. You may also contact Member Services.	100%, No Deductible	100%, No Deductible	NO BENEFITS

PRESCRIPTION DRUGS[5]			
Group Numbers 105113-78, 79; 105120-38, 39	**Mon Health Pharmacy**	**Network**	**Non-Network**
Prescription drugs are subject to the tier 2 deductible. Copays will be assessed once the tier 2 deductible has been met. **The following prescription drug information is for members who work at designated off site clinics outside of the Morgantown area.** **Members who work at designated off site clinics outside of the Morgantown area will be able to obtain their prescriptions from any network retail pharmacy at the same member cost share as the Mon Health Pharmacy.**			
Prescription Drugs are provided through a Retail Pharmacy Network[5] If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, even if the physician writes "Dispense As Written" (DAW) on the prescription, unless no generic equivalent exists. Maximum 30 day supply. **Note**: Prescription Copayments apply toward the Total Maximum Out-of-Pocket	Generic - $5 Co-Pay; Preferred Brand $40 Co-Pay; Non-Preferred Brand $75 Co-Pay	Generic - $5 Co-Pay; Preferred Brand $40 Co-Pay; Non-Preferred Brand $75 Co-Pay	NO BENEFITS
Prescription Drugs are provided through a Retail Pharmacy Network[5] If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, even if the physician writes "Dispense As Written" (DAW) on the prescription, unless no generic equivalent exists. Maximum 31-90 day supply. **Note**: Prescription Copayments apply toward the Total Maximum Out-of-Pocket	Generic - $12.50 Co-Pay; Preferred Brand $100 Co-Pay; Non-Preferred Brand $187.50 Co-Pay	NO BENEFITS	NO BENEFITS
Specialty Drug Program[5]- Specialty drugs must be obtained directly from Mon Health Pharmacy or Walgreens Specialty Pharmacy. For additional information please contact Customer Service. Maximum 30 day supply. Note: Prescription Copayments apply toward the Total Maximum Out-of-Pocket.	$100	$100	NO BENEFITS
Maintenance Drugs Members who take maintenance drugs (those prescription drugs used to treat long-term conditions on a regular basis are required to purchase those drugs through Mon Health Pharmacy or Mail Order Service after three (3) fills at a retail pharmacy.			
Mail Order Drugs[5] If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, even if the physician writes "Dispense As Written" (DAW) on the prescription, unless no generic equivalent exists. Maximum 90 day supply. **Note**: Prescription Copayments apply toward the Total Maximum Out-of-Pocket	Maintenance Drugs can be obtained from Mon Health Pharmacy. See Retail Pharmacy Network section above for Co-Pays	Generic - $50 Co-Pay; Preferred Brand $150 Co-Pay; Non-Preferred Brand $250 Co-Pay Specialty drugs – Not covered	NO BENEFITS
Additional Preventive Prescription Benefits [3] (Retail or Mail Order) **-** Guidelines as determined by certain Governmental Agencies. You may access this information at www.healthcare.gov. You may also contact Member Services.	100%, No Deductible	100%, No Deductible	NO BENEFITS

PREVENTIVE CARE SERVICES[3]			
	Tier 1	**Tier 2**	**Tier 3**
	MHS Network – Mon Health Medical Center, Preston Memorial Hospital, and Stonewall Jackson Memorial Hospital	**BCBS PPO Network Providers When Services are NOT Available within MHS Network**	**All Non-Network Services & Any BCBS PPO Network Providers When Services ARE Available within MHS Network**
Routine Adult			
Physical exams	100%, No Deductible	100%, No Deductible	40%
Adult immunizations	100%, No Deductible	100%, No Deductible	40%
Colorectal cancer screening	100%, No Deductible	100%, No Deductible	40%
Routine gynecological exams, including a Pap Test	100%, No Deductible	100%, No Deductible	40%
Mammograms, annual routine and medically necessary	Routine: 100%, No Deductible Medically Necessary: 80% after deductible	Routine: 100%, No Deductible Medically Necessary: 60% after deductible	40%
Diagnostic services and procedures	100%, No Deductible	100%, No Deductible	40%
Additional Preventive Diagnostic Services (TSH, A1C, Comprehensive Metabolic Panel, CBC and Lipid Panel)	100%, No Deductible	No Benefits	No Benefits
Routine Pediatric			
Physical exams	100%, No Deductible	100%, No Deductible	40%
Pediatric immunizations	100%, No Deductible	100%, No Deductible	40%
Diagnostic services and procedures	100%, No Deductible	100%, No Deductible	40%

PHYSICIAN SERVICES			
	Tier 1	**Tier 2**	**Tier 3**
	MHS Network – Mon Health Medical Center, Preston Memorial Hospital, and Stonewall Jackson Memorial Hospital	**BCBS PPO Network Providers When Services are NOT Available within MHS Network**	**All Non-Network Services & Any BCBS PPO Network Providers When Services ARE Available within MHS Network**
In-Hospital Medical Visit	80%	60%	40%
Surgery, Assistant to Surgery, Anesthesia	80%	60%	40%
Second Surgical Opinion Services (outpatient)	80%	60%	40%
Maternity Care - Dependent daughters are covered.	80%	60%	40%
Newborn Care including circumcision.	80%	60%	40%
Occupational and Physical Therapy -(Rehabilitative and Habilitative)**Precertification required after the 15th visit.** These visits cross accumulate among all tiers.	80% at Healthworks	60%	40%
Chiropractic Spinal Manipulations (Rehabilitative and Habilitative)	80% after Tier 1 Deductible		
Respiratory Therapy	80%	60%	40%
Cardiac Rehabilitation Therapy	80%	60%	40%
Dialysis	80%	60%	40%
Chemotherapy	80%	60%	40%
Radiation Therapy	80%	60%	40%
Infusion Therapy	80%	60%	40%
Speech Therapy-(Rehabilitative and Habilitative) when necessary due to a medical condition. - Precertification required after the 15th visit. These visits cross accumulate among all tiers.	80%	60%	40%
Rehabilitation Services - **Precertification required after the 15th visit.** These visits cross accumulate among all tiers.	80%	60%	40%
Massage Therapy- Precertification needed after the 15th visit. These visits cross accumulate among all tiers.	80%	NO BENEFITS	40%
Temporomandibular Joint Dysfunction / Craniomandibular Disorders	80%	60%	40%
Removal of Impacted Teeth by oral surgeon	80%	60%	40%
Diagnostic, X-ray, Lab and Testing	80%	60%	40%
Allergy Testing and Treatment	80%	60%	40%

INPATIENT HOSPITAL / FACILITY SERVICES			
	Tier 1	**Tier 2**	**Tier 3**
	MHS Network – Mon Health Medical Center, Preston Memorial Hospital, and Stonewall Jackson Memorial Hospital	**BCBS PPO Network Providers When Services are NOT Available within MHS Network**	**All Non-Network Services & Any BCBS PPO Network Providers When Services ARE Available within MHS Network**
Unlimited Days Semi-Private Room and Board - Monongalia General Hospital only offers Private Rooms.	80%	60%	40%
Ancillaries, Drugs, Therapy Services, X-ray and Lab	80%	60%	40%
General Nursing Care	80%	60%	40%
Surgical Services	80%	60%	40%
Birthing Center Care / Maternity Services - Dependent daughters are covered.	80%	60%	40%
Inpatient Rehabilitation Services- Limited to 60 Days all tiers combined	80%	60%	40%
OUTPATIENT HOSPITAL / FACILITY SERVICES			
Non-Emergency Medical Care provided in the ER	80%	60%	40%
Pre-Admission Testing	80%	60%	40%
Diagnostic, X-ray, Lab and Testing	80%	60%	40%
Surgery, Operating Room	80%	60%	40%
Radiation and Chemotherapy	80%	60%	40%
Cardiac Rehabilitation Therapy	80%	60%	40%
Dialysis	80%	60%	40%
Infusion Therapy	80%	60%	40%
Occupational and Physical Therapy (Rehabilitative and Habilitative) **-** Precertification required after the 15th visit. These visits cross accumulate among all tiers.	80% at Healthworks	60%	40%
Respiratory Therapy	80%	60%	40%
Speech Therapy-(Rehabilitative and Habilitative) when necessary due to a medical condition. - Precertification required after the 15th visit. These visits cross accumulate among all tiers.	80%	60%	40%
Rehabilitation Services - **Precertification required after the 15th visit.** These visits cross accumulate among all tiers.	80%	60%	40%
Massage Therapy- Precertification needed after the 15th visit. These visits cross accumulate among all tiers.	80%	NO BENEFITS	40%

BEHAVIORAL HEALTH SERVICES			
	Tier 1	**Tier 2**	**Tier 3**
	MHS Network – Mon Health Medical Center, Preston Memorial Hospital, and Stonewall Jackson Memorial Hospital	**BCBS PPO Network Providers When Services are NOT Available within MHS Network**	**All Non-Network Services & Any BCBS PPO Network Providers When Services ARE Available within MHS Network**
Outpatient Mental Health Services	80%	60%	40%
Outpatient Substance Use Disorder	80%	60%	40%
Inpatient Mental Health Care Services	NOT AVAILABLE	60%	40%
Inpatient Substance Use Disorder	NOT AVAILABLE	60%	40%
OTHER COVERED SERVICES			
Private Duty Nursing	NO BENEFITS	NO BENEFITS	NO BENEFITS
Skilled Nursing Facility - Limited to 100 Days per admission for all tiers combined.	80%	60%	40%
Durable Medical Equipment and Oxygen at home	80% at Mon Healthcare, Fairmont Home Medical or Stonewall Home Oxygen	60%	40%
Orthotic Devices and Prosthetic Appliances	80%	60%	40%
Routine Foot Orthotics	80%	60%	40%
Home Health Care - Maximum 60 visits **Note:** Maximums are all tiers combined.	80% at Care Partners Home Health	60%	40%
Infertility Benefit- (diagnostics to diagnose paid under diagnostic benefit) A $5,000 Lifetime Maximum applies to Assisted Fertilization benefits.	80%	60%	40%
Family Planning Procedures	80%	60%	40%
Emergency Ambulance - Tier 1 Deductible applies to all Tiers	80%	80%	80%
Other Ambulance Services	80%	60%	40%
Hospice Care	NOT AVAILABLE	60%	40%
Diabetes Education & Control	80%	60%	NO BENEFITS

HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES			
	Tier 1	**Tier 2**	**Tier 3**
	MHS Network – Mon Health Medical Center, Preston Memorial Hospital, and Stonewall Jackson Memorial Hospital	**BCBS PPO Network Providers When Services are NOT Available within MHS Network**	**All Non-Network Services & Any BCBS PPO Network Providers When Services ARE Available within MHS Network**
Human Organ Transplant –Includes transportation, meals and lodging.	NOT AVAILABLE	60%	40%
Bone Marrow Procedures – Includes transportation, meals and lodging.	NOT AVAILABLE	60%	40%

Eligible Dependent Age Limitation	Coverage stops at the end of the month of the 26th birthday for an adult dependent who is an Eligible Dependent.

Please note providers with the specialty of Dermatology, Nephrology, Endocrinology, ENT, Gastroenterology, Mental Health/Substance Use Disorder, Neurology, Pain management, and Skilled Nursing Facility are available in the Monongalia Health System. Services received from a BCBS PPO Network provider outside of the Monongalia Health System from a provider with one of these specialties will be covered at the tier 2 benefit level. This listing of provider specialties is subject to change. Pediatric specialties and inpatient services not available in the Monongalia Health System will be covered at the tier 1 level when received in West Virginia from a BCBS PPO Network provider.

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). On the chart above, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital. **If you enroll as an individual, the deductible and out-of-pocket maximums for the "Employee Only Plan" apply. If you enroll as a family, the deductible and out-of-pocket maximums for the "Family Plan" apply and can be satisfied by one or more of your family members.**

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

[1] Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

[2]Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.

[3] Services are limited to those listed on the Highmark WV Preventive Schedule (Women's Health Preventive Schedule may apply

[4]The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. If you are enrolled in a "Family" plan, with your non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. In addition, with your non-embedded out-of-pocket limit, the entire family out-of-pocket limit must be satisfied before additional claims reimbursement begins. Finally, with your embedded TMOOP, once any eligible family member satisfies his/her individual TMOOP, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year.

[5]At a retail or mail-order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled. The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. This formulary covers all FDA-approved generic and brand-name drugs. Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs.

V. Description of Benefits

This Section describes the Covered Services available to you. 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.

Transportation 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 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. BONE MARROW PROCEDURES

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

- Allogeneic.
- Autologous.
- Syngeneic.
- 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.
- Re-transplantation; 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.

      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.

D. 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.

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 Benefit Booklet 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 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.

H. DIAGNOSTIC SERVICES

Diagnostic Services include:

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

I. EMERGENCY 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.

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 at a minimum 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. Please refer to Section IV. Schedule of Benefits for benefit limitations.***

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 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.

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 Disorder 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.
- 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. 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.

h. 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 coverage 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 coverage 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, delivery and treatment rooms and equipment.
- Drugs and medicine provided to you while 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 under Subsection 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 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.

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. 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. INFERTILITY TREATMENT BENEFIT

The following are covered services under the infertility treatment benefit – Artificial insemination (AI), Intrauterine Insemination (IUI), In Vitro fertilization (IVF) and G.I.F.T. (Gamete Intrafallopian Transfer). Note: These services are limited to a lifetime maximum of $5,000.

Q. INFUSION THERAPY SERVICES

Benefits will be provided when Covered Services are performed by a Provider on an Outpatient basis or if the components are furnished and billed by a Provider. Certain infusion drugs may require 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 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 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.

R. 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.

S. 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.

T. MATERNITY SERVICES

Hospital, medical and surgical Services for a normal pregnancy and complications of pregnancy, miscarriage, and therapeutic abortions are Covered Services. These are Covered Services for the Eligible Employee and all Eligible Dependents. These are not Covered Services if the Member has become pregnant to serve in the capacity of a Surrogate Mother or 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. Prior Authorization is required **only** when the Inpatient stay exceeds 48 hours and 96 hours, respectively.

U. 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.

V. 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 Disorder 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 Health Care

Covered Services for the treatment of Mental Health 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 Benefit Booklet. 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.
- 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 as listed in this Benefit Booklet. 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.

W. ORGAN TRANSPLANT SERVICES

The following human organ transplants are Covered Services:

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

The Group Health Plan 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 Group Health Plan, 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.

X. 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, consultations for the examination, diagnosis and treatment of an injury or illness. 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.

Y. PRESCRIPTION DRUG CLAIMS

If your Group Health Plan includes a Prescription Drug benefit offered by Highmark WV, you may be able to fill a prescription through a Network of Participating Pharmacies, Non-Participating Pharmacies, or a Mail Order Pharmacy Service. Please refer to Section IX for details of your Prescription Drug Benefits.

Z. 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 Affordability Care Act (PPACA). For additional information, go to www.healthcare.gov or contact Member Services. Their phone number is on the back of your ID Card.

1. Routine Gynecological Services

- Pap smears (including related Office Visits) - annually or more often if recommended by a Physician.
- Human Papilloma Virus (HPV) Testing - one every 3 years age 30 and older.
- Mammograms according to the following schedule:
  Age 35 through 39 years of age - one baseline mammogram
  Age 40 and over - one per Benefit Period

2. Well-Woman Care Services

Benefits are provided for female Members for items and services in accordance with a predefined schedule based on age and sex, including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling and breastfeeding support and counseling.

3. Prostate screening exam and prostate specific antigen (PSA) test for males over age 50 - one per Benefit Period.

4. Colorectal Cancer Screening for individuals age 50 and older or a person under age 50 with high risk factors (e.g. family history).

- Exam - one per Benefit Period.
- Fecal Occult Test - one per Benefit Period.
- Flexible Sigmoidoscopy - one every 5 years.
- Colonoscopy - one every 10 years.
- Double Contrast Barium Enema - one every 5 years.

Note: Benefits for Colorectal Cancer Screening are also provided for symptomatic persons under age 50. Coverage for this benefit is provided under Physician and/or Outpatient Hospital/Facility Services level as set forth in Section III rather than at the Preventive Care level.

5. Annual Kidney disease screening and laboratory testing; including any combination of blood pressure testing, urine albumin or urine protein testing, and serum creatinine testing.

6. Other preventive Services as indicated in Section III.

AA. 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 at a minimum 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. Please refer to Section IV. Schedule of Benefits for benefit limitations.***

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 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.

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 due to a medical condition. 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.

BB. 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 intellectual disability, Substance Use Disorder, or pulmonary tuberculosis.

CC. SPECIAL SERVICES

1. 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 intellectual disability, 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 temporal mandibular joint disorders.

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; (paid under your Prescription Drug benefits);
- 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.

Diabetes Prevention Program offered through a Diabetes Prevention Provider is a twelve (12) month program utilizing a curriculum approved by the Centers for Disease Control to deliver a prevention lifestyle intervention for individual at high risk of developing type 2 diabetes. The Diabetes Prevention Program includes behavioral and motivational content focusing on moderate changes in both diet and physical activity.

Education Services may be provided by:

- A licensed pharmacist when providing instruction on the proper use of equipment covered by this Benefit Booklet 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. Pre-Admission Testing.

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

DD. 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

- Sterilization.
- Removal of impacted teeth. Partial and Full-boney impacted teeth are covered under your medical benefits; all soft tissue impactions would be covered under your Dental benefits, if applicable.
- Mandibular staple implant, due to trauma and/or accidental injury.
- Maxillary or mandibular frenectomy.
- Kidney transplants
- Mastectomy and Breast Cancer Reconstruction.
- 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 symmetrcal appearance.
- Prostheses and coverage for physical complications at all stages of the mastectomy procedure, including lymphedemas in a manner determined in consultation with the attending Physician and the patient.
- Minimum stay of 24 hours of Impatient 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 Plan including any applicable Deductible and Coinsurance limitations consistent with those established for other benefits under this Plan.***

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.

EE. 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.

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 on an Outpatient basis 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-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-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. VALUE PROGRAMS

The Group Health Plan may offer Members the opportunity to participate in programs which create incentives to use lower cost Services. At times, these incentives may offer rewards to Members. Such rewards may take the form of cash or cash equivalents and, therefore, may be subject to taxation as miscellaneous income. Any such programs will be offered to all Members. Whether or not Members decide to participate in such programs will not affect their continued eligibility, benefits, premiums, or cost-sharing obligations under this Group Health Plan.

II. WELL CHILD CARE AND IMMUNIZATION SERVICES

1. Well Baby Care Services.

Routine Office Visits, lab tests and immunizations for ages one month to six years are Covered Services. Allowable Office Visits, lab tests and immunizations will follow the schedule recommended by the American Academy of Pediatrics (AAP). You may access this information at www.aap.org or contact Member Services.

2. Well Child Care Service.

Routine immunizations and related Office Visits for children ages six years through seventeen years are Covered Services. Allowable Office Visits and immunizations will follow the schedule recommended by the AAP. You may access this information at www.aap.org or contact Member Services.

JJ. 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 Benefit Booklet.

At times, this Contract 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.

NOTE: ***In the event the other coverage is a non-High Deductible Health Plan, certain tax advantages of this High Deductible Health Plan, when used in connection with a Health Savings Account, may be lost. Please consult your tax advisor for information.***

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:

1. 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 Eligible Employee. 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.

2. 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.

3. Each plan determines its order of benefits using the first of the following rules that apply:

   a. Non-Dependent/Dependent.

      The plan which covers the person other than as a Dependent, for example as an employee, Member, Eligible Employee, subscriber 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, Eligible Employee, subscriber or retiree is the secondary plan and the other plan is the primary plan.

b. 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:
  - plan of the parent whose birthday falls earlier in a calendar year is the primary plan; or
  - 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 marred:
  - 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 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 of the parent not having custody of the child;

c. 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;

d. 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.

e. 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.

f. 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.

4. 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.

5. 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, subscriber or retiree or covering the person as a Dependent of an employee

Member, subscriber or retiree is the primary plan and the COBRA or 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.

6. Longer or Shorter Length of Coverage.

   The plan that covered a person as an employee, Member, subscriber or retiree longer is the primary plan and the plan that covered that person for the shorter period of time is the secondary plan.

7. 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 plan will not pay more than it would have paid had it been the primary plan.

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 payor 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 plan. 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 plan.

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 Benefit Booklet. 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; or
- 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. 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 Group Health Plan 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 Benefit Booklet, or for the payment or reimbursement associated with a Service that has been received by a Member. Claims for benefits provided under this Benefit Booklet include the following types:

- **Pre-Service Claim.** A Pre-Service Claim is a Claim for Services that has not yet been rendered and for which you are required under the Group Health Plan to contact us in advance.
- **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.
- **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.
- **Post-Service Claim.** A Post-Service Claim is a Claim for Services that already have been rendered or where the Group Health Plan does not require prior contact with us.

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 Benefit Booklet will not cover Claims when premiums payable by the Group 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 Benefit Booklet in such circumstances.

1. **Filing Claims.**

A Claim must be filed for you to receive benefits. Many 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.

2. **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 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.**

Out-of-Network Providers are not obligated to bill Highmark WV directly. As a result, it will be your responsibility to submit to us 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 procedure:

- **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.

- **Claim Forms**

  Proof of loss for benefits under the Group Health Plan 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 following the date a notice of a Claim is received, furnish to the Member Claim forms for filing proofs of loss.

- **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 be provided to Highmark WV within ninety (90) days after the date of such loss. Proof of loss must include all data necessary for Highmark WV to determine benefits. Failure to submit a proof of loss to Highmark WV within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss submitted as soon as possible, but in no event, except in the absence of legal capacity, will Highmark WV be required to accept a proof of loss later than one (1) year from the time proof is otherwise required.

- **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 Contract. 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.

3. **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 Eligible Employee. Eligible Employee 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 both 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 or provided to 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 doesn't guarantee coverage or payment.***

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 procedures or Covered Services. You will be held harmless whenever Precertification for such procedures or Covered Services is not obtained. If the procedure or Covered Service is determined not to be Medically Necessary and Appropriate, you will be held harmless, except when we provide prior written notice to you 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 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 Benefit Booklet. 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

Whenever you utilize an Out-of-Network Provider, it is your 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 Benefit Booklet. You will be financially responsible for the difference between what is covered by this Benefit Booklet and the full amount of the Out-of-Network Provider's charge. 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-Network Provider's charge.

If you are admitted to an Out-of-Network Facility for non-emergency care, you must call our Utilization Management staff seven (7) to fourteen (14) days before your planned admission at the Member Service number on the back of your ID card. If you are admitted to an Out-of-Network Facility for an Emergency Medical Condition or for maternity-related care, you must call Utilization Management 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 plan. You could be responsible for the costs.

3. Exceptions to the Responsibility for Requesting Authorizations

a. 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 admission 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 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.

- Behavioral health Intensive Outpatient and Partial Hospitalization.
- Substance Use Disorder Intensive Outpatient and Partial Hospitalization.
- Certain non-emergency Outpatient imaging Services.
- Clinical trials.
- Durable medical equipment listed on the Highmark WV website and any non-standard issue (i.e. deluxe) DME.
- Home Health Care.
- Hospice.
- Hospital admissions for childbirth if the Inpatient stay extends beyond 48 hours after a vaginal delivery or 96 hours after a cesarean section delivery.
- Injectable drugs listed on the Highmark WV website.
- Inpatient admissions (e.g. Skilled Nursing Facility, rehabilitation, behavioral health, long term acute).
- Outpatient procedures listed on the Highmark WV website.
- Outpatient therapies (physical, occupational, speech, chiropractic) after a specified number of Visits or Treatments.
- Potentially Experimental, Investigational or cosmetic Services.
- Pulmonary rehabilitation.
- Transplant Services.

C. CLAIMS PROCESS FOR INITIAL CLAIMS FOR BENEFITS

1. Pre-Service Claims

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 15 days from the receipt of the Claim. We may extend this period for another 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 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 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

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 24 hours after receipt of the Claim provided that any such Claim is made to us at least 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 VIII 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 a Claim is denied, in whole or in part, you will receive written notice with the following information:

- The specific reason or reasons for the decision;
- 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 statement of ERISA rights (to bring a civil action), if ERISA applicable, should the Claim be denied on appeal;
- 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; and
- A declaration that any scientific or clinical judgment involved in the decision and applied in the circumstances, if applicable (i.e. Medical Necessity, Experimental Treatment, etc.), will be provided free of charge upon request.

If Services are approved after appeal, payment of Claims will be dependent upon all provisions, limitations, and conditions of this Benefit Booklet. For instance, all Deductibles, Co-Insurance, Co-Pays and other limitations still apply.

E. APPEAL PROCEDURES

1. Standard Internal Appeal Process

Highmark WV maintains an internal Appeal process involving one (1) level of review.

- 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. For purposes of this Subsection, determinations made by Highmark WV to rescind a Member's coverage or to deny the enrollment request of an individual that Highmark WV has determined is ineligible for coverage under this Agreement, can also be appealed in accordance with the procedures set forth in this Subsection. The Member's appeal must be submitted within one hundred eighty (180) days from the date of the Member's receipt of notification of the 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 an Appeal.

- The Member, upon request to Highmark WV, may review all documents, records and other information relevant to the Appeal and 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 Appeal.

- Highmark WV will perform a new review and we will not assume the correctness of the original determination. The Appeal will be reviewed by a representative from Highmark WV. The representative 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. In rendering a decision on the Appeal, Highmark WV 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. For appeals of Adverse Benefit Determinations which were based on medical judgment, including Medical Necessity 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 Appeal will be promptly investigated and Highmark WV will notify you of our coverage decision by phone and will provide written notification of its decision within the following time frames regardless of outcome:

    i. When the Appeal 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;

    ii. When the Appeal involves an Urgent Care Claim, as soon as possible taking into account the medical exigencies involved but not later than seventy-two (72) hours following receipt of the Appeal; or

    iii. When the 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 Appeal.

- In the event that Highmark WV renders an adverse decision on the Appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding the right of the Member to request an external review

- If Highmark WV fails to provide notice of its decision within the above-stated time frames or otherwise fails to strictly adhere to these Appeal procedures, the Member shall be permitted to request an external review.

- There is a process for an expedited review, which is reserved for Urgent Care Claims. In such cases, you or your authorized representative (your family, your Provider or other designee) can request an expedited review by calling Highmark WV. We will arrange to have the Adverse Benefit Determination reviewed by a clinical peer reviewer as soon as possible, but no later than 72 hours after we receive your request for review.

2. **External Review Process**

a. Where the Claim that has been denied or the matter involved in the internal Appeal process relates to determinations made by Highmark WV to rescind a Member's coverage, the external review process will be as follows.

A Member will have four (4) months from the receipt of the notice of Highmark WV's decision to request an external review of the decision. The request shall be in writing unless the Member is required to file the request in an alternative format.

Requests for an external review may be filed at the following address:

For Rescissions and Enrollment Denials:
Highmark Blue Cross Blue Shield West Virginia
ATTN: Underwriting
P.O. Box 1948
Parkersburg, WV 26102-1948

All records from the initial review shall be forwarded to an external Independent Review Organization (IRO). The external review will be conducted by an IRO selected by Highmark WV or as otherwise required by law. We will notify the Member or the Provider of the name, address and telephone number of the IRO assigned within two (2) business days following receipt of the request for assignment. Additional material related to the issue which is the subject of the external review may be submitted by the Member, the Provider or Highmark WV. Each shall provide to the other, copies of additional documents provided.

b. Where the Claim that has been denied in the internal Appeal process is based on Highmark WV's requirements as to Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the Service, a Member or a Provider, with the written consent of the Member, may within four (4) months from the receipt of the notification of the decision, appeal the denial by filing a request for an external review with Highmark WV. The Member should include any material justification and all reasonably necessary supporting information as part of the external review filing.

For medical judgment including Medical Necessity or Experimental Treatment:
Highmark
P O Box 535095
Pittsburgh, PA 15253-5095
ATTN: Appeals Committee

For other types of appeals:
Highmark WV
ATTN: Member Services Appeals
P.O. Box 7026
Wheeling, WV 26003

Within five (5) business days of the filing of the request for an external review, Highmark WV will notify the Member or the Provider, as appropriate, that an external review request has been filed. Highmark WV shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision to the IRO conducting the external review within fifteen (15) days of the receipt of notice that the external review request was filed. Within this same period, the Highmark WV shall provide the Member or the Provider with a list of documents forwarded to the IRO for the external review. The Member or the Provider may supply additional written information, with copies to Highmark

WV, to the IRO for consideration on the external review within fifteen (15) days of receipt of notice that the external review request was filed.

The external review will be conducted by an IRO selected by Highmark WV, or as required by law. Highmark WV will notify the Member or the Provider of the name, address and telephone number of the IRO assigned within two (2) business days following receipt of the request for assignment. We will notify the Member or the Provider of the name, address and telephone number of the IRO assigned within two (2) business days following receipt of the request for assignment.

The IRO conducting the external review shall review all the information considered in reaching any prior decisions to deny payment for the Health Care Service and any other written submission by the Member or the care Provider.

Within sixty (60) days of the filing of the external review, the IRO conducting the external review shall issue a written notification of the decision to Highmark WV, the Member or the health care Provider, including the basis and clinical rationale for the decision.

Highmark WV shall authorize any Health Care Service or pay a Claim determined to be Medically Necessary and Appropriate based on the decision of the IRO.

Expedited External Review. If your situation meets the definition of an Urgent Care Claim, your external review will be completed as expeditiously as possible.

3. **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.

4. **Prescription Drug Claim Appeals**

You may dispute a Prescription Drug benefit decision 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 previously.

5. **Additional Levels of Appeal**

Members may have an additional level of voluntary Appeal in certain circumstances. If a voluntary level of Appeal for an Adverse Benefit Determination is offered:

- We will notify you of the availability of a voluntary level of Appeal in the notification of the Appeal decision;
- We will waive any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to any such voluntary level of Appeal provided by us;
- We agree that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary Appeal is pending;
- You may elect to submit a benefit dispute to such voluntary level of Appeal only after exhaustion of the Appeals permitted under the Standard Internal Appeal Section under the General Provisions portion of this Benefit Booklet.
- We will provide to you upon request sufficient information relating to the voluntary level of Appeal to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of Appeal, including a statement that the decision by you as to whether or not to submit a benefit dispute to the voluntary level of Appeal will have no

effect on the your rights to any other benefits under the plan and information about the applicable rules, your right to representation, the process for selecting the reviewer, and the circumstances, if any, that may affect the impartiality of the reviewer, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

- No fees or costs will be imposed on you as part of the voluntary level of Appeal.

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 WV, 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 to us as specified in Section V. When we approve this, we will give your Provider authorization for additional treatments or Services. The Services or number of additional treatments authorized will depend upon the treatment plan. We may need to request updated treatment plans as your treatment progresses. If a treatment plan is not submitted or approved, Services will be denied as not Medically Necessary and Appropriate. If you change Providers, a new treatment plan must be submitted. We will be flexible in allowing additional Visits while your treatment plan is being prepared or under review. A treatment plan typically involves a written course of Services and information to evaluate Medical Necessity and Appropriateness of proposed treatment(s). 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 and Appropriateness. 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 Network 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. 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 an Out-of-Network 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 .

You will typically Incur a higher Coinsurance percentage for Out-of-Network Services (Out-of-Network Coinsurance). Also, you may Incur an additional amount for Out-of-Network Liability. See the Provider Payment and Member Cost Sharing Section below and Section VIII for more specific details.

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 VII for how to verify a Provider's status.

3. Provider Status (Network or Non-Network)

Providers are designated as Network or Out-of-Network. The amount of benefits that you will receive for Covered Services may vary depending on whether the Provider is in the Network. You will receive greater benefits by seeking Covered Services from a Network Provider.
You will typically Incur a higher Coinsurance percentage for Out-of-Network Services (Out-of-Network Coinsurance). Also, you may Incur an additional amount for Out-of-Network Liability. See the How Claims are Paid Section below and Section VIII for more specific details.

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 applicable Deductibles, Coinsurances or Fees. Network Providers have the right to request proof that any required Deductible or other Covered Person cost sharing has been met before filing your Claim with Highmark WV. See Section III 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, Coinsurances and Out-of-Network Liabilities required under the Contract for Covered Services received from a Provider. See Section III for specific additional details.

This coverage shares the cost of your medical expenses with you. Each Benefit Period before we start to pay, you must pay a certain dollar amount of Covered Services at a Network or Out-of-Network Provider, as specified in Section IV. This front-end payment is your Deductible. Our records must show that you

have met this Deductible. Submit copies of all your bills, even those that you must pay to meet the Deductible.

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 pay is called the Coinsurance. When you receive Covered Services from an Out-of-Network Provider not otherwise approved by us, the amount that you pay is called the Out-of-Network Coinsurance. There are limits to the amount of Network and Out-of-Network Coinsurances for which you are responsible. The Deductible, Network and Out-of-Network Coinsurance amounts will renew each Benefit Period. Some of the benefits of this Benefit Booklet have a maximum amount payable each Benefit Period. In addition to any Deductibles and Coinsurances, you may also be responsible for an Out-of-Network Liability. The Out-of-Network Liability is not applied towards any Network or Out-of-Network Coinsurance limits.

Providers must bill you for all Network and Out-of-Network Coinsurances specified in this Benefit Booklet. If a Provider does not bill you for, or waives a Network or Out-of-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 Deductible, Network and Out-of-Network Coinsurances will be applied in the sequence that Claims are received and processed by us.

1. Out-of-Network Liability

In addition to those Deductibles and Coinsurances described above and elsewhere, you are responsible for some or all of the Charges in excess of the Plan Allowance for Covered Services received from an Out-of-Network Provider. Your Out-of-Network Liability is not capped by any Deductible or Coinsurance Limits or Maximum Out-of-Pocket.

2. 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 greater benefits when Services are received from a Network Provider:

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 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:

<u>Out-of-Network Providers Located in the Service Area</u>
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 Covered Person 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.

<u>Out-of-Area Providers</u>
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. When Highmark WV does not receive pricing from a local licensee, the Plan Allowance is determined by Highmark WV in its sole discretion and in most circumstances is unrelated to Actual Charges.

Any waiver of a Covered Person'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.

L. OUT-OF-AREA SERVICES

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 Health Care 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.

1. **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 Health Care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Health Care 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 Health Care 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.

2. **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.

3. **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.

4. **Nonparticipating Providers Outside Highmark WV's Service Area**

- **Member Liability Calculation**

  When Covered Services are provided outside of Highmark WV's Service Area by Nonparticipating Providers, the amount you pay for such Services will normally be based on either the Host Blue's Nonparticipating 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 Nonparticipating 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 Health Care Services had been obtained within our Service Area, or a special negotiated payment to determine the amount we will pay for Services provided by Nonparticipating Providers. In these situations, you may be liable for the difference between the amount that the Nonparticipating Provider bills and the payment Highmark WV will make for the Covered Services as set forth in this paragraph.

5. **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 Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield 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 Blue Cross Blue Shield 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 Blue Cross Blue Shield 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 service center or online at www.bcbsglobalcore.com. If you need assistance with your Claim submission, you should call the 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.

6. **Common Accident Deductible**

   Only one Covered Person's Deductible is required when two or more Covered Persons in a Eligible Employee'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.

M. HOW TO REPORT FRAUD

Fraud increases the cost of health care for everyone and increases your Group's 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 Group Health Plan 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.

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.
   - 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 IV (unless he / she is disabled and incapable of self-support).

If you have questions about the eligibility of a Dependent, check with your Group or call Member Services.

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.

NOTE: ***You can be prosecuted for fraud and your Group may take action against you 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 Group Health Plan.***

N. 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 Contract may be taken before the Grievance and Appeals 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.

O. NON-WAIVER PROVISION

Any failure of Highmark WV to enforce any term or condition of this Benefit Booklet shall not constitute a waiver in the future of any term or condition of this Benefit Booklet. Highmark WV may choose not to enforce any term or condition of this Group Health Plan. Such choice shall not constitute a waiver in the future of any such term or condition.

P. SEVERABILITY

If any portion of this Benefit Booklet shall be held invalid, illegal, or unenforceable for any reason, the remainder shall continue to be effective.

Q. GOVERNING LAW

This Benefit Booklet 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 Service 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. Received from other than a Provider.

5. Experimental or Investigational.

6. Not Medically Necessary and Appropriate. (See Sections V and VIII 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;
    - X-ray Medical imaging examinations made without film 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. Where 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, if 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, residential 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 here in.

24. Services related to Autism Spectrum Disorders.

25. Topical anesthetics or stand-by anesthesia, except as specified.

26. 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.

27. The treatment of 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.

28. 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.

29. Pet therapy, dance therapy, art therapy, nature therapy or any therapy which is not specifically listed as a Covered Service.

30. The treatment of sexual problems not caused by organic disease or physical trauma.

31. Reversal of sterilization.

32. Unless otherwise stated, other ova transfer procedures.

33. The treatment of cysts or abscesses associated with the teeth, dental X-rays, dentistry or any other dental processes, except as specified.

34. Appliances designed for orthodontic purposes such as braces, bionators, functional regulators, Frankel, and similar devices.

35. Personal hygiene and convenience items. Examples include diapers, cervical pillows, lift chairs, Jacuzzi's, exercise equipment and special linens, pillows, and air filters for allergy conditions.

36. 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.

37. Hearing aids.

38. Hypnosis, and acupuncture and massage therapy.

39. Telephone consultations, missed appointments, or completion of a Claim form.

40. Human organ transplant Services, other than as listed in this Benefit Booklet.

41. Fraudulent or misrepresented Claims.

42. Rehabilitation Services for Vocational Rehabilitation, long-term maintenance, or Custodial Care.

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 states, the treatment of Temporomandibular Joint Syndrom with intraoral prosthetic devices or by any other method to alter vertial dimension; for the treatment of Temporomandibular Joint dysfunction not caused by documented organic disease or physical trauma

46. Routine immunizations, except as specified.

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. Any Service for or related to surrogate motherhood unless the Services are otherwise eligible and provided to the Covered Person under the terms of the Group Health Plan.

49. Partial birth abortion.

50. Cloning or any Services related to cloning.

51. Cleft Palate Orthodontic treatment.

52. Injuries sustained while committing an illegal act or as a result of action on the part of any civil authority.

53. Defective Services or Supplies.

54. Services or Supplies in excess of any maximum limits or benefits.

55. Services excluded elsewhere in this Benefit Booklet.

56. Private Duty Nursing.

IX. Prescription Drug Benefits

Note: The Prescription Drug Deductible and Coinsurance applies to the health care coverage Deductible, Network and Non-Network Coinsurance Limits and the Lifetime Maximum. The terms and conditions of Sections I through IX shall apply to this Section X. In the event of a conflict, Section X shall control.

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 IV.

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 V, 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; and
   - 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. *Claim forms are available from your employee benefits department, or by calling the Member Services.*
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.

Remember: 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 a 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 Group 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 Group 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.

- *Requests for New Prescriptions online.*
  Refer to your packet for the internet address and how to register and order online.

  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.

9. 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**.

a. Coverage is provided for:

- Prescription Drugs, including Specialty Prescription Drugs obtained from a retail Pharmacy or through a mail order Pharmacy Provider;
- 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 only when:
- Dispensed through an Exclusive Pharmacy Provider; or
- Within, but not limited to, the following drug classifications only when such drugs are covered medications and when dispensed through an Exclusive Pharmacy Provider:
  - Oncology related therapies;
  - Interferons;
  - Agents for multiple sclerosis and neurological related therapies;
  - Anticoagulants;
  - Hematinic agents;
  - Immunomodulators;
  - Growth hormones; and
  - Hemophilia related therapies.

These selected Prescription Drugs may be ordered by a Professional Provider 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.

- **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 them on to you. 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 (Incentive Formulary)

Your Prescription Drug benefits may include a Formulary which is a list of Brand Name 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 Member Services 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 including compounded medications, consisting of the mixture of at least two ingredients other than water, one of which must be a legend drug that requires a pharmacist dispenses it);
- Prescribed injectable insulin;
- Diabetic Supplies, including needles and syringes; and
- Certain drugs that may require Prior Authorization.
- Long-term antibiotic therapy for Lyme disease.

Information on preventive prescription benefits (Retail or Mail Order) can be accessed at www.healthcare.gov. You may also contact Member Services. The guidelines are determined by certain governmental agencies

To get additional information regarding your Formulary or to obtain an exception form, please either visit www.highmarkbcbswv.com or contact Member Services. Their phone number is on the back of your ID Card.

Your program includes coverage for both formulary and non-formulary drugs.

C. RETAIL AND MAIL ORDER PRESCRIPTION DRUG MANAGEMENT

1. Preauthorization

Certain covered medications, as designed by the Plan, may require Preauthorization to ensure the Medical Necessity and Appropriateness of the prescription order. The Member's Physician must obtain Preauthorization from the Plan prior to the dispensing of the drug at a Network Pharmacy 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 then be dispensed by the Network Pharmacy Provider or through mail order, if applicable.

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 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.

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.

3. Quantity Level Limits

Quantity level limits may be imposed on certain Prescription Drugs. Such limits are based on the manufacturer's recommended daily dosage or as determined by us. 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 Pharmacy Provider may limit the amount dispensed.

D. EXCLUSIONS AND LIMITATIONS SPECIFIC TO PRESCRIPTION DRUGS

In addition to the exclusions in Section IV, 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 30-day supply of a Retail Prescription Drug.

6. More than a 90-day supply of a maintenance Prescription Drug through the Home Delivery (Mail Order) program.

7. Any Prescription Refill dispensed more than one year after the date of the original Prescription Order.

8. A Prescription Drug which is entirely consumed or administered at the time and place where the Prescription Order is issued.

9. 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.

10. 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.

11. Over the counter medications other than certain preventive drugs described in Section V - DESCRIPTION OF BENEFITS, Subsection. Preventive Care Services and only if prescribed in accordance with any State or Federal mandates.

12. 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.

13. More than the number of Prescription Refills specified by a Physician or Professional Other Provider.

14. Prescription Drugs for the Treatment of obesity or for weight reduction.

15. Prescription Drugs that are Experimental or Investigational for a given Treatment, as determined by us. Prescription Drugs that are part of an approved Clinical Trial may be covered.

16. Prescription Drugs not specified as Covered Services or which are specifically excluded in the text.

17. Prescription Drugs that are determined to be not Medically Necessary and Appropriate.

18. Prescription Drugs and over the counter drugs not listed in the formulary applicable to your program.

19. Prescription Drugs that are not FDA approved.

20. Food supplements.

E. PRESCRIPTION DRUG CLAIM APPEALS

You may dispute a Prescription Drug benefit decision 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 previously.

DEFINITIONS

Brand Name Prescription Drug. A Prescription Drug that has been patented and is only produced by one manufacturer.

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 Benefit Booklet, 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.

Incentive Formulary. A Prescription Drug program that pays benefits for Prescription Drugs on three levels. Prescription Orders filled with Generic Prescription Drugs receive the highest level of benefit, Preferred Drugs the second highest level of benefits, and non-Preferred drugs the lowest level of benefits

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 Group Health Plan'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 Drug Deductible. The amount of Actual Charges or the Prescription Drug Allowance for Covered Services, usually stated in dollars, for which you are responsible, before we start to pay..

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.

Discrimination is Against the Law

The claims administrator 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 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- 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 has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, 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.

Please note that your plan sponsor – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/program.

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).

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).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

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

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).

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).

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.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

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

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (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).

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).

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.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณ โดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुनुछन्। तपाईको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

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