

# HEALTH CARE BENEFITS

FOR

**Marshall Health - Main**

Administered By:



**An Independent Licensee of the Blue Cross and Blue Shield Association**

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**YOUR HEALTH CARE BENEFITS  
AND  
HOW TO USE THEM**

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**Super Blue Plus<sup>sm</sup>  
Comprehensive Major Medical  
Health Care Benefit Booklet  
with  
Prescription Drug**

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# **I. Health Care Benefit Booklet**

## **A. GROUP CONTRACT AND BENEFIT BOOKLET**

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**. The benefits provided under the Contract are referred to as **Plan or Group Health Plan**. 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](http://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 Section II and Section VII. 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](http://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. Receive advance explanation of benefits (EOBs) for Covered Services from a particular Provider. EOBs will include, among other items deemed necessary by Highmark WV, information regarding whether the provider is a Network or Out-of-Network Provider; a good faith estimate of the Plan Allowance, your applicable Cost-sharing and impact on the Deductible and Out-of-Pocket accumulations; and whether any medical management requirements apply.

### ***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, Prescription Drug, 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.

#### **G. HEALTH IMPROVEMENT SERVICES AND SUPPORT**

From time to time, we may directly or indirectly make available to you information and access to non-medical items, services and support programs designed to address underlying social and environmental factors that may negatively impact your health status. Information, items, services and support programs will not affect your continued eligibility, your premium, or reduce your benefits.

## 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;
- Suppliers, and
- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists.

**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.

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

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

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

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

**Autism Spectrum Disorder.** Any pervasive developmental disorder, including Autism Spectrum Disorder, Asperger's Syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

**Balance Bill/Billing.** Generally, the practice wherein a Provider bills a patient directly for the balance remaining for services rendered following a Health Plan's payment.

**Behavioral Health/Mental Health Condition.** A condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of: (1) The International Statistical Classification of Diseases and Related Health Problems; (2) The Diagnostic and Statistical Manual of Mental Disorders; or (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.

**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.

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

**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 Eligible Employee.

**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.

**Cranio-mandibular 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.

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

**Dependent.** See Eligible Dependent.

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

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

**Designated Agent.** An entity that has contracted, either directly or indirectly, with Highmark WV to perform a function and/or serve 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.

**Emergency Care Services/Emergency 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: 1) placing the member's health, or with respect to a pregnant member, the health of the member or the unborn child in serious jeopardy, 2) causing serious impairment to bodily functions, 3) 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.

Emergency Services includes medical screening exams, treatment and examination to stabilize a patient (regardless of whether this occurs in the emergency room or another hospital department), post-stabilization inpatient and outpatient stays, outpatient observation (unless an exception applies), and air ambulance services.

**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
- Dialysis Facility
- Substance Use Disorder Treatment Facility
- Freestanding Renal Dialysis Centers
- Home Health Care Agency
- Hospice
- 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.

**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 Program.** A time-limited, separate and distinct Outpatient program that includes individual therapy, family therapy, group therapy and medication management following an individualized treatment plan. Participation in an Intensive Outpatient Program may involve two (2) or more hours of programming a week. The program may be offered during the day or evening hours and can be a step-down from a higher level of care or a step-up to prevent the need for a higher level of care. The goals of an Intensive Outpatient Program are to prevent or reduce the need for Inpatient hospitalization and to reduce or stabilize symptoms and functional impairment of a psychiatric or co-occurring substance use disorder. Medically Necessary treatment is provided within a structured therapeutic environment.

**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.

**Mental Health Condition.** See Behavioral Health/Mental Health Condition.

**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 Based Opioid Treatment Program.** An Outpatient treatment program for the treatment of opioid use disorder. This program is also known as medication assisted treatment.

**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.

**Outpatient Substance Use Disorder Treatment Facility.** A Facility Other Provider which, for compensation from its patients, is primarily engaged in providing Detoxification Services and/or rehabilitative counseling services for the treatment of Substance Use Disorder and diagnostic and therapeutic services for the treatment of Substance Use Disorder on an Outpatient basis. This Facility must also meet the minimum standards set by appropriate governmental agencies.

**Opioid Treatment Program.** An Outpatient treatment program for the treatment of severe opioid use disorder. The program consists of daily or several times weekly medication and counseling available to maintain stability for those with severe opioid use disorder.

**Partial Hospitalization Program.** A time-limited, Outpatient treatment program that is offered in the day or evening hours for a minimum of four (4) hours per day, three (3) days per week. A Partial Hospitalization Program is a less restrictive alternative to Inpatient hospitalization for individuals presenting with acute symptoms of a severe psychiatric disorder who cannot be effectively or safely treated in a lower level of care, and would otherwise require Inpatient treatment. The goals of a Partial Hospitalization Program are to prevent or reduce the need for Inpatient hospitalization or re-hospitalization following discharge from Inpatient treatment and to reduce or stabilize symptoms and functional impairment of a psychiatric or co-occurring substance use disorder. Medically Necessary treatment is provided within a structured therapeutic environment.

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

**Participating Provider.** A provider who, under a contract with Highmark WV or with its 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, except for covered Emergency Care Services, approved exceptions, and for Covered Services delivered by Out-of-Network Providers who provide Covered Services at a Network Hospital or Facility. 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, or as required by law. 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.

If you receive covered Emergency Services or non-Emergency Services rendered at a Network Hospital or Facility by an Out-of-Network Provider (also known as an "invisible provider") and receive a Provider bill for those services (also known as a "surprise bill") the Plan Allowance shall be based on the qualifying payment amount, which is generally the carrier's historical median Network rate for relevant like Services rendered by a Network Provider in the same geographic region.

- 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, vision care, and Telemedicine 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 | • Nurse Practitioner |
| • Dentist                                | • Nurse-midwife      |
| • Doctor of chiropractic medicine        | • Physical therapist |

- 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.)
- Physician's assistant
- Podiatrist
- Psychologist
- Psychotherapist
- Registered nurse (R.N.)
- Social worker

**Provider.** A Hospital, Facility Other Provider, Physician or Professional Other Provider, or Ancillary 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 Hospital.** A Facility Other Provider approved by The Joint Commission, the American Osteopathic Hospital Association, Council on Accreditation or Commission on Accreditation of Rehabilitation Facilities which, for compensation from its patients, is primarily engaged in providing diagnostic 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. Continuous nursing services are 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 licensed psychiatric residential facility that provides medical monitoring and twenty-four hour individualized treatment to a group of individuals. The treatment is provided by paid staff unrelated to the individual. A Residential Treatment Program must provide the following:

- Awake adult supervision twenty-four hours per day;
- Clinical assessment at least once a day;
- Individual, group, or family therapy at least three times per week;
- Medical history and physical examination of patient within six months prior to admission or within thirty days after admission;
- Review of patient's current medication(s) initiated within twenty-four hours;
- Initiation of a multidisciplinary treatment plan within one week;
- Nursing staff on-site or on-call twenty-four hours per day;
- Parent training for patient's parents/guardians or family if return to family is expected;
- Discharge planning initiated within twenty-four hours;
- Psychiatric evaluation/updated (initial within one business day, updates at least once a week);

- Psychosocial assessment and substance evaluation within forty-eight hours;
- School or vocational program as per the clinical needs and/or age of the patient; and
- Toxicology screen, quantitative drug analysis, self-help, 12-step, or education group as needed.

**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 or Complex Medical Condition.** In the case of an acute condition, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling or congenital, and requires specialized care over a prolonged period of time.

**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 Facility Other Provider approved by an external accreditation body (i.e., The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation) which, for compensation from its patients, is primarily engaged in providing detoxification and/or rehabilitation treatment for alcohol abuse and/or drug abuse. This Facility must also meet the minimum standards set by appropriate governmental agencies.

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

**Supply.** See Service.

**Surgery.**

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

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

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

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

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

- **Radiation Therapy.** The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

- **Chemotherapy.** The treatment of malignant disease by chemical or biological antineoplastic agents.
- **Dialysis Treatments.** The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.
- **Respiratory Therapy.** Introduction of dry or moist gasses into the lungs for treatment purposes.
- **Hyperbaric and Pulmonary Therapy.** The administration of oxygen in a pressurized chamber. Under pressurization, oxygen levels are increased.
- **Infusion Therapy.** The treatment by 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.

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

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

**Visit(s).** When a Covered Service is limited to a maximum number of Visits, Visit refers to one session or appointment with a Physician, Professional Other Provider, Hospital, or Facility Other Provider, regardless of the number of Treatments or Services provided during that Visit. See Section IV of this 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; or
- 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's 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's spouse.
  - Children for whom either the Eligible Employee or the Eligible Employee's 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 26<sup>th</sup> 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 Enrollment 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 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, their Eligible Dependent(s), shall become Covered Person(s) effective on the date they first becomes an Eligible Employee (the Covered Person's "Enrollment Date"), or as determined by your employer. Please contact your employer for additional eligibility information. 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.

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 III. 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.

***NOTE: 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 not continued under your former employer's Group Contract and you are not eligible for Medicare, you may be eligible for coverage under our individual conversion product. Coverage under the conversion coverage 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 III, Subsection Q.
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; 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 they are 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 coverage 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 coverage 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. 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](http://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;
- Handicap accessibility;
- Languages spoken; or
- Gender.

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

## **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**

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 providing the Services is a Network Provider or an 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 Network Services.

Once you can travel using non-medical or non-emergency medical transport and are in a condition to receive notice of, and to consent to, Out-of-Network Services, immediately required post-evaluation or post-stabilization services will no longer qualify as Emergency 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 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.

The Out-of-Network Coinsurance Limit is in addition to your Network Coinsurance Limit. After your Out-of-Network Coinsurance Limit is satisfied, benefits for Covered Services 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**

When the maximum amount of expenses Incurred for Deductibles, Coinsurance and Copayments, 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 Member 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, except for Emergency Services and approved exceptions.

#### **10. Out-of-Network Providers at Network Hospitals or Facilities**

If you receive Emergency Services or non-emergency Services, rendered at a Network hospital or Facility by an Out-of-Network Provider (also known as an invisible provider) and receive a Provider bill for those services (also known as a “surprise bill”) you will only be responsible for the Network Cost-share applicable to the Covered Service and the Out-of-Network Provider cannot Balance Bill you for the difference between the Provider’s charged amount and Highmark WV’s payment.

#### **11. 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.

#### **12. 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.

Members who choose to use Out-of-Network Providers can execute waivers with their Providers to accept responsibility for charges in excess of the applicable Plan Allowance unless the services performed are related to Emergency Services including air ambulance services, anesthesiology, pathology, radiology, neonatology, diagnostic testing, and services provided by assistant surgeons, hospitalists and intensivists.

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

**Super Blue Plus 2010<sup>1</sup>**  
**University Physicians & Surgeons, Inc.**  
**dba Marshall Health**  
**SUMMARY OF BENEFITS**

Effective Date	July 1, 2023		
Benefit Period (used for Deductible and Coinsurances limits and certain benefit frequencies.)	Contract Year <sup>2</sup>		
Note: All Services are subject to the Deductible unless otherwise specified.			
Deductible (Enhanced and Standard cross apply. Non-Network does not cross apply) Individual Family (may be met collectively)	ENHANCED	STANDARD	NON-NETWORK
	\$300	\$1,000	\$1,500
	\$600	\$2,000	\$3,000
Carry-Over Deductible Period	NONE		
Coinsurance Limit: (Enhanced/Standard and Non-Network Coinsurance do cross apply. Does not include Deductible) Individual Family (may be met collectively)	ENHANCED	STANDARD	NON-NETWORK
	\$2,500	\$3,000	\$5,000
	\$5,000	\$6,000	\$10,000
Total Maximum Out-of-Pocket <sup>6</sup> (Includes Deductible, Copays, and Coinsurance per Benefit Period, Enhanced and Standard only) Individual Family (may be met collectively)	ENHANCED	STANDARD	NON-NETWORK
	\$4,500		Not Applicable
	\$9,000		Not Applicable
Non-Network Liability	UNLIMITED		
Lifetime Maximum Benefit for all Covered Services	UNLIMITED		
BENEFIT HIGHLIGHTS			
	ENHANCED	STANDARD	NON-NETWORK
Primary Care Medical Office Visit / Office Consultation (Includes Primary Care Virtual Visits) Co-Pay applies to Charges for Visit only. Does not apply to other Services received during Visit. Co-Pays do not apply to Deductible or Coinsurance limits.	\$0 Co-Pay per Office Visit, 100% thereafter, No Deductible	\$30 Co-Pay per Office Visit, 100% thereafter, No Deductible	60%
Specialist Care Medical Office Visit / Office Consultation (Includes Specialist Virtual Visits) Co-Pay applies to Charges for Visit only. Does not apply to other Services received during Visit. Co-Pays do not apply to Deductible or Coinsurance limits.	\$20 Co-Pay per Office Visit, 100% thereafter, No Deductible	\$50 Co-Pay per Office Visit, 100% thereafter, No Deductible	60%
Telemedicine Service (Only through Well360 Virtual Health) <sup>4</sup>	\$10 per Visit, 100% thereafter, No Deductible		No Benefits
Urgent Care Center Visits Co-Pay applies to Charges for Visit only. Does not apply to other Services received during Visit. Co-Pays do not apply to Deductible or Coinsurance limits.	\$0 Co-Pay per Office Visit, 100% thereafter, No Deductible	\$75 Co-Pay per Office Visit, 100% thereafter, No Deductible	60%
Virtual Visit Originating Site	100%	80%	60%

# **PRESCRIPTION DRUGS<sup>7</sup>**

Prescription Drug Deductible Individual Family	ENHANCED	STANDARD	NON-NETWORK
	\$0 \$0	\$50 \$100	No Benefits No Benefits
<b>Prescription Drugs: 1-34 Day Supply</b> If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowances, in addition to the Co-Pay or Coinsurance, unless the Physician writes 'Brand Necessary' (DAW) on the prescription, or if no generic equivalent exists. <b>Note:</b> Prescription Deductibles, Copayments and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket	<b>1-34 Day Supply</b> Member Pays: \$0 Co-Pay – Generic \$20 Co-Pay – Formulary 25% Non-Formulary Brand 35% up to \$200 maximum – Specialty Medication	<b>1-34 Day Supply</b> Member Pays: \$5 Co-Pay – Generic \$20 Co-Pay – Formulary 25% Non-Formulary Brand 35% up to \$200 maximum – Specialty Medication	No Benefits
<b>Prescription Drugs: 35-90 Day Supply</b> If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowances, in addition to the Co-Pay or Coinsurance, unless the Physician writes 'Brand Necessary' (DAW) on the prescription, or if no generic equivalent exists. <b>Note:</b> Prescription Deductibles, Copayments and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket	<b>35-90-Day Supply</b> Member Pays: \$0 Co-Pay – Generic \$50 Co-Pay Formulary 25% Co-Pay Non-Formulary Brand 35% up to \$200 maximum – Specialty Medication	<b>35-90-Day Supply</b> Member Pays: \$12 Co-Pay – Generic \$50 Co-Pay Formulary 25% Co-Pay Non-Formulary Brand 35% up to \$200 maximum – Specialty Medication	No Benefits
<b>Mail Order - Maximum 90 day Supply</b> If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowances, in addition to the Co-Pay or Coinsurance, unless the Physician writes 'Brand Necessary' (DAW) on the prescription, or if no generic equivalent exists. <b>Note:</b> Prescription Deductibles, Copayments and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket	N/A	90 Day Supply Member Pays: \$12 Co-Pay – Generic \$50 Co-Pay – Formulary 25% Non-Formulary Brand 35% up to \$200 maximum – Specialty Medication	No Benefits
<b>Additional Preventive Prescription Benefits<sup>5</sup></b> (Retail or Mail Order). Guidelines as determined by certain Governmental Agencies. You may access this information at <a href="http://www.healthcare.gov">www.healthcare.gov</a> . You may also contact Member Services.	100%, No Deductible		No Benefits



## PREVENTIVE CARE SERVICES<sup>5, 9</sup>

### Routine Adult

Physical exams	100%, No Deductible		60%
Adult immunizations	100%, No Deductible		60%
Colorectal cancer screening	100%, No Deductible		60%
Routine gynecological exams, including a Pap Test	100%, No Deductible		60%
Mammograms, annual routine and medically necessary	Routine: 100%, No Deductible		60%
	Medically Necessary: 100% after deductible	Medically Necessary: 80% after deductible	
Diagnostic services and procedures	100%, No Deductible		60%

### Routine Pediatric

Physical exams	100%, No Deductible		60%
Pediatric immunizations	100%, No Deductible		60%
Diagnostic services and procedures	100%, No Deductible		60%

## AUTISM SPECTRUM DISORDER<sup>3, 9</sup>

Services for diagnosis and treatment of Autism Spectrum Disorder (See Section V for additional information). Note: Covered Services will be paid according to the benefit category (e.g. Speech Therapy, Office Visit, etc.)	90%	80%	60%
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PHYSICIAN SERVICES <sup>9</sup>			
	ENHANCED	STANDARD	NON-NETWORK
In-Hospital Medical Visit	90%	80%	60%
Skilled Nursing Facility Medical	90%	80%	60%
Surgery, Assistant to Surgery, Anesthesia	90%	80%	60%
Second Surgical Opinion Consultations (Outpatient)	\$100 Co-Pay per visit, 90% thereafter		
Maternity Care - Dependent daughters are covered.	100%	80%	60%
Newborn Care including circumcision.	100%	80%	60%
Occupational Therapy (Rehabilitative and Habilitative) - Maximum 30 visits per Benefit Period. Limitations are for Physician & Outpatient Facility, Enhanced, Standard and Non Network, Rehabilitative and Habilitative, combined.	80%		60%
Physical Therapy (Rehabilitative and Habilitative) - Maximum 30 visits per Benefit Period. Limitations are for Physician & Outpatient Facility, Enhanced, Standard and Non Network, Rehabilitative and Habilitative, combined.	80%		60%
Spinal Manipulations (Rehabilitative and Habilitative) – Maximum 30 visits per Benefit Period. Limitations are for Enhanced, Standard and Non Network, Rehabilitative and Habilitative, combined.	80%		60%
Respiratory Therapy	80%		60%
Cardiac Rehabilitation Therapy	80%		60%
Dialysis	80%		60%
Chemotherapy	80%		60%
Radiation Therapy	80%		60%
Infusion Therapy	80%		60%
Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition.	80%		60%
Temporomandibular Joint Dysfunction / Craniomandibular Disorders	100%	80%	60%
Diagnostic, X-ray, Lab and Testing	100%	80%	60%
Allergy Testing and Treatment	100%	80%	60%
INPATIENT HOSPITAL / FACILITY SERVICES <sup>10</sup>			
Unlimited Days Semi-Private Room and Board	\$100 Co-Pay per admission 90% thereafter	\$100 Co-Pay per admission 80% thereafter	\$100 Co-Pay per admission 60% thereafter
Ancillaries, Drugs, Therapy Services, X-ray and Lab	\$100 Co-Pay per admission 90% thereafter	\$100 Co-Pay per admission 80% thereafter	\$100 Co-Pay per admission 60% thereafter
General Nursing Care	\$100 Co-Pay per admission 90% thereafter	\$100 Co-Pay per admission 80% thereafter	\$100 Co-Pay per admission 60% thereafter
Surgical Services	\$100 Co-Pay per admission 90% thereafter	\$100 Co-Pay per admission 80% thereafter	\$100 Co-Pay per admission 60% thereafter
Birthing Center Care / Maternity Services - Dependent daughters are covered.	\$100 Co-Pay per admission 100% thereafter	\$100 Co-Pay per admission 80% thereafter	\$100 Co-Pay per admission 60% thereafter

OUTPATIENT HOSPITAL / FACILITY SERVICES <sup>9</sup>			
	ENHANCED	STANDARD	NON-NETWORK
Pre-Admission Testing	100%	80%	60%
Diagnostic, X-ray, Lab and Testing	100%	80%	60%
Surgery, Operating Room	100%	80%	60%
Occupational Therapy (Rehabilitative and Habilitative) - Maximum 30 visits per Benefit Period. Limitations are for Physician & Outpatient Facility, Enhanced, Standard and Non Network, Rehabilitative and Habilitative, combined.	80%		\$100 Co-Pay per visit, 60% thereafter
Physical Therapy (Rehabilitative and Habilitative) - Maximum 30 visits per Benefit Period. Limitations are for Physician & Outpatient Facility, Enhanced, Standard and Non Network, Rehabilitative and Habilitative, combined.	80%		\$100 Co-Pay per visit, 60% thereafter
Respiratory Therapy	\$100 Co-Pay per visit, 80% thereafter		60%
Cardiac Rehabilitation Therapy	\$100 Co-Pay per visit, 80% thereafter		60%
Dialysis	\$100 Co-Pay per visit, 80% thereafter		60%
Chemotherapy	\$100 Co-Pay per visit, 80% thereafter		60%
Radiation Therapy	\$100 Co-Pay per visit, 80% thereafter		60%
Infusion Therapy	\$100 Co-Pay per visit, 80% thereafter		60%
Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition.	\$100 Co-Pay per visit, 80% thereafter		\$100 Co-Pay per visit, 60% thereafter
BEHAVIORAL HEALTH SERVICES <sup>9</sup>			
Outpatient Mental Health Services	100%	80%	60%
Outpatient Substance Use Disorder	100%	80%	60%
Inpatient Mental Health Care Services	\$100 Co-Pay per admission 100% thereafter	\$100 Co-Pay per admission 80% thereafter	\$100 Co-Pay per admission 60% thereafter
Inpatient Substance Use Disorder	\$100 Co-Pay per admission 100% thereafter	\$100 Co-Pay per admission 80% thereafter	\$100 Co-Pay per admission 60% thereafter
EMERGENCY CARE SERVICES			
	ENHANCED	STANDARD	NON-NETWORK
Emergency Accident Care and /or Emergency Medical Care provided in the ER <sup>10</sup>	\$150 Co-Pay per visit, 80% after Enhanced Deductible Co-Pay waived if admitted		
Emergency Ambulance (ground, water, air)	90%, No Deductible		
NON-EMERGENCY CARE SERVICES			
Non-Emergency Medical Care provided in the ER	\$200 Co-Pay per visit, 80% after Enhanced Deductible		
Non-Emergency Ambulance Services (ground, water) <sup>8</sup>	80%	80%	60%
Non-Emergency Ambulance Services (air)	80%, after Enhanced Deductible		
OTHER COVERED SERVICES <sup>9</sup>			
Private Duty Nursing – Maximum 35 visits per Benefit Period Note: Maximums are Enhanced, Standard and Non Network combined.	80%		60%
Skilled Nursing Facility	80%		60%
Durable Medical Equipment and Oxygen at home	80%		60%
Orthotic Devices and Prosthetic Appliances	80%		60%
Home Health Care – Maximum100 Visits per Benefit Period Note: Maximums are Enhanced, Standard and Non Network combined.	80%		60%
Hospice Care	100%		60%
Diabetes Education and Control	100%	80%	60%

## HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES

<b>Human Organ Transplant</b> • Includes transportation, meals and lodging	90%	80%	60%
<b>Bone Marrow Procedures</b> • Includes transportation, meals and lodging	90%	80%	60%

<b>Eligible Dependent Age Limitation</b>	Coverage stops at the end of the month of the 26 <sup>th</sup> birthday for an adult Dependent who qualifies as an Eligible Dependent.
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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.

<sup>1</sup> 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. Please note that certain outpatient procedures also require prior authorization. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that your services are not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

<sup>2</sup> 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.

<sup>3</sup> After initial evaluation, Applied Behavioral Analysis will be covered as specified above. All other covered services for the treatment of autism spectrum disorders will be covered according to the benefit category (e.g speech therapy, diagnostic services). Treatment for autism spectrum disorders does not reduce visit/day limit.

<sup>4</sup> Telemedicine services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark approved telemedicine vendor. Additional services provided by a Highmark approved Telemedicine vendor are paid according to the benefit category that they fall under (e.g.PCP is eligible under the PCP office visit benefit, behavioral health is eligible under outpatient mental health).

<sup>5</sup> Services are limited to those listed on the Highmark WV Preventive Schedule (Women's Health Preventive Schedule may apply).

<sup>6</sup> 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.

<sup>7</sup> 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. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft 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, unless your doctor requests that the brand drug be dispensed. Anti-Cancer medications orally administered or self-injected. Deductible, copayment and coinsurance amounts for patient administered anti-cancer medications that are covered benefits are applied on no less favorable basis than for provider injected or intravenously administered anti-cancer medications. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment.

<sup>8</sup>Unless otherwise provided for benefits for emergency ambulance services rendered by a non-network provider will be subject to the same cost-sharing amount, if any, that is applicable to network services. The member will be responsible for any amounts billed by the non-network provider for non-emergency ground and water ambulance services that are in excess of the amount that Highmark WV pays.

<sup>9</sup>Covered virtual services will be paid according to the benefit category (e.g., primary care provider office visit, maternity visit, etc.) For example, virtual visits relating to the treatment of mental illness or substance use disorder are covered under your outpatient mental health and substance use disorder benefit and subject to the cost sharing amount in this schedule of benefits.

<sup>10</sup>Benefits for care services rendered by an out-of-network provider will be paid at the highest network level of benefits. Benefits for hospital services or medical care services rendered by an out-of-network provider to a member requiring an inpatient admission or observation immediately following receipt of emergency care services will be paid at the highest network level of benefits. The member will not be responsible for any amounts billed by the out-of-network provider that are in excess of the plan allowance for such services.



## 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](http://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. AUTISM SPECTRUM DISORDER**

Treatments include those that are ordered or prescribed by a licensed Physician or licensed Psychologist in accordance with a treatment plan developed from a comprehensive evaluation by a Certified Behavior Analyst for an individual diagnosed with Autism Spectrum Disorder. See Section VII for information regarding treatment plans. Treatment may include, but not be limited to, Applied Behavioral Analysis provided or supervised by a Certified Behavioral Analyst.

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

## **D. BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE**

For purposes of mental health parity, Behavioral Health Condition, Mental Health Condition, and Substance Use Disorder means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of: (1) The International Statistical Classification of Diseases and Related Health Problems; (2) The Diagnostic and Statistical Manual of Mental Disorders; or (3) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, including Autism Spectrum Disorder.

### **1. Behavioral Health Services/Mental Health Services**

#### **a. Inpatient Facility Services**

Hospital Services are provided for the Inpatient treatment of Mental Health Conditions by a Facility Other Provider. Inpatient Facility Services must be provided twenty-four hours a day, seven days a week by or under the direction of a psychiatrist, a psychiatric nurse practitioner or a Psychologist when legally authorized by the state. Inpatient Facility Services are recommended for patients who are an acute danger to themselves or others and who are unable to provide required self-care and lack available support.

#### **b. Inpatient Medical Services**

The following Services are provided for the Inpatient treatment of Mental Health Conditions by a Professional Provider:

- Individual psychotherapy;
- Group psychotherapy;
- Family counseling; counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Policy. Charges will be applied to the Covered Person who is receiving family counseling Services, not necessarily the patient;
- Electroshock Therapy or convulsive drug Therapy and related anesthesia when administered concurrently with the treatment by the same Professional Provider.;
- Psychological testing; and
- Medication management,

#### **c. Partial Hospitalization Program**

Benefits are only available for Mental Health Care Conditions provided on a Partial Hospitalization basis when received through a Partial Hospitalization Program. Services



provided on a Partial Hospitalization basis shall be deemed an Outpatient care Visit subject to Outpatient care cost-sharing amounts.

**d. Outpatient Mental Health Care Services**

Inpatient Facility Services and Inpatient Medical Services as described in this Subsection are also available when provided for the Outpatient treatment of Mental Health or Behavioral Health Condition/Disorder by a Facility Other Provider, or a professional provider. Benefits are also provided for Mental Health Care Services received through an Intensive Outpatient Program.

**2. Substance Use Disorder Services**

Benefits are provided for Detoxification Services (withdrawal management), individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of Substance Use Disorder when rendered to a Member by a Facility Other Provider or professional provider and include the following:

**a. Detoxification Services rendered:**

- on an Inpatient basis in a Hospital or Substance Use Disorder Treatment Facility; or
- on an Outpatient basis;

**b. Substance Use Disorder Treatment Facility Services for non-Hospital Inpatient residential treatment and rehabilitation Services.** Residential treatment and rehabilitation Services include medically monitored high intensity Inpatient Services with twenty-four hour nursing care and Physician availability and medically managed intensive Inpatient Services with twenty-four hour nursing care and daily Physician oversight; and

**c. Outpatient Services rendered in a Hospital, Substance Use Disorder Treatment Facility, Outpatient Substance Use Disorder Treatment Facility, or through an Intensive Outpatient Program or Partial Hospitalization Program for rehabilitation therapy.** For purposes of this benefit, a Substance Use Disorder Service provided on a Partial Hospitalization basis shall be deemed an Outpatient care Visit subject to Outpatient care cost-sharing amounts. Benefits are also provided for Substance Use Disorder Services rendered through an Opioid Treatment Program or Office Based Opioid Treatment Program.

**E. BONE MARROW PROCEDURES**

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

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

Covered Services include the following.

- Bone marrow donation and storage;
- Pre-transplant Chemotherapy and/or Radiation treatment;
- Bone marrow or peripheral stem cell transplant;
- Post-transplant Outpatient care directly related to the transplant;
- 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 five (5) days prior to a transplant and ends twelve (12) months after the date of the transplant. Reimbursement applies to recipient (adult) and one other person. If the recipient is a minor, two adults are covered.

## **F. 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 management programs as deemed appropriate from time to time by us. Care management programs may include, but are not limited to, disease or other health condition monitoring, consultations with health care Providers or other health care professionals participating in the care management program, health coaching, medication management and optimization.

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.

## **G. 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.

## **H. 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.

## **I. 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.

## **J. DIAGNOSTIC SERVICES**

Diagnostic Services include:

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

## **K. EMERGENCY CARE SERVICES**

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

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

Transportation and related Emergency Services provided by an Ambulance Service shall constitute Emergency Ambulance Service if the injury or the condition satisfies the criteria above. Use of an Ambulance as transportation to an Emergency Room of a Facility Provider for an injury or condition that does not satisfy the criteria above will not be Covered as Emergency Ambulance Services.

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

In the event that the Member requires Emergency Services, all benefits will be provided at the Network Services level of benefits. Once you can travel using non-medical or non-emergency medical transport and are in a condition to receive notice of, and to consent to, Out-of-Network Services, immediately required post-evaluation or post-stabilization services will no longer qualify as Emergency Services, and 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.**

## **L. 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).

## **M. 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;
- Behavioral Health or Substance Use Disorder Services;
- Private duty nursing; and
- Personal comfort items.

## **N. 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 if your coverage includes Prescription Drug coverage. Contact Medical Management for additional information. Their phone number is located on the back of your ID Card.

## **O. 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; and
- Chemotherapy or Radiation Therapy if other than palliative.

## **P. 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.
- Therapy Services.
- Pathology.

- Radiology.
- Neonatology.
- Items and services provided by assistant surgeons, hospitalists, and intensivist.

**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 if your coverage includes Prescription Drug coverage and only when received from a Network Pharmacy Provider.
- 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.
- Pathology.
- Radiology.
- Neonatology.
- Items and services provided by assistant surgeons, hospitalists, and intensivist.

### **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.

## **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. Benefits for certain Infusion Therapy Prescription Drugs as identified by Highmark WV and which are appropriate for self-administration, will be provided only if your coverage includes Prescription Drug coverage. Contact



Medical 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. MATERNITY SERVICES**

Hospital, medical and surgical Services for a normal pregnancy and complications of pregnancy, miscarriage, and therapeutic and elective abortions are Covered Services. Coverage includes procedures, equipment, Services, Supplies, or Charges for abortions, to the extent permitted by state and federal law. Coverage includes procedures, equipment, Services, Supplies, or Charges for abortions, to the extent permitted by state and federal law. Coverage for non-elective abortion is limited to those necessary to avert the death of the Member or to terminate pregnancies caused by rape or incest. These are Covered Services for the Eligible Employee and all Eligible Dependents. These are not Covered Services if the Eligible Employee or Eligible Dependent 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.

## **T. 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 appliance;
- 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.

## U. ORGAN TRANSPLANT SERVICES

The following human organ transplants are Covered Services:

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

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

Benefits will be provided for:

- Expenses of the recipient directly related to the transplant procedure. This includes pre-operative care and post-operative care, and immunosuppressant drugs.
- Expenses for the acquisition, transportation, and storage costs directly related to the donation of a human organ to be used in a covered organ transplant procedure.
- Re-transplantation.
- 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 five (5) days prior to a transplant and ends twelve (12) months after the date of the 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.

## V. OUTPATIENT MEDICAL CARE SERVICES

Medical care rendered by a Professional Provider to a Member who is an Outpatient for a condition not related to Surgery, Maternity, Behavioral Health, 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, Behavioral Health, or Substance Use Disorder please refer to those benefit categories within the Description of Benefits Section.

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

## **W. PRESCRIPTION DRUG CLAIMS**

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.

## **X. PREVENTIVE CARE SERVICES**

**NOTE: In addition to the Covered Services listed below, there are other routine screening, immunization and Diagnostic Services covered as afforded by the Patient Protection and Affordability Care Act (PPACA). For additional information, go to [www.healthcare.gov](http://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.**

## **Y. PRIVATE DUTY NURSING SERVICES**

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

## **Z. REHABILITATION SERVICES**

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

### **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 Vocational Rehabilitation, or long-term maintenance or custodial Services.***

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

## **AA. SKILLED NURSING FACILITY SERVICES**

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

No benefits are payable:

- Once a patient can no longer significantly improve from treatment for the current condition as determined by us:
- For Custodial Care; or
- Solely for the treatment of Behavioral Health or pulmonary tuberculosis.

## **BB. 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. Diabetes Treatment**

### **a. Services and Supplies**

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

- Blood glucose monitors and monitor Supplies; (paid under your durable medical equipment (DME) benefits);
- Insulin infusion devices; (paid under your DME benefits);
- Insulin (Cost-sharing for Prescription Insulin Drugs are paid under your Prescription Drug benefits and will not exceed \$100 for a 30 day supply, if applicable);
- Syringes and insulin injection aids or devices; (paid under your Prescription Drug benefits, if applicable);
- Pharmacological agents for controlling blood sugar (paid under your Prescription Drug benefits, if applicable);
- 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.***

### **b. Diabetes Education Program**

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 dietitians.

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

**c. Diabetes Care Management Program (Digitally Monitored)**

Members who have been diagnosed with type 2 diabetes and who meet other program and clinical criteria have the option to register for a digitally-monitored diabetes care management program. Such Members will have access to Telehealth consults with specific health care Providers participating in the diabetes care management program. The Telehealth consults may involve coaching and medication management and optimization. Additionally, Members will receive a cellular-enabled blood glucose monitor, supplies including testing strips for the digital monitor, access to a mobile application, and additional devices such as continuous glucose monitors when determined necessary by the diabetes care management program.

**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.

**CC. SURGICAL SERVICES**

**1. Surgery**

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

**2. Special Surgery**

- 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 symmetrical 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 Inpatient 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.

## **DD. TELEHEALTH SERVICES**

### **1. Telemedicine Services**

Benefits will be provided for Covered Services for acute care for minor illnesses 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. These Services are covered under your Telemedicine Service benefit and subject to the cost sharing amount in your Schedule of Benefits. For a current list of approved telemedicine vendors contact Member Services. Their phone number is located on the back of your ID card.

Additional Services may be provided by an approved telemedicine vendor and are paid according to the benefit category (e.g. Primary Care Provider Office Visit, Behavioral Health Visit, Dermatology Visit). For example, Telemedicine Services relating to the treatment of Behavioral Health 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.

### **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 Behavioral Health or Substance Use Disorder are covered under your Outpatient Mental Health and Substance Use Disorder benefit and subject to the cost sharing amount in your Schedule of Benefits.

#### **EE. TEMPOROMANDIBULAR DISORDERS (TMD) / CRANIOMANDIBULAR DISORDERS (CMD)**

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

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

#### **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;
- 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 if your coverage includes Prescription Drug coverage. Contact Medical Management for additional information. Their phone number is located on the back of your ID Card.

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

- Speech Therapy;

- Occupational Therapy;
- Cardiac Rehabilitation; and
- Physical Therapy.

## **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](http://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](http://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, you may be offered rewards for your participation in certain of these programs. Any reward provided by the Plan in connection with these programs will not be offered or conditioned upon the Member satisfying a standard that is based on a health related factor.

## **VI. Coordination of Benefits, Right of Recovery, Right of Reimbursement/Subrogation and Work Related Injuries or Illnesses**

### **A. DOUBLE COVERAGE**

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called “Coordination of Benefits (COB)” to determine how much each should pay when you have a Claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

COB is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, contact your Member Services or your state insurance department.

### **B. PRIMARY OR SECONDARY?**

You will be asked to complete questionnaires from time to time to identify all the plans that cover members of your family. We need this information to determine whether Highmark WV is the “primary” or “secondary” benefit payer. To avoid possible Claim denials you need to complete and return the questionnaires promptly. Also, please notify us timely with any changes to the other health care coverage.

### **C. ORDER OF BENEFIT DETERMINATION RULES**

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

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 married:
  - 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 responsibility 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.

There may be some instances when Covered Services may only be performed by an Out-of-Network Provider. You have the right to Appeal these Services to be paid with the higher level of benefits available for Network Providers. If approved, additional payment will be based upon the Plan Allowance. You will still be responsible for any Out-of-Network Liability. Please include the following information with your Appeal:

- An explanation of why the Covered Services could not have been provided by a Network Provider;
- Copies of your medical records, including diagnostic reports.

Refer to the Internal Grievance Appeal Procedures as indicated below for additional information.

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.

#### **2. 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.

### 3. **Notice of Claim and Proof of Loss (Applies to Post-Service Claims Only)**

#### a. **Network Providers**

Network Providers have entered into an agreement with Highmark WV for the provision of Covered Services rendered to a Member. When a Member receives Services from a Network Provider, it is the responsibility of the Network Provider to submit its Claim to Highmark WV in accordance with the terms of its agreement with Highmark WV. Should the Network Provider fail to submit its Claim in a timely manner or otherwise satisfy Highmark WV's requirements as they relate to the filing of Claims, the Member will not be liable and the Network Provider shall hold the Member harmless relative to payment of Covered Services received by the Member.

#### b. **Out-of-Network Providers**

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 procedures:

- **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.

## **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, for other than an emergency. 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, for other than an emergency.

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, for other than an emergency.

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 Services 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, Utilization Management may 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 the facility's Actual Charge(s). 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 Actual Charges associated with these Services.

**3. Exceptions to the Responsibility for Requesting Authorizations**

**a. Substance Use Disorders**

Facility shall notify us of both the admission and the initial treatment plan within forty-eight (48) hours of the admission or initiation of treatment. If there is no Network Facility immediately available, we will provide an exception to our Network to ensure admission in a treatment Facility within seventy-two (72) hours. If you are being treated at an Out-of-Network Facility and a Network Facility becomes available during the course of your treatment plan, you may be required to transfer to an In-Network Facility.

If we determine that continued Inpatient care in a Facility is no longer Medically Necessary and Appropriate, we shall, within seventy-two (72) hours, provide written notice to you and your Provider of our decision and the right to file for an Expedited review.

**NOTE: Prior Authorization and concurrent review are not required for In-Area Network or Out-of-Area Network Partial Hospitalization or Intensive Outpatient and Substance Use Disorder Services.**

**b. Emergency Medical Condition and Child Birth Admissions**

For an admission for an Emergency Medical Condition or an admission related to childbirth Services, you or your Physician must contact us within forty-eight (48) hours of the admission for an Emergency Medical Condition or for lengths of stay beyond forty-eight (48) hours for



vaginal delivery or ninety-six (96) hours for cesarean delivery. Prior to each admission which is not an emergency 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](http://www.highmarkbcbswv.com). After you log in go to Your Coverage Tab, Useful Coverage 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 woman, 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. EXPLANATION OF BENEFITS**

### **1. Pre-service Advance Explanation of Benefits (EOBs)**

You or your Provider may request from Highmark WV advance EOBs regarding Covered Services that will be performed by a particular Provider. In addition to other information deemed necessary by Highmark WV, EOBs will include the following information:

- Whether the provider is Network or Out-of-Network; and
- A good faith estimate of the Plan Allowance, applicable Cost-sharing amounts, impact on your Deductible and Out-of-Pocket accumulations, and whether any medical management requirements apply.

You can request advance EOBs by giving Highmark WV notice prior to the receipt of the Services. Please contact Membership Services at the number listed on the back of your Membership ID card.

### **2. Post-service Explanation of Benefits (EOBs)**

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 Policy Holder. Policy Holders may view EOB's at [www.highmarkbcbswv.com](http://www.highmarkbcbswv.com). You may also request a copy of a particular EOB or you may request to continue to receive paper EOBs through Member Services.

In some limited circumstances, Highmark WV may permit an alternative recipient for the EOB if specifically requested. EOB's are available for Custodial and Non-Custodial parents/guardians of Eligible Dependents. See Section III for additional information regarding custodial parents.

## **E. 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.***

## **F. 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.

To be eligible for external review, the decision of the Plan must involve:

- A Claim that was denied involving medical judgement, including application of Highmark WV's requirements as to medical necessity, appropriateness, health

care setting, level of care, effectiveness of a Covered Service or a determination that the treatment is experimental or investigational.

- A Claim that Highmark WV has concluded is not subject to legal prohibitions against balance billing; or
- A determination made by Highmark WV to rescind your coverage.

In the case of a denied Claim, the request for external review may be filed by either the Member or a Provider, with the written consent of the Member in the format required by or acceptable to the Highmark WV. The request for external review should include any reasons, material justification and all reasonably necessary supporting information as part of the external review filing.

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.

#### **G. 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.

#### **H. 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.

#### **I. 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.

## **J. 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.

## **K. PROVIDER SERVICES**

### **1. Non-Assignability**

You authorize us to make payments directly to Network Providers who have performed Covered Services for you. 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.

### **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 Out-of-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. Provider Termination from the Network**

If, at the time you are receiving medical care from a Network Provider, notice is received from the Highmark WV that:

- Highmark WV intends to terminate or has terminated all or portions of the contract of that Network Provider for reasons other than cause; or
- The contract of that Network Provider will not be renewed, or the participation status of that Network Provider is changing.

You may, at your option, continue an active course of treatment with that Provider until the treatment is complete or for a period of up to ninety (90) days from the date the notification of the termination or pending termination is received, whichever is shorter. For purposes of this Subsection, active course of treatment means:

- An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;
- An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring specialized medical treatment to avoid the reasonable possibility of death or permanent harm or complex ongoing care which the Member is currently receiving, such as chemotherapy, radiation therapy or post-operative visits;
- Confirmed pregnancy, through the postpartum period;
- Scheduled nonelective surgery, through postoperative care; or
- An ongoing course of treatment for a health condition that is life-threatening, degenerative, potentially disabling or congenital and that requires specialized medical care over a prolonged period of time or for which a treating Physician or health care provider attests that discontinuing care by that Physician or health care provider would worsen the condition or interfere with anticipated outcomes; or
- Treatment for terminal illness.

If, however, the Network Provider is terminated for cause and you continue to seek treatment from that Provider, Highmark WV will not be liable for payment for health care services provided to you following the date of termination.

Any Services authorized under this Subsection will be covered in accordance with the same terms and conditions as applicable to a Network Provider. Nothing in this Subsection shall require the Plan to pay benefits for health care services that are not otherwise provided under the terms and conditions of this Policy.

#### **5. 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.

### **L. 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:

### 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, or as required by law. 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.

If you receive covered Emergency Services or non-Emergency Services rendered at a Network Hospital or Facility by an Out-of-Network Provider (also known as an invisible provider) and receive a Provider bill for those services (also known as a "surprise bill") the Plan Allowance shall be based on the qualifying payment amount, which is generally the carrier's historical median Network rate for relevant like Services rendered by a Network Provider in the same geographic region.

#### 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, and telemedicine 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.

### **M. 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.

#### **a. 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.

b. **Out of Area Ancillary Services**

**There are special rules for certain ancillary Services, including independent clinical laboratories, specialty Pharmacy and durable medical equipment/prosthetics, when these Services are obtained outside the Highmark WV Service Area.**

- If the ordering Physician is located in West Virginia, any laboratory Provider the Member uses must contract directly with Highmark WV for benefits to be paid at the Network benefit level. If the laboratory does not contract directly with Highmark WV, the Service will be paid as Out-of-Network. However, if the ordering Physician is located in another state, for benefits to be paid at the Network benefit level, the Member must use a laboratory Provider that contracts directly with the Blue Cross Blue Shield plan in whose state the ordering Physician is located.

For example, if the ordering Physician is in Maryland, the laboratory Provider must contract directly with the Maryland Blue Cross Blue Shield plan for Network benefits to apply; if not, no Network benefit will be available whether the laboratory Provider contracts with Highmark WV or not.

- Similarly, a specialty Pharmacy must contract directly with the Blue Cross Blue Shield plan in whose state the ordering Physician is located.
- A durable medical equipment Provider must contract with the local Blue Cross Blue Shield plan in whose state the equipment is being shipped or delivered for benefits to be paid at the Network benefit level. For example, if the durable medical equipment Provider is located in West Virginia but is shipping to Maryland, the Provider must contract directly with the Maryland plan for Network benefits to apply; if not, no Network benefit will be available whether the provider contracts with Highmark WV or not. If a Member is purchasing and picking up durable medical equipment, the Provider must be a Network Provider for the BCBS service area where the retailer is located for Network benefits to apply.

If you are unsure of the Network status of a particular Provider, you should call Member Services at the number on the back of your ID card for clarification before seeking Services.

c. **Special Cases: Value-Based Programs**

*BlueCard® Program*

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Highmark WV through average pricing or fee schedule adjustments.

*Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements*

If Highmark WV has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to your employer on your behalf, Highmark WV will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

d. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, Highmark WV will include any such surcharge, tax or other fee as part of the Claim charge passed on to you.

e. **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.

If you receive covered Emergency Services, including air ambulance services, or non-Emergency Services rendered at a Network Hospital or Facility by an Out-of-Network Providers ( i.e., also known as an invisible provider) and receive a Provider bill for those services (also known as a "surprise bill") you will only be responsible for the Network cost-share applicable to the service and the Out-of-Network provider cannot Balance Bill you for the difference between the provider's charged amount and Highmark WV's payment.

- **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.

f. **Blue Cross Blue Shield Global Core**



If you are outside the United States, (hereinafter “BlueCard service area”), you may be able to take advantage of the 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](http://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.

g. **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.

**N. 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 III (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.***

## **O. 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.

## **P. 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.

**Q. 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.

**R. GOVERNING LAW**

This Contract 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 IV 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. Topical anesthetics or stand-by anesthesia, except as specified.
25. Arch supports, molded removable foot orthotics, and other foot care or foot support devices only to improve comfort or appearance such as care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses, ingrown toenails and similar foot conditions, including Visits Incurred specifically to prepare or fit for such devices.
26. The treatment 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.
27. Marital counseling or any Service for marital maladjustments. Specific non-covered therapies are: marital therapy or sexual therapy, or any therapy which is not specifically listed as a Covered Service.
28. Massage therapy, pet therapy, dance therapy, art therapy, nature therapy or any therapy which is not specifically listed as a Covered Service.
29. The treatment of sexual problems not caused by organic disease or physical trauma.
30. Reversal of sterilization.
31. Unless otherwise stated, in-vitro fertilization, gamete intra-fallopian transfer and other ova transfer procedures.

32. The treatment of cysts or abscesses associated with the teeth, dental X-rays, dentistry or any other dental processes, except as specified.
33. Appliances designed for orthodontic purposes such as braces, bionators, functional regulators, Frankel, and similar devices.
34. Personal hygiene and convenience items. Examples include diapers, cervical pillows, lift chairs, Jacuzzi's, exercise equipment and special linens, pillows, and air filters for allergy conditions.
35. Unless otherwise stated, eyeglasses, contact lenses, or examinations for prescribing or the fitting of them, excluding those for aphakic patients and soft lenses or sclera sheets for use as corneal bandages.
36. Hearing aids.
37. Hypnosis, and acupuncture and massage therapy, except as specified.
38. Telephone consultations, missed appointments, or completion of a Claim form.
39. Human organ transplant Services, other than as listed in this Benefit Booklet.
40. Fraudulent or misrepresented Claims.
41. Rehabilitation Services for Vocational Rehabilitation, long-term maintenance, or Custodial Care.
42. 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.
43. Prescription Drugs, except as specified. Prescription Drugs purchased from a Pharmacy on an Outpatient basis are payable under Prescription Drug Benefits.
44. Unless otherwise stated, the treatment of Temporomandibular Joint Syndrome with intraoral prosthetic devices or by any other method to alter vertical dimension; for the treatment of Temporomandibular Joint dysfunction not caused by documented organic disease or physical trauma.
45. Routine immunizations, except as specified.
46. 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.
47. 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.
48. Partial birth abortion.
49. Services not permitted under applicable state law. Some state laws restrict the scope of health care Services that a Provider may render. In such cases, the Plan will not cover such health care Services. For detailed information about these excluded Services, contact Member Services at the number on the back of your ID card.
50. Travel-related expenses for medical care that exceed or do not otherwise satisfy the criteria set forth in this Booklet.

51. Cloning or any Services related to cloning.
52. Cleft Palate Orthodontic treatment.
53. Injuries sustained while committing an illegal act or as a result of action on the part of any civil authority.
54. Defective Services or Supplies.
55. Services or Supplies in excess of any maximum limits or benefits.
56. Services excluded elsewhere in this Benefit Booklet.
57. Services and supplies provided at Methadone clinics for the treatment of opioid dependency.

## **IX. Prescription Drug Benefits**

Generally, all terms and conditions of Sections I through VIII shall apply to this Section IX. In the event of a conflict involving Prescription Drug benefits, this Section IX shall control. If you need more information on specific Prescription Drug coverage under your Group Health Plan, please contact Highmark WV at the phone number or the internet address shown on your ID Card.

### **A. PRESCRIPTION DRUG BENEFITS**

See Section V for specifics or exceptions to the following.

#### **1. Prescription Drug Coinsurance**

You must pay a certain percentage or dollar amount for each Medically Necessary and Appropriate Prescription Order or Refill. This payment is referred to as your Prescription Drug Coinsurance. The Prescription Drug Coinsurance for Prescription Drugs received from Network Pharmacies and Mail Order Prescription Drugs are indicated in Section IV.

#### **2. Network Pharmacies**

You must fill prescriptions at a Network Pharmacy to receive benefits under your Prescription Drug Program. If a Medically Necessary and Appropriate Prescription Drug is filled by a Network Pharmacy, you simply present your ID Card and pay only the Prescription Drug Coinsurance. You may fill your prescription at any Network Pharmacy you choose, whether at a physical retail location or through mail order. You may review the Network Pharmacy List by calling Member Services or through our website. This information is located on your ID Card.

#### **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 not 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 not 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 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 an Out-of-Network Pharmacy. You are responsible for paying the Out-of-Network Pharmacy the full cost of the Prescription Drugs.

## 8. Home Delivery (Mail Order) Prescription Drug Benefits.

- ### a. Using the Mail Order Service for the first time.

You may request a new prescription by mail, fax, or through the internet.

- Requests for New Prescriptions by mail.

Ask your Physician or Professional Other Provider to write a new prescription for the maximum Supply allowed by your 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. A Generic Prescription Drug will be dispensed unless a Brand Name Prescription Drug is requested by your Physician or Professional Other Provider or if a Generic Prescription Drug is not available.

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.**

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

Deductibles, Copayments and Coinsurance amounts for patient administered Anti-Cancer Medications that are a covered benefit are applied on a no less favorable basis than for Provider injected or intravenously administered Anti-Cancer Medication.

No coverage is provided for Market Watch Prescription Drugs unless an exception is granted pursuant to the process set forth in Section C. **RETAIL AND MAIL ORDER PRESCRIPTION DRUG MANAGEMENT**, Subsection **Market Watch Prescription Drug Exceptions** below.

#### 10. **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](http://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](http://www.highmarkbcbswv.com) or contact Member Services. Their phone number is on the back of your ID Card.

Insulin syringes, needles, and/or selected disposable diabetic testing materials will be covered by the same Coinsurance as the insulin, if dispensed in days supply corresponding to the amount of insulin dispensed. Insulin syringes, needles and/or disposable diabetic testing material dispensed without insulin will require Coinsurance when dispensed.

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.

A prescription written for an Inpatient at the time of discharge requiring a Prior Authorization shall not be subject to Prior Authorization requirements and shall be immediately approved for not less than three days. Provided, that the cost of the medication does not exceed \$5,000 per day and the Physician shall note on the prescription or notify the Pharmacy that the prescription is being provided at discharge. After the three (3) day time frame, a Prior Authorization must be obtained.

### **2. Managed Prescription Drug Coverage**

A Prescription Order or Refill which may exceed the manufacturer's recommended dosage over a specified period of time may be denied when presented to the Pharmacy Provider. The managed Prescription Drug coverage (MRxC) program also consists of online edits that encourage the safe and effective use of targeted medications.

We may contact the prescribing Physician to determine if the Prescription Drug is Medically Necessary and Appropriate. If it is determined by us that the prescription is Medically Necessary and Appropriate, the Prescription Drug will be dispensed.

### **3. Market Watch Prescription Drug Exceptions**

Coverage is not provided for Market Watch Prescription Drugs, unless an exception has been granted by Highmark WV. The Member, the Member's Authorized Representative, or the Member's prescribing Physician may request coverage of the Market Watch Prescription Drug. Highmark WV will review the exception request and notify the Member, the Member's Authorized Representative, or the Member's prescribing Physician of its determination within two (2) business days of the request, not to exceed seventy-two (72) hours of receiving sufficient information to begin its review of the request.

If the Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Market Watch Prescription Drug appearing on the market watch program list, the Member, the Member's Authorized Representative, or the Member's prescribing Physician may request an expedited review based on exigent circumstances. In the case of such an exigent circumstance, Highmark WV will notify the Member, the Member's Authorized Representative, or the Member's prescribing Physician of its coverage determination within twenty-four (24) hours of receiving sufficient information to begin its review of the request.

In the event that Highmark WV denies a request for exception, the Member, the Member's Authorized Representative, or the Member's prescribing Physician may request that the exception and subsequent denial of the exception be reviewed by an independent review organization. Highmark WV must make its determination on the external exception request and notify the Member, the Member's Authorized Representative, or the Member's prescribing Physician of its coverage determination no later than seventy-two (72) hours following its receipt of sufficient information to begin its review of the exception, or if the exception was an expedited exception request, no later than twenty-four (24) hours following its receipt of sufficient information to begin its review of the request for exception.

If Highmark grants the request for exception, the Prescription Drug will be covered for the duration of the prescription, or if pursuant to an expedited exception request, for the duration of the exigency. Coverage will be provided in accordance with the Schedule of Benefits.

#### **4. 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.

The authorization is not applicable to those brand drugs which are subject to the requirement described above in the Preauthorization subsection.

### **D. EXCLUSIONS AND LIMITATIONS SPECIFIC TO PRESCRIPTION DRUGS**

In addition to the exclusions in Section VIII, we do not provide benefits for the following Services, Supplies, or Charges.

1. For Market Watch prescription drugs, except as provided herein.
2. Therapeutic devices or for artificial appliances.
3. Prescription Drugs that are received as an Inpatient or administered by a Physician or Professional Other Provider.
4. Hypodermic needles, syringes or comparable devices, unless stated as Covered Services.
5. Fees for administering or injecting Prescription Drugs.
6. More than a 90-day supply of a Retail Prescription Drug.

7. More than a 90-day supply of a maintenance Prescription Drug through the Home Delivery (Mail Order) program.
8. Any Prescription Refill dispensed more than one year after the date of the original Prescription Order.
9. A Prescription Drug which is entirely consumed or administered at the time and place where the Prescription Order is issued.
10. 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.
11. 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.
12. 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.
13. 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.
14. More than the number of Prescription Refills specified by a Physician or Professional Other Provider.
15. Prescription Drugs for the Treatment of obesity or for weight reduction.
16. 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.
17. Prescription Drugs not specified as Covered Services or which are specifically excluded in the text.
18. Prescription Drugs that are determined to be not Medically Necessary and Appropriate.
19. Prescription Drugs and over the counter drugs not listed in the formulary applicable to your program.
20. Prescription Drugs that are not FDA approved, such as compound medication.
21. Food supplements.
22. Services and supplies provided at Methadone clinics for the treatment of opioid dependency.

#### **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.



## F. 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.

**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.

**Market Watch Prescription Drug.** A select Prescription Drug identified by Highmark WV as having:

- Having an over-the-counter drug equivalent;
- Having relatively low value with respect to the cost in light of available alternative covered medications; or
- Being newly approved by the Food and Drug Administration for treating a condition for which there are existing covered medications have previously been approved.

**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.

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

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

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

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

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

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

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

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

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

## COVERAGE

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

## EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does not provide coverage for:

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

## LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

## HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA NOTICE OF PRIVACY PRACTICES

### PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

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#### **Our Legal Duties**

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

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

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

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members’ protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change. Any change to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

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

#### **I. Uses and Disclosures of Protected Health Information**

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

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

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

##### **Payment**

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

##### **► For example:**

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

##### **Health Care Operations**

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

##### **► For example:**

We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct Quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business.

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

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

##### **(i) Business Associates.**

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

##### **(ii) Other Covered Entities.**

In addition, we may use or disclose your protected health information to assist health care providers in connection with their treatment or

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

## **II. Other Possible Uses and Disclosures of Protected Health Information**

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

### **A. To Plan Sponsors**

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

### **B. Required by Law**

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

### **C. Public Health Activities**

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

### **D. Health Oversight Activities**

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

### **E. Abuse or Neglect**

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

### **F. Legal Proceedings**

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

### **G. Law Enforcement**

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

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

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

### **I. Research**

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

### **J. To Prevent a Serious Threat to Health or Safety**

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

### **K. Military Activity and National Security, Protective Services**

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

### **L. Inmates**

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

### **M. Workers' Compensation**

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

### **N. Others Involved in Your Health Care**

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

### **O. Underwriting**

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

### **P. Health Information Exchange**

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



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

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

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

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

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

### III. Required Disclosures of Your Protected Health Information

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

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

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

#### B. Disclosures to You

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

### IV. Other Uses and Disclosures of Your Protected Health Information

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

1. For marketing purposes
2. If we intend to sell your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a

conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:

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

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

### V. Your Individual Rights

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

#### A. Right to Access

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

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

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

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same



one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

#### **B. Right to an Accounting**

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

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

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

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

#### **C. Right to Request a Restriction**

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

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

#### **D. Right to Request Confidential Communications**

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

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

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

#### **E. Right to Request Amendment**

If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected

health information. Your request must be in writing, and it must explain why the information should be amended.

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

#### **F. Right to a Paper Copy of this Notice**

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

#### **VI. Questions and Complaints**

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

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

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

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

Contact Office: Highmark West Virginia Privacy Office

Telephone: 1-304-424-9026

Fax: 1-304-424-0322

Address: 614 Market Street  
Parkersburg, WV 26101

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

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

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

available information or statistical information that does not identify individual persons.

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

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.
- We collect and create information about our members' transactions with Highmark WV, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

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

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.
- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services

to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.

- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.
- We may disclose information under order of a court of law in connection with a legal proceeding.
- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.
- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

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

For questions about this Privacy Notice, please contact:

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

## Discrimination is Against the Law

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

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

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

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

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

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

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

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

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

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

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

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

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

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

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

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

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

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

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

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

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

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



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