


COVACare

MEMBER HANDBOOK

Effective July 1, 2007

This Web version of the booklet reflects the most current description of benefits, limitations and exclusions under your plan as of *July 1, 2007*.

The provisions in this booklet supersede all previous versions.

COVA Care Member Handbook

This member booklet fully explains your health care benefits and how you can maximize them. Treat it as you treat the owner's manual for your car - store it in a convenient place and refer to it whenever you have questions about your health care coverage.

Important contacts:

Anthem Blue Cross and Blue Shield - Medical, and Optional Vision and Hearing

800- 552- 2682

For the hearing impaired, please contact your state's relay service by dialing 711.

Hours of Operation:

Monday- Friday 8:00 a.m. to 6:00 p.m. ET

Saturday 9:00 a.m. to 1:00 p.m. ET

www.anthem.com/cova

Delta Dental of Virginia - Dental

888- 335- 8296

Hours of Operation:

Monday- Thursday 8:15 a.m. to 6:00 p.m. ET

Friday 8:15 a.m. to 4:45 p.m. ET

www.deltadentalva.com (Select the Commonwealth of Virginia link)

Medco Health Solutions, Inc. - Outpatient Prescription Drugs

800- 355- 8279

Hours of Operation:

24 hours a day, 7 days a week

www.medco.com

ValueOptions, Inc. - Behavioral Health and Employee Assistance Program (EAP)

866- 725- 0602

Hours of Operation:

24 hours a day, 7 days a week

www.achievesolutions.net/covacare

Department of Human Resource Management

www.dhrm.virginia.gov

ID Card Order Line

866- 587- 6713

Key words

There are a few key words *you* will see repeated throughout this booklet. We've highlighted them here to make the booklet easier to understand. In addition, we have included a **Definitions** section on page 82 that lists the various words referenced. A defined word will be italicized each time it is used.

Coinsurance

The percentage of the *allowable charge you* pay for some covered services.

Copayment

The fixed dollar amount *you* pay for some covered services.

Covered persons

You and enrolled eligible dependents.

Deductible

The fixed dollar amount of covered services *you* pay in a plan year before *your health plan* will pay for certain remaining covered services during that plan year. The *deductible* amount is for a twelve month period and begins again each plan year. Deductible amounts incurred from April 1 through June 30 carry over to the new plan year.

Inpatient

When *you* are a bed patient in the hospital.

Out-of-pocket expense limit

The amount of money that *you* pay out of your pocket for certain covered medical and behavioral health expenses (combined) during the plan year. Once the limit is reached, almost all other covered expenses are paid in full (100% of the *allowable charge*) for the rest of the plan year. The out-of-pocket expense limit is for a twelve month period and begins again each plan year.

Outpatient

When *you* receive care in a hospital *outpatient* department, *emergency* room, professional provider's office, or your home.

Plan administrator

Your health plan benefits are administered by four *plan administrators*: Anthem Blue Cross and Blue Shield for medical, and the optional vision and hearing benefits; Delta Dental of Virginia for routine dental benefits, including the optional expanded dental benefits; Medco Health Solutions, Inc. for outpatient *prescription drugs*; and ValueOptions, Inc. for behavioral health and Employee Assistance Program (EAP) benefits.

Plan year

The period for which benefits are administered, which is July 1 through June 30.

You

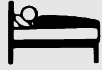
The enrolled member.

Your health plan

Your employer's health care plan through which benefits described in this booklet are available.



Helpful tip: Look for these icons to identify which services are considered *inpatient* and which are *outpatient* or to identify the individual, individual plus one, and family *deductible* and out-of-pocket expense limits.



Inpatient



Outpatient



Individual



Individual + one



Family

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COVA Care Basic Plan Summary of Benefits

This chart is an overview of your benefits for covered services under the basic plan. They are listed in detail beginning on page 18. A list of services that are not covered begins on page 36. Optional benefits, which may be purchased for additional cost, are shown beginning on page 91.

What will I pay?

This chart shows what you pay for *deductibles* and out-of-pocket expenses for covered services in one plan year, along with your *copayment* or *coinsurance* amounts.

Your coverage includes a \$25,000 lifetime maximum for each covered person for the identification of a suitable donor for organ and tissue transplant services. See page 31 for organ and tissue transplant coverage.

	In- network			Detail
				Page number
				
Plan year deductible (applies as indicated)	\$200	\$400	\$400	45
Plan year out-of-pocket expense limit	\$1,500	\$3,000	\$3,000	45

	Copayment	In- network*		Detail
		Copayment	Coinsurance	Page number
Ambulance Travel	\$0	20%	after deductible	18
No plan year limit				
Behavioral health and EAP				18
Administered by ValueOptions				
Inpatient treatment				18
<i>Facility services</i>	\$300	0%		18
<i>per stay</i>				
<i>Professional provider services</i>	\$0	0%		18
Partial day program	\$300	0%		18
<i>per stay</i>				
Outpatient treatment program				
<i>Facility services</i>	\$100	0%		18
<i>Specialty Care Providers</i>	\$35	0%		18
Employee assistance program	\$0	0%		18
Up to four visits per incident				
Dental services (non- routine medical)	\$0	20%	after deductible	21
Diabetic equipment	\$0	20%	after deductible	22
Diabetic education	\$0	0%		22

* Except in an emergency, you do not have Out-of-network benefits unless you purchase the Out-of-network option. See **Optional benefits** section.

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	In-network*		Detail Page number
	Copayment	Coinsurance	
Diagnostic tests and x- rays for specific conditions or diseases at a doctor's office, emergency room, or outpatient hospital department	\$0	10% after deductible	22
Dialysis treatments			
<i>Facility</i>	\$0	0%	23
<i>Doctor's Office</i>	\$0	0%	23
Doctor visits on an outpatient basis			
<i>Primary Care Physicians</i>	\$25	0%	23
<i>Specialty Care Providers</i>	\$35	0%	23
Early intervention services	Copayment/coinsurance determined by service received.		23
Emergency room visits			
<i>Facility services</i>	\$100 <i>per visit</i> (waived if admitted)	0%	24
<i>Professional provider services</i>			
<i>Primary Care Physicians</i>	\$25	0%	24
<i>Specialty Care Providers</i>	\$35	0%	24
<i>Diagnostic tests, x- rays</i>	\$0	10% after deductible	22
Home care services 90- visit plan year limit for home health services	\$0	0%	24
Home private duty nurse's services	\$0	20% after deductible	24
Hospice care services	\$0	0%	25
Hospital services			
Inpatient treatment			
<i>Facility services</i>	\$300 <i>per stay</i>	0%	25
<i>Professional provider services</i>			
<i>Primary Care Physicians</i>	\$0	0%	25
<i>Specialty Care Providers</i>	\$0	0%	25
Outpatient treatment			
<i>Facility services</i>	\$100	0%	25
<i>Professional provider services</i>			
<i>Primary Care Physicians</i>	\$25	0%	25
<i>Specialty Care Providers</i>	\$35	0%	25
<i>Diagnostic tests, x- rays</i>	\$0	10% after deductible	22
Infusion services** By infusion therapy providers			
<i>Facility services</i>	\$0	0%	26
<i>Professional provider services</i>	\$0	0%	26
<i>Home services</i>	\$0	0%	26
<i>Infusion medications</i>			
<i>Outpatient settings</i>	\$0	0%	26
<i>Home settings</i>	\$0	0%	26

* Except in an emergency, you do not have Out- of- network benefits unless you purchase the Out- of- network option. See Optional benefits section.

** See Hospital services for payment amounts for inpatient therapy.

	In- network*		Detail
	Copayment	Coinsurance	Page number
Maternity			
Professional provider services			
Prenatal and postnatal care			
<i>Primary Care Physicians</i>	\$25	0%	26
<i>Specialty Care Providers</i>	\$35	0%	26
Delivery			
<i>Primary Care Physicians</i>	\$0	0%	26
<i>Specialty Care Providers</i>	\$0	0%	26
Hospital services for delivery	\$300	0%	26
delivery room, anesthesia, nursing care for newborn	<i>per stay</i>		
Diagnostic tests	\$0	10%	after deductible 22
Medical equipment (durable), appliances, formulas and supplies	\$0	20%	after deductible 27
Shots (allergy and therapeutic injections)	\$0	10%	after deductible 28
at a doctor's office, emergency room or outpatient hospital department			
Skilled nursing facility stays			29
180- day per stay limit			
<i>Facility services</i>	\$0	0%	29
	<i>per stay</i>		
<i>Professional provider services</i>	\$0	0%	29
Spinal manipulations			
and other manual medical interventions			
\$500 plan year limit			
<i>Primary Care Physicians</i>	\$25	0%	29
<i>Specialty Care Providers</i>	\$35	0%	29
Surgery			29
Inpatient			
<i>Facility services</i>	\$300	0%	29
	<i>per stay</i>		
<i>Professional provider services</i>			
<i>Primary Care Physicians</i>	\$0	0%	29
<i>Specialty Care Providers</i>	\$0	0%	29
Outpatient			
<i>Facility services</i>	\$100	0%	29
	<i>per visit</i>		
<i>Professional provider services</i>			
<i>Primary Care Physicians</i>	\$25	0%	29
<i>Specialty Care Providers</i>	\$35	0%	29
<i>Diagnostic tests, x-rays</i>	\$0	10%	after deductible 22
Therapy - outpatient services**			
Cardiac rehabilitation therapy			
<i>Hospital services</i>	\$0	0%	32
<i>Professional provider services</i>	\$0	0%	32

* Except in an emergency, you do not have Out- of- network benefits unless you purchase the Out- of- network option. See Optional benefits section.

** See Hospital services for payment amounts for inpatient therapy.

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	In- network*		Detail
	Copayment	Coinsurance	Page number
Chemotherapy			
Hospital services	\$0	0%	32
Professional provider services	\$0	0%	32
Occupational therapy visits			
Hospital services	\$35	0%	32
Professional provider services			
Primary Care Physicians	\$25	0%	32
Specialty Care Providers	\$35	0%	32
Physical therapy visits			
Hospital services	\$35	0%	32
Professional provider services			
Primary Care Physicians	\$25	0%	32
Specialty Care Providers	\$35	0%	32
Radiation therapy			
Hospital services	\$0	0%	32
Professional provider services	\$0	0%	32
Respiratory therapy			
Hospital services	\$0	0%	33
Professional provider services	\$0	0%	33
Speech therapy visits			
Hospital services	\$35	0%	33
Professional provider services			
Primary Care Physicians	\$25	0%	33
Specialty Care Providers	\$35	0%	33
Vision correction	\$0	20%	33
after surgery or accident		after deductible	
Wellness services			
Well child			
Office visits at specified intervals through age 6			
Primary Care Physicians	\$0	0%	33
Specialty Care Providers	\$0	0%	33
Immunizations			
Primary Care Physicians	\$0	0%	33
Specialty Care Providers	\$0	0%	33
Screening tests	\$0	0%	33
Routine wellness (age 7 and older)			
Check-up visit (one per plan year)			
Primary Care Physicians	\$0	0%	33
Specialty Care Providers	\$0	0%	33
Immunizations			
Primary Care Physicians	\$0	0%	33
Specialty Care Providers	\$0	0%	33
Lab and x- ray services	\$0	0%	33

* Except in an emergency, you do not have Out- of- network benefits unless you purchase the Out- of- network option. See Optional benefits section.

	In-network*		Detail
	Copayment	Coinsurance	Page number
Preventive care (one of each per plan year)			
Gynecological exam			
<i>Primary Care Physicians</i>	\$0	0%	33
<i>Specialty Care Providers</i>	\$0	0%	33
Pap test	\$0	0%	33
Mammography screening	\$0	0%	33
Prostate exam (digital rectal exam)			
<i>Primary Care Physicians</i>	\$0	0%	33
<i>Specialty Care Providers</i>	\$0	0%	33
Prostate specific antigen test	\$0	0%	33
Colorectal cancer screenings	\$0	0%	33

	Copayment	Coinsurance	Detail
			Page number
Prescription drugs (outpatient)			28
Administered by Medco			
Retail pharmacy			13
covered drugs per 34- day supply			
First tier	\$15		13
Second tier	\$20		13
Third tier	\$35		13
Diabetic blood glucose test strips and blood glucose meters (no deductible)		20%	13
Home Delivery Services			15
covered drugs for up to a 90- day supply			
First tier	\$30		15
Second tier	\$40		15
Third tier	\$70		15
Diabetic blood glucose test strips and blood glucose meters (no deductible)		20%	15

Dental services
Administered by Delta Dental

Plan year deductible	\$0
The most your plan pays per plan year	\$1,200

	Copayment	Coinsurance	Detail
			Page number
Diagnostic and preventive services	\$0	0%	20
Primary services (no deductible)	\$0	20%	20

How your health plan works

Your COVA Care health plan provides a wide range of health care services within special networks for medical, behavioral health, dental, and pharmacy *providers* and *facilities*. You will receive benefits based on where you receive health care services and the limits stated in the **Summary of benefits** (see page 1) and related exclusions. Your *health plan* is a self-funded benefits plan sponsored by the Commonwealth of Virginia, which has entered into separate administrative services contracts with Anthem Blue Cross and Blue Shield for covered medical services and the optional vision and hearing services; ValueOptions, Inc. for covered behavioral health services and the Employee Assistance Program (EAP); Delta Dental of Virginia for routine dental and the optional expanded dental coverage; and Medco Health Solutions, Inc. for outpatient prescription drug coverage.

Carry your ID card

Your ID card identifies you as a *covered person* and contains important health care coverage information. When you show your ID card to your doctor, hospital, pharmacist, dentist, or other health care *providers*, they will file your claims for you in most cases. Carrying your card at all times will ensure you always have this coverage information with you when you need it.

In an emergency or if specialty care is not reasonably available in the network

In an *emergency*, go to the nearest appropriate *provider* or medical *facility*. If the *provider* or *facility* is not in the network, you or your network physician can call Anthem to have medical services authorized for coverage, or ValueOptions to have behavioral health services authorized for coverage. Non-*emergency* medical or behavioral health care received from *providers* and *facilities* not in the network is not covered.

If specialty care is required and it is not available from a *provider* within the network, your *provider* can call Anthem or ValueOptions in advance of your receiving care to request authorization for coverage.

Allowable Charge

For care by a physician or other health care professional, the *allowable charge* is the lesser of the *plan administrator's* allowance for that service, or the *provider's* charge for that service.

For hospital services, the *allowable charge* is the *plan administrator's* negotiated compensation to the *facility* for the covered service, or the *facility's* charge for that service, whichever is less.

For other services such as ambulance or home private duty nursing which are not considered *provider* or *facility* services, the *allowable charge* is the amount the *plan administrator* determines to be reasonable for the services rendered.

For *prescription drugs*, the *allowable charge* is the lesser of the *plan administrator's* allowance for the prescription, or the cost of the drug.

Pre-existing conditions

Pre-existing conditions are covered under *your health plan*. You do not have to satisfy a waiting period before services for pre-existing conditions are covered.

Hospital admission review required for medical and behavioral health services

All hospital *stays* except for maternity admissions as specified in the maternity section of this booklet, skilled nursing home *stays*, or behavioral health treatment in partial day programs should be approved before each admission. If *you* are admitted to the hospital as a result of an *emergency*, within 48 hours of admission your hospital *stay* should be reviewed by Anthem for medical services or by ValueOptions for behavioral health services. The *emergency* room doctor, a relative, or a friend can call for hospital admission review. Network *providers* and *facilities* handle hospital admission review for *you*. If *you* receive care from a network *facility* or *provider* while outside of Virginia or overseas, *you* must initiate the hospital admission review process. If *you* fail to obtain approval for an *inpatient stay*, and the *stay* is later determined not to be *medically necessary*, *you* may have to pay the entire hospital bill in addition to any charges for services provided while *you* were an *inpatient*. Strict adherence to this procedure may not be required for services that arise over the weekend.

Before *you* are admitted to the hospital for medical care or surgery, *you* or someone *you* authorize must call Anthem member services at **800- 552- 2682**. For a behavioral health hospital admission, call ValueOptions at **866- 725- 0602**. *You* should have the following information available:

- your identification number (shown on your ID card);
- your doctor's name and phone number;
- the date *you* plan to enter the hospital and length of *stay*; and
- the reason for hospitalization.

Anthem or ValueOptions will respond to a request for hospital admission within 2 working days after receiving all of the medical information needed to process the request, but not to exceed 15 days from the receipt of the request. 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* will be notified prior to the expiration of the initial 15-day period.

In cases where the hospital admission is an urgent care claim, a coverage decision will be completed within 24 hours. Your physician will be notified verbally of the coverage decision within this time frame.

Once a coverage decision has been made regarding your hospital admission, *you* will receive written notification of the coverage decision. In the event of an *adverse benefit determination*, the written notification will include the following:

- the specific reason(s) and the plan provision(s) on which the determination is based;

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- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of *your health plan's* appeal procedures and applicable time limits; and
- in the case of an urgent care claim, a description of the expedited review process applicable to such claims.

If all or part of a hospital admission was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that *your health plan* relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, *you* are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to your medical condition.

Hospital admissions for covered radical or modified radical mastectomy for the treatment of breast cancer shall be approved for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours. Hospital admissions for a covered laparoscopy-assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy shall be approved for a period of no less than 48 hours.

The length of *stay* for maternity admissions is determined according to the Newborn's and Mother's Health Protection Act. This federal law allows for 48 hours for vaginal delivery or 96 hours for caesarian section. Admissions for maternity care do not, initially, require hospital admission review. However, if complications develop and additional days are necessary, hospital admission review is required. We request that your doctor contact Anthem to establish eligibility and waiting periods.

Admissions to hospitals located outside of Virginia

If *you* are admitted to a hospital outside of Virginia, *you* or someone on your behalf must initiate the hospital admission review process. This applies in all cases, whether *you* live, work, or travel outside of Virginia. If approval is not obtained for an *inpatient stay* and the *stay* is later determined by Anthem or ValueOptions not to be *medically necessary*, *you* may have to pay the entire hospital bill in addition to any charges for services provided while *you* were an *inpatient*.

Medical necessity review for medical and behavioral health services

Your health plan requires medical necessity review of selected services. Some examples of these services include:

- elective ambulance services;
- non-routine dental and oral surgery services covered under your medical benefits;
- diabetic education;
- medical equipment, devices, appliance and supplies;
- spinal manipulations in conjunction with physical therapy; and
- morbid obesity treatment.

Your health plan recommends completing the medical necessity review process in advance of actually receiving services so that *you* will know beforehand whether or not the services meet the medical necessity criteria. Services that do not meet the medical necessity criteria are not covered. If *you* do not complete the medical necessity review process prior to receiving services, the review will be completed at the time the claim is processed.

Contact Anthem member services at **800-552-2682**, or ValueOptions member services at **866-725-0602** for assistance with medical necessity review.

Health services review

Your health plan requires health services review of selected medical services. Formerly called pre-authorization, this is a pre-service review that determines whether certain outpatient medical services are a covered benefit and are medically necessary. Some examples of these services include:

- Cardiac nuclear studies;
- CT scans;
- Home health services;
- MRI, MRA;
- Organ, stem cell and bone marrow transplants; and
- PET, SPECT scans.

Contact Anthem member services at **800-552-2682** for assistance with health services review.

Individual case management under your medical and behavioral health services

In addition to the covered services listed in this booklet, *your health plan* may elect to offer benefits for an approved alternate treatment plan for a patient who would otherwise require more expensive covered services. This includes, but is not limited to, long term *inpatient* care. *Your health plan* will provide alternate benefits at its sole discretion. It will do so only when and for so long as it decides that the services are *medically necessary* and cost effective. The total benefits paid for such services may not exceed the total that would otherwise be paid without alternate benefits. If *your health plan* elects to provide alternate benefits for a *covered person* in one instance, it will not be required to provide the same or similar benefits for any *covered person* in any other instance. Also, this will not be construed as a waiver of *your health plan's* right to enforce the terms of *your health plan* in the future in strict accordance with its express terms.

Also, from time to time *your health plan* may offer a *covered person* and/or their *provider* or *facility* information and resources related to disease management and wellness initiatives. These services may be in conjunction with the *covered person's* medical condition or with therapies that the *covered person* receives, and may or may not result in the provision of alternative benefits as described in the preceding paragraph.

How your medical benefits work (Anthem)

Covered medical providers and facilities

Your health plan covers certain care from medical *providers* and *facilities*. To ensure coverage, *providers* and *facilities* must be licensed in the state where they operate to perform the service you receive. The service also must be covered by your health plan. Certain services are covered by the plan and rendered by other covered medical suppliers, such as suppliers of *medical equipment (durable)*, private duty nursing services, *prescription drugs*, ambulance services, etc.

A *provider* may delegate to his employee the responsibility for performing a covered service. Your health plan will cover this care if it is determined that a bona fide employer-employee relationship exists, based on information given by the *provider*. Under these circumstances:

- both the *provider* and the delegated employee must be licensed/certified to render the service;
- the service must be performed under the direct supervision of the *provider* since the *provider* is primarily responsible for the patient's care; and
- the *provider* who is directly supervising the service must bill for the service.

Because the service of the delegated employee is a substitute for the *provider's* service, your health plan will not pay a supervisory or other fee for the same service performed by both the *provider* and his delegated employee.

Primary care physicians and specialty care providers

Your health plan covers care provided by *primary care physicians* and *specialty care providers*. To see a *primary care physician*, simply visit any network physician who is a general or family practitioner, internist or pediatrician. Your health plan also covers care provided by any *specialty care provider* you choose. Referrals are never needed to visit any *specialty care provider*. However, higher *copayments* will apply for specialist visits.

Your medical provider networks

There are several ways you can find out if a *provider* or *facility* is in your Anthem network:

- The directory may be accessed online at www.anthem.com/cova.
- Refer to the printed Anthem Commonwealth of Virginia Medical Provider Directory.
- Check with your doctor or health care *facility*.
- Call Anthem member services.



Helpful tip: Under COVA Care basic, you have no out-of-network coverage except in an emergency. If you purchased the Out-of-network option, you have coverage outside the network, but the *provider* may bill you for amounts above the *allowable charge*.

BlueCard® PPO for Care within the United States

If *you* need medical care outside the Anthem network and within the United States, *you* will have access to care from a BlueCard PPO *provider*. Through the BlueCard PPO program, your Anthem Blue Cross and Blue Shield ID card is accepted by physicians and hospitals throughout the country who participate with another Blue Cross Blue Shield company. These *providers* accept your *copayment* or *coinsurance* at the time of service instead of requiring full payment. They file claims directly to their local Blue Cross Blue Shield company for *you*, and have agreed to accept the *allowable charge* established by the local company as payment in full.

To locate a BlueCard PPO physician or hospital call **800-810-BLUE (2583)**. Or use the BlueCard Doctor and Hospital Finder on the Web at **www.bcbs.com**. *Providers* can also tell *you* if they participate in BlueCard PPO when *you* call to make an appointment.

Simply present your Anthem ID card when *you* receive care. The PPO suitcase logo at the top of your card tells the physician or hospital that your plan includes the BlueCard PPO program.

How Charges Are Calculated for BlueCard PPO Services

The amount used to calculate your payment responsibility for a covered service will usually be the lower of:

- the billed charge for the covered service; or
- the negotiated price passed on to Anthem through the BlueCard program.

Often, this “negotiated price” will consist of a simple discounted price. It can also be an estimated or average price allowed by the BlueCard program and the terms of your health care plan. An estimated price takes into account special arrangements with a provider or provider group that include settlements, withholds, non-claims transactions (such as provider advances) and other types of variable payments. An average price is based on a discount that takes into account these same special arrangements. Of the two, estimated prices are usually closer to the actual prices.

Negotiated prices may be adjusted going forward to correct for over- or under-estimation of past prices. However, the amount *you* pay is considered a final price.

Laws in a small number of states may require the local Blue Cross and/or Blue Shield plan to use another method for calculating the charge, or add a surcharge to your liability calculation. In these states, Anthem Blue Cross and Blue Shield would calculate your liability according to the applicable state law in effect when *you* received care.

BlueCard® Worldwide for Care outside the United States

If *you* live or travel outside the United States, the BlueCard Worldwide program assists *you* to obtain *inpatient* and *outpatient* hospital care and physician services.

Follow these steps before you travel:

1. Obtain a list of BlueCard Worldwide hospitals located where *you* will be traveling or staying. *You* may obtain this information on the Web at www.bcbs.com . Select “Healthcare Anywhere” then “PPO Coverage”. Or *you* may call **800- 810- BLUE (2583)** for assistance.
2. Be sure to carry your ID card with *you* and present it when *you* need *inpatient* care.

If you need care once you arrive at your destination, follow these simple steps:

Inpatient hospital care (non- emergency):

1. Call the BlueCard Worldwide Service Center at **804- 673- 1177** (use a local operator to set up a collect call to the U.S.). A BlueCard Worldwide Service Center representative will accept the charges and will facilitate hospitalization at a BlueCard Worldwide hospital. It is important that *you* call the Service Center in order to obtain cash- less access for *inpatient* care. The hospital will submit your claim for *you*. The Service Center is staffed with multilingual representatives and is available 24 hours a day, seven days a week.
2. Call Anthem member services at **800- 552- 2682** for hospital admission review.

Inpatient hospital care (emergency):

Bypass the above steps. Go to the nearest hospital. Call the BlueCard Worldwide Service Center at **804- 673- 1177** (use a local operator to set up a collect call to the U.S.) if *you* are admitted to arrange cash- less access (available in most cases). A BlueCard Worldwide Service Center representative will assist *you*. A family member or friend can make this call for *you*.

Outpatient hospital care/physicians services:

1. Call the BlueCard Worldwide Service Center at **804- 673- 1177** (use a local operator to set up a collect call to the U.S.) if *you* would like information on physicians or *outpatient facilities*. A BlueCard Worldwide Service Center representative will accept the charges, and if *you* want, make an appointment with a doctor for *you*, or will direct *you* to a hospital.
2. *You* will need to pay for your care and then submit a claim using the International Claim Form to the BlueCard Worldwide Service Center (address is on the claim form). Contact the Service Center for the form, or online at www.bcbs.com/bluecardworldwide.

How your dental benefits work (Delta Dental)

Your dental providers

In order to receive the highest level of benefits, *you* should receive dental care from DeltaPremier network dentists. DeltaPremier dentists will file claims for *you* and agree to accept Delta’s *allowable charge* as payment in full. *You* are only responsible for the applicable *coinsurance*.

You may receive care from an out-of-network dentist and still receive the highest level of payment. Remember, however, that the out-of-network dentist may bill *you* for any amount above the plan’s *allowable charge*. *You* also may have to complete a dental claim form and send it to Delta Dental.

After consulting with your dentist, *you* may select a more expensive covered benefit than the one Delta Dental determines is necessary or customary for the diagnosis or treatment of your condition. However, Delta Dental will pay only the amount that it would have paid for the less expensive covered benefit. In most cases, Delta Dental's payment for the more expensive service will not exceed what Delta Dental customarily pays to restore your tooth to its proper contour and function. *You* are responsible for the entire balance of the dentist's fee for the more expensive covered benefit. Preauthorizations are recommended for procedures over \$250.

To find a DeltaPremier dentist visit the Delta Dental of Virginia Web site at www.deltadentalva.com. Click on the "Searching for a Dentist?" link and select the DeltaPremier program. *You* may also call Delta Dental member services at **888- 335- 8296** for assistance.

Predetermination plan

If dental services for a single procedure or series of procedures cost more than \$250, your dentist may submit a predetermination plan to Delta Dental before services are provided. By submitting a predetermination plan, both *you* and your dentist will be informed of the following:

- total costs associated with a particular procedure or series of procedures;
- confirmation of the exact amounts that will be covered by *your health plan*; and
- the portion of the charges for which *you* will be responsible.

A predetermination plan is not required by *your health plan*, but recommended when extensive dental work is expected. A claim will not be denied for failure to obtain predetermination.

How your outpatient prescription drug benefits work (Medco)

Your prescription network pharmacies

Your outpatient *prescription drug* benefits cover prescriptions obtained from a pharmacy which participates in the Medco pharmacy network. *You* may receive up to a 34- day supply of medicine for an original prescription or refill for up to one year. Your benefits also include a 35- 68 day supply for two times the retail pharmacy *copayment* amount and a 69- 102 day supply for three times the retail pharmacy *copayment* amount. Simply choose a pharmacy that participates in the Medco pharmacy network and show your ID card to receive benefits.

To find a pharmacy that participates in the Medco pharmacy network:

- go to www.medco.com and click on the "Find a local pharmacy" link. To find a participating retail pharmacy, simply enter your member number, member's (cardholder's) date of birth and location using either a valid zip code or the city and state. (Be sure to include a comma between the city name and the state abbreviation.) Then click on the "locate pharmacy" button;
- check with your local pharmacy to see if they participate in the network; or
- call Medco at **800- 355- 8279**.

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Participating retail pharmacies will automatically file claims for *you* and charge *you* only the required amount under your health care plan for covered prescriptions. At non-network pharmacies *you* pay the total price of the drug and then file a Prescription Drug Reimbursement Form. Reimbursement is limited to the *allowable charge* for the drug minus your *copayment* amount.

You must have used 75% of your medication before it can be refilled. In the event that your physician increases the amount of your dosage, your physician should provide a new prescription order to be filled by your pharmacy.

There is no coverage for prescriptions that are lost or stolen. *You* will need to have your prescription refilled and *you* will be responsible for the full cost of the prescription.

First- tier, second- tier, and third- tier drugs

The amount *you* will pay for a *prescription drug* depends on whether the drug *you* receive is a *first-tier*, *second-tier*, or *third-tier drug*. Refer to the **Summary of benefits** to determine your *copayment* amounts. *You* may request the brand name drug, and pay the difference in the *allowable charge* between the generic and the brand name drug, in addition to your *second-tier* or *third-tier copayment*. By law, generic and brand name drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves *you* and *your health plan* money, yet provides the same quality.

The determination of whether a particular drug is a *first-tier*, *second-tier*, or *third-tier drug* is made by the *plan administrator*. In exercising its discretion, the *plan administrator* will consider the absolute cost of a drug, the relative cost of a drug within its therapeutic class, the availability of over-the-counter alternatives, and certain clinical economic factors. The plan reserves the right, in its sole discretion, to move any *prescription drug* from one tier to another.



Helpful tip: Find out a drug's tier assignment on the Web at www.medco.com.

Drug prior authorization

Your health plan requires prior review of selected drugs before payment is authorized. *You* may view the list on the Web at www.medco.com under Search the Drug Listing. This list is periodically modified. A verbal prior authorization request, including drug name, quantity per day and strength, period of time the drug is to be administered, medical condition for which the drug is being prescribed, the patient's name, ID number, date of birth, and relationship to the employee, must be called in by your doctor to Medco member services at **800- 753- 2851**.

You will receive a written notice when a prescription prior authorization request is denied. Your doctor will be notified of both approval and denial decisions.

If prescribed in compliance with established statutes pertaining to patients with intractable cancer pain, *your health plan* will not deny *prescription drugs* (or *inpatient* or IV therapy drugs) used in the treatment of cancer pain on the basis that the dosage exceeds the recommended dosage of the pain relieving agent.

Medco by Mail

The Medco by Mail service allows *you* to purchase up to a 90-day supply of your *maintenance medication* through the mail and have your prescription delivered directly to your home. To receive your *maintenance medicine* prescription by mail, follow these steps:

1. Ask your doctor to prescribe a 90- day supply of your *maintenance medicine* plus refills. If *you* need the medicine immediately, ask your doctor for two prescriptions: one to be filled right away and another to send to Medco by Mail.
2. Mail your 90- day prescription, a check to cover your *copayment(s)*, the Medco by Mail order form and Patient Profile questionnaire in the home delivery window envelope to Medco by Mail. The forms are available on the Web at www.medco.com, from your *benefits administrator*, or from Medco at 800- 355- 8279.

You will receive your *prescription drugs* via first class mail or UPS approximately 14 days from the date *you* sent your order.



Helpful tip: We suggest that *you* order your refill two weeks before *you* need it to avoid running out of your medication.

You will receive refill forms and a notice that shows the number of refills your doctor ordered in the package with your drugs. To order refills, *you* must have used 75% of your medication. Mail the refill notice and the appropriate *copayment* amount to Medco by Mail in the envelope provided, or call 800- 4REFILL (800- 473- 3455), or visit www.medco.com to order online.

Prescription drugs when traveling

If *you* are planning to travel on vacation or leaving home for an extended period, *you* may need one or more early refills of your medication. Participating retail pharmacies and the Medco by Mail service may routinely provide one early refill (up to a 34-day or a 90-day supply, as appropriate) to accommodate travel. However, for extended travel members should complete the Prescription Drug Refill Exception Request form available on the DHRM Web site at www.dhrm.virginia.gov or from your *benefits administrator*. Send the completed signed form by fax or U.S. Mail to:

The Department of Human Resource Management (DHRM)
Office of Health Benefits
Attention: Policy and Instruction
101 North 14th Street, 13th Floor
Richmond, VA 23219
Fax: (804) 371- 0231

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DHRM will approve all valid requests and forward them to Medco Health Solutions, Inc. A member of Medco's customer service team will contact *you* to obtain specific medication information. Once *you* provide the medication information, a prior authorization will be entered for each medication requested and *you* will have 14 days to complete your purchase.

Please note:

- the maximum supply *you* may purchase at one time is 12 months;
- *you* will not be allowed to purchase more refills than prescribed. For example, if your one-year prescription expires six months from the date of your request, *you* cannot purchase more than a six-month supply of medication;
- *you* will be charged the appropriate co-payments for refills requested on the form. For example, *you* will be charged for a 6-month supply of medication if *you* requested a 6-month supply on the form and later decided to purchase only a 3-month supply at the pharmacy;
- the Food and Drug Administration limits early refills on certain medications;
- allow at least two weeks for complete processing of your request; and
- the Commonwealth reserves the right to bill a participant for any months of medication remaining if employment terminates.

How your behavioral health benefits work (ValueOptions)

ValueOptions administers the behavioral health, substance abuse and Employee Assistance Program (EAP) benefits that are covered under *your health plan*.

You are encouraged to have all behavioral health services preauthorized by calling ValueOptions at **866- 725- 0602** before receiving care, or within 48 hours of an *emergency* admission. This includes all *inpatient*, partial hospitalization, and *outpatient behavioral health services*. While preauthorization is not required, it does ensure that *you* are using a participating *provider* and that services are covered and *medically necessary*. If services are not considered *medically necessary* to treat a condition, or if *you* use a non-ValueOptions participating *provider*, benefits will not be payable. (See the **Optional benefits** section for information about the out-of-network optional benefit.)

When *you* receive care from a *provider* to whom *you* have been referred by ValueOptions, the *provider* works with a ValueOptions care manager to ensure that the services *you* receive are covered under *your health plan*. Professional staff members are available 24 hours a day, every day, to answer questions, assist with *referrals* to participating *providers*, and preauthorize care. When *you* do not obtain preauthorization, *you* are responsible for making sure that the services *you* receive are *medically necessary* for your condition.

In the event of a behavioral health or substance abuse crisis, behavioral health professionals are available at all times to assist *you* and to connect *you* to the appropriate local resources to ensure that your situation is managed safely.

The Employee Assistance Program is also available to provide confidential short-term counseling, education and referral services for *you* and your family members to assist with a variety of issues.

The ValueOptions Achieve Solutions Web site is another resource for *you* and family members to confidentially access information about behavioral health issues, resources, productivity and self-assessment tools. Go to **www.achievesolutions.net/covacare** .

Your behavioral health provider network

To identify a ValueOptions participating *facility* or *provider* and to obtain preauthorization for services, call **866- 725- 0602** . If *you* wish to review the ValueOptions provider directory, *you* may do so online at **www.achievesolutions.net/covacare** .

What is covered

Your health plan covers only those services that are *medically necessary*, with the exception of wellness and preventive services as outlined in this booklet. Just because the service is prescribed by a *provider* does not mean the service is *medically necessary*. In addition, *your health plan* requires that services be safely performed in the least costly *setting*.



Helpful tip: For information concerning coverage not listed in this booklet, contact the appropriate *plan administrator*.

See the **Summary of benefits** (page 1) for payment levels and limits for the covered services. For details of the specific coverage provided as well as what is not covered, use the page number references on the summary. All of the following services, except as noted, must be rendered by covered *facilities* or *providers*.

Ambulance travel



Your health plan covers professional ambulance services to or from the nearest facility or provider adequate to treat your condition. Included are:

- emergency ambulance;
- non-emergency ambulance services, such as transport of a patient from a hospital to another type of facility, or from the hospital to a residence after a hospital stay; and
- air ambulance.

Non-emergency ambulance and air ambulance services require medical necessity review. *Your health plan* highly recommends completing the medical necessity review process in advance of actually receiving these ambulance services so that *you* will know beforehand whether or not the services meet the medical necessity criteria.

Ambulance services billed through the facility are covered the same as all other facility services. However, if *you* use a non-network provider, *you* may be responsible for the difference between *your health plan's* allowable charge and the ambulance provider's fee.

Behavioral health and EAP



ValueOptions administers *your health plan's* behavioral health and EAP benefits. Contact ValueOptions to obtain *preauthorization* for services.

Services may be provided in various *settings* or *levels of care* depending upon the treatment that is needed. Care managers approve the appropriate *levels of care* based on your diagnosis and ValueOption's medical necessity criteria. *Acute care* requires the most intensive level of skills and services, and is provided in a psychiatric hospital or a detoxification unit. These *facilities* are licensed as hospitals and provide 24-hour medical and nursing care.

Partial day services combine intensive treatment in a medically supervised *setting*, with the opportunity for the patient to return home or to another residential *setting* at night. Care includes individual, group, family, educational, and rehabilitation services. These programs usually offer services three to five times per week for more than several hours per day.

Outpatient behavioral health services are the most frequently prescribed level of care provided for an individual, group, or family basis in an office *setting*. Therapists include licensed social workers, master's level psychiatric nurses, doctoral level psychologists, or psychiatrists.

Employee assistance program (EAP)

The EAP is a confidential assessment, referral, and short-term problem-solving service available to *you* and family members in your household. *You* are automatically enrolled in the program as part of *your health plan* coverage. The EAP helps *you* deal with problems affecting personal and work life, such as:

- conflicts within the family and workplace;
- personal and emotional concerns;
- alcohol and substance abuse;
- financial and legal problems;
- elder and child care; and
- career concerns and other challenges.

Your health plan covers up to four counseling sessions per incident at no cost to *you*. Contact ValueOptions at **866-725-0602** for assistance.

Medication management

Visits to your doctor are covered to make sure that medication *you* are taking for a behavioral health problem is working and that the dosage is right for *you*.

Dental services



Delta Dental administers *your health plan's* dental benefits. Benefits are available on a plan year basis (July 1 through June 30). The following list includes the majority of dental services covered by Delta Dental. All services are subject to Delta Dental's processing policies and guidelines.

After consulting with your dentist, *you* may select a more expensive covered benefit than the one Delta Dental determines is necessary or customary for the diagnosis or treatment of your condition. However, Delta Dental will pay only the amount that it would have paid for the less expensive covered benefit. In most cases, Delta Dental's payment for the more expensive service will not exceed

what Delta Dental customarily pays to restore your tooth to its proper contour and function. *You* are responsible for the entire balance of the dentist's fee for the more expensive covered benefit. Preauthorizations are recommended for procedures over \$250.

Diagnostic and preventive services

Your health plan provides coverage for *you* to see your dentist twice a year for a checkup. This allows your dentist to identify any possible problems and to try and prevent cavities and serious dental problems. Covered services include:

- two routine oral evaluations per plan year;
- two dental prophylaxes (cleanings) per plan year, including scaling and polishing of teeth;
- dental x-rays (except x-rays needed to fit braces);
- space maintainers used to keep teeth from moving into space left when deciduous teeth are pulled;
- two tests to see if a tooth is still alive (pulp vitality tests) every 12 months (the 12-month count starts the month in which *you* receive the pulp vitality test);
- care for a toothache (palliative *emergency* care);
- two sets of bitewing x-rays (two or more films) per plan year (vertical bitewings are considered a full mouth series and are allowed once every 36 months);
- one complete full mouth x-ray series (vertical bitewings are considered a full mouth series) or a panorex every 36 months (the 36-month count starts the month in which *you* receive the x-ray series or panorex);
- two topical fluoride applications per plan year only to *covered persons* under age 19;
- dental pit/fissure sealants to the unrestored occlusal surface of the first and second permanent molars (limited to one application per tooth). Dental pit/fissure sealants are available only to *covered persons* under age 19;
- occlusal adjustments, bite planes or splints for temporomandibular joint disorders; and
- occlusal night guards for demonstrated tooth wear due to bruxism and temporomandibular joint disorder (TMJ). Services are limited to once every five-year period.

Primary services

After your dentist has examined your teeth, *you* may need additional dental work. *Your health plan* includes coverage for the following:

- fillings (amalgam or tooth-colored materials);
- pin retention;
- simple extractions of natural teeth and surgical extractions of fully erupted teeth;
- root canal therapy (endodontics);
- care for abscesses in the mouth (excision and drainage);
- repair of broken removable dentures;
- surgical preparation of ridges for dentures;
- re-cementing existing crowns, inlays and bridges;
- removing infected parts of the gum and replacing them with healthy tissue (gingivectomy and gingivoplasty);
- scaling and root planing of the gum;

- stainless steel crowns for eligible children under age 16;
- sedative fillings;
- therapeutic pulpotomy for primary “baby” teeth only;
- periodontal evaluations (not in addition to periodic evaluations);
- an operation to remove diseased portions of bone around the teeth (osseous surgery);
- soft tissue grafts;
- bone grafts (only around natural teeth);
- guided tissue regeneration;
- general anesthesia in connection with a covered surgical dental service;
- crown lengthening when bone is removed and at least six weeks are allowed for healing;
- frenectomies;
- hemisection and root amputations;
- apicoectomies;
- periodontal maintenance (limited to two per plan year); and
- trips by the dentist to your home if *you* need any of the services *you* see listed here.

Dental services (non- routine medical)

Your health plan provides coverage for the following non-routine dental services through the Anthem medical benefits. The services listed below are covered as *other covered services* and are subject to the medical plan year *deductible* and out-of-pocket expense limit:

- *medically necessary* dental services resulting from an accidental injury, provided that, for an injury occurring on or after your effective date of coverage, *you* seek treatment within 60 days after the injury. Injury as a result of chewing or biting is not considered an accidental injury. *You* must submit a plan of treatment from your dentist or oral surgeon for prior approval by Anthem;
- *medically necessary* dental services when required to diagnose or treat an accidental injury to the teeth if the accident occurs while *you* are covered under the plan. These services and appliances are covered for adults if rendered within a two-year period after the accidental injury. The two-year restriction may be waived for children under age 18. Actual treatment may be delayed if tooth/bone maturity is in question and standard industry protocols are followed. However, a treatment plan must be filed within six months of the accident and treatment must be completed within two years of active treatment commencement and prior to age 20. For the waiver to be granted, continuous coverage under the plan is required;
- the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face;
- dental services and dental appliances furnished when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer.

The following services are covered as professional *provider* or *facility* services subject to the specialty care *provider* or *facility copayment*, and the plan year *deductible* does not apply:

- covered general anesthesia and hospitalization services for children under the age of 5, *covered persons* who are severely disabled, and *covered persons* who have a medical condition that requires admission to a hospital or *outpatient* surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the *covered person's* treating physician, that such services are required to effectively and safely provide dental care.

This is to clarify that oral surgery and certain non-routine dental services are covered under your Anthem medical benefits. Oral surgery includes surgical removal of impacted teeth and treatment of medically diagnosed cleft palate, or ectodermal dysplasia. A health service review is recommended prior to an oral surgery procedure.

Diabetic equipment and education



Your health plan covers medical supplies, equipment, and education for diabetes care. The following are covered under your medical plan through Anthem:

- insulin pumps and associated supplies;
- lancet devices;
- calibrator solution; and
- *outpatient* self-management training and education performed in person; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional. Diabetic education is covered at no cost to you.

The following are covered under your outpatient prescription drug plan through Medco:

- insulin;
- lancets;
- hypodermic needles and syringes;
- blood glucose test strips; and
- blood glucose meters.



Helpful tip: Amounts you pay under the medical benefit for diabetic equipment and supplies may apply to your *out-of-pocket expense limit*. See *Out-of-pocket expenses* section.

Diagnostic tests



Your health plan covers the following procedures when ordered by your doctor to diagnose a definite condition or disease because of specific signs and/or symptoms:

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

Observation, diagnostic examinations, or diagnostic laboratory testing that involves a hospital *stay* is covered under your health plan only when:

- your medical condition requires that medical skills be constantly available;
- your medical condition requires that medical supervision by your doctor is constantly available; or
- diagnostic services and equipment are available only as an *inpatient*.

Outpatient advanced diagnostic imaging tools can be the key to identifying underlying health problems, but unnecessary imaging may contribute to patient safety issues: increased radiation exposure and false positive findings that may result in additional unnecessary testing and potential surgical procedures. To help ensure that *you* are receiving services that are safe and appropriate, *we* have made available a health services review process for physicians ordering these services. Health services review is a process performed in advance of receiving an outpatient advanced diagnostic imaging service. The purpose is to review for safety, appropriateness, and medical necessity, and to determine whether the service meets coverage guidelines. If your doctor orders one of the following tests for *you*, *we* suggest that *you* ask your doctor to initiate a health services review by contacting *Anthem*:

- magnetic resonance angiography (MRA);
- magnetic resonance imaging (MRI);
- magnetic resonance spectroscopy (MRS);
- computed tomographic angiography (CTA);
- positron emission tomography (PET) scans; and
- computed tomography (CT) scans.



Helpful tip: While there is no penalty if the health services review is not performed in advance of receiving the service, the advantage of the front-end review is that *you* and your doctor know beforehand whether the service is appropriate, medically necessary, and meets coverage guidelines. If advance approval is not obtained and the service is later determined not to be *medically necessary*, *you* may have to pay for the service.

Dialysis



Your health plan covers dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis.

Doctor visits and services



Your health plan covers:

- visits to a doctor's office or your doctor's visits to your home;
- visits to an urgent care center;
- visits to a hospital *outpatient* department or *emergency* room; and
- visits for shots needed for treatment (for example, allergy shots).

Early intervention services



Your health plan covers early intervention services for covered dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services ("DMH") as eligible for services under Part H of the Individuals with Disabilities Education Act. These services consist of:

- speech and language therapy;
- occupational therapy;

- physical therapy; and
- assistive technology services and devices.

Early intervention services for the population certified by DMH are those services listed above which are determined to be *medically necessary* by DMH and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not *medically necessary*.

Emergency room care



Your health plan covers emergency room visits, services, and supplies. If you are admitted to the hospital from the emergency room, the hospital stays must be reviewed by Anthem for medical services or by ValueOptions for behavioral health services within 48 hours of admission. The emergency room doctor, a relative, or a friend can call for hospital admission review in an emergency.

Hearing services



Your health plan only covers services for hearing impairment due to illness or accident. If you selected the vision, hearing and expanded dental option, see the **Optional benefits** section for a description of your routine hearing benefits.

Home care services



Your health plan covers treatment provided in your home on a part-time or intermittent basis. This coverage allows for an alternative to repeated hospitalizations that will provide the quality and appropriate level of care to treat your condition. To ensure benefits, your doctor must provide a description of the treatment you will receive at home. Your coverage includes the following home health services:

- visits by a licensed health care professional, including a nurse, therapist, or home health aide; and
- physical, speech, and occupational therapy (services provided as part of home health are not subject to dollar-limits).

These services are only covered when your condition confines you to your home at all times except for brief absences.

Home private duty nurse's services



Your health plan covers the cost of medically skilled services of a currently licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in your home when the nurse is not a relative or member of your family. Your doctor must certify to your plan administrator that the services are *medically necessary* for your condition, and not merely custodial in nature.

Hospice care services



Hospice care will be covered for *covered persons* diagnosed with a terminal illness who have a life expectancy of six months or less. Covered services include the following:

- skilled nursing care, including IV therapy services;
- drugs and other *outpatient* prescription medications for palliative care and pain management;
- services of a medical social worker;
- services of a home health aide or homemaker;
- short-term *inpatient* care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute *inpatient* care for the *covered person* in order to provide the *covered person's* primary caregiver a temporary break from caregiving responsibilities. Respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided for more than five days every 90 days;
- physical, speech, or occupational therapy;
- *medical equipment (durable)*;
- routine medical supplies;
- routine lab services;
- counseling, including nutritional counseling with respect to the *covered person's* care and death; and
- bereavement counseling for immediate family members both before and after the *covered person's* death.

Hospital services



Your *health plan* covers the hospital and doctors' services when you are treated on an *outpatient* basis, or when you are an *inpatient* because of illness, injury, or pregnancy. (See **Maternity** on page 26 for an additional discussion of pregnancy benefits.) Your *health plan* covers *medically necessary* care in a semi-private room or intensive or special care unit. This includes your bed, meals, special diets, and general nursing services.

In addition to your semi-private room, general nursing services and meals, your *health plan* covers *allowable charges* for *medically necessary* services, supplies and medications furnished by the hospital when prescribed by your doctor or *provider*.

The hospital must meet the American Hospital Association's standards for registration as a hospital. Remember that your share of the cost of covered services will change if you use a doctor, *facility*, or other health care *provider* that is outside your network.

While you are an *inpatient* in the hospital, your *health plan* covers the *medically necessary* services rendered by doctors and other covered *providers*.



Helpful tip: All non-emergency *inpatient* hospital stays must be approved in advance, except hospital stays for vaginal or cesarean deliveries without complications (see **Hospital admission review**).

Private room

Your *health plan* covers the private room charge if you need a private room because you have a highly contagious condition; you are at greater risk of contracting an infectious disease because of your medical condition; or if the hospital only has private rooms. Otherwise, your *inpatient* benefits would cover the hospital's charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your *copayment* and *coinsurance* (if any).

Infusion services



Your *health plan* covers infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.

Maternity



Prenatal and newborn care

If you (or your covered dependent) become pregnant, your *health plan* provides several coverage features. Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered by your *health plan*.



Helpful tip: You must add your newborn to your plan within 31 days of the date of birth, or your newborn will not be covered.

Your benefits include:

- use of the delivery room and care for normal deliveries;
- home *setting* covered with nurse midwives;
- anesthesia services to provide partial or complete loss of sensation before delivery;
- hospital services for routine nursery care for the newborn during the mother's normal hospital *stay*;
- prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
- initial examination of a newborn and circumcision of a covered male dependent; and
- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

If your doctor submits one bill for delivery, prenatal, and postnatal care services, payment will be made at the same level as *inpatient* professional *provider* services. If your doctor bills for these services separately your payment responsibility will be determined by the services received.

Future Moms (formerly Baby Benefits)

You (or your covered dependent) are eligible to participate in the Future Moms program. This free program is designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery. A Future Moms consultant is assigned to women identified as having greater risk of premature delivery. The consultant (a nurse or health educator) works with the mother and her doctor during the pregnancy to determine what may be needed to help achieve a full-term delivery.

As soon as pregnancy is confirmed, sign up for the program by calling **800-828-5891**. You will receive:

- toll-free access to a registered nurse, any time day or night, in case you have questions or concerns along the way;
- a prenatal book to help you follow your pregnancy week by week, materials to help you handle the unexpected; and
- postpartum support and guidance in areas like breastfeeding and depression.

Medical equipment (durable)



Your health plan covers the rental (or purchase if that would be less expensive) of *medical equipment (durable)* when prescribed by your doctor. Also covered are maintenance and necessary repairs of *medical equipment (durable)* except when damage is due to neglect. Medical necessity review is required. Contact Anthem member services at **800-552-2682** for assistance with medical necessity review. Network *medical equipment (durable)* providers are shown in the Anthem Commonwealth of Virginia Medical Provider Directory under Ancillaries, *Durable Medical Equipment*. If you obtain equipment from a non-network *medical equipment (durable)* provider, you will still have coverage. However, in addition to your *deductible* and *coinsurance*, the non-network provider may bill you for the difference between the plan's *allowable charge* and the provider's charge.

Coverage includes equipment such as:

- nebulizers;
- hospital-type beds;
- wheelchairs;
- traction equipment;
- walkers; and
- crutches.

Medical devices and appliances



Your health plan covers the cost of fitting, adjustment, and repair of the following items when prescribed by your doctor for *activities of daily living*:

- artificial limbs, including accessories;
- orthopedic braces;
- leg braces, including attached or built-up shoes attached to the leg brace;
- arm braces, back braces, and neck braces;

- head halters;
- catheters and related supplies;
- orthotics, other than foot orthotics; and
- splints.

Medical necessity review is required. Contact Anthem member services at **800- 552- 2682**.

Medical formulas



Your health plan covers special medical formulas which are the primary source of nutrition for *covered persons* with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

Medical supplies

Medical supplies are covered under *your health plan* if they are prescribed by a covered *provider*. Some medical supplies require medical necessity review. An example of medical supplies is oxygen and equipment (respirators) for its administration.

Prescription drugs (outpatient) - mandatory generic program



Medco administers your benefits for *outpatient prescription drugs* received through a retail pharmacy or the Medco by Mail service.

Also covered are *prescription drugs* and devices approved by the Food and Drug Administration (FDA) for use as contraceptives, and *outpatient prescription drugs* for smoking cessation.

Your *outpatient prescription drug* benefits provide the following to treat diabetes:

- insulin;
- lancets;
- hypodermic needles and syringes;
- blood glucose test strips; and
- blood glucose meters.

Shots (Injections)



Your health plan covers therapeutic injections (shots) that a *provider* gives to treat illness (e.g., allergy shots) or pregnancy-related conditions. Also included is allergy serum for allergy shots. In addition, *you* have coverage for immunizations and self-administered injections.

Skilled nursing facility stays



Your coverage includes benefits for skilled nursing home *stays*. Coverage for your *stay* requires prior approval. Your doctor must submit a plan of treatment that describes the type of care *you* need. The following items and services will be provided to *you* as an *inpatient* in a skilled nursing bed of a *skilled nursing facility*:

- room and board in semi-private accommodations;
- rehabilitative services; and
- drugs, biologicals, and supplies furnished for use in the *skilled nursing facility*, and other *medically necessary* services and supplies.

Your *health plan* will cover the private room charge if *you* need a private room because *you* have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your *inpatient* benefits would cover the skilled nursing facility's charges for a semi-private room. If *you* choose to occupy a private room, *you* will be responsible for paying the daily differences between the semi-private and private room rates in addition to your *copayment* and *coinsurance* (if any).

Custodial or residential care in a *skilled nursing facility* or any other facility is not covered except as rendered as part of Hospice care.

Spinal manipulation and other manual medical interventions



Your *health plan* covers spinal manipulation services (manual medical interventions) and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations.

Surgery



General surgery

Surgery charges are covered under your medical benefits when treatment is received at an *inpatient*, *outpatient* or ambulatory surgery *facility*, or doctor's office.

Allowable charge for surgical services

Your *health plan* will not pay separately for pre- and post-operative services. If more than one surgical procedure is performed during the same operation, we will calculate the *allowable charge* for all of the services combined by adding:

- the *allowable charge* for the service with the highest *allowable charge*; plus
- 50% of the *allowable charge* for each of the additional surgical services if they had been performed separately.

This is the most *your health plan* will pay during a single operation, unless extraordinary circumstances exist.

Assistant at surgery

Services of a physician who actively assists the operating surgeon to perform a covered surgical service are covered services. However, when two or more surgeons provide a covered surgical service that could have been performed by one surgeon, the *allowable charge* will not be more than that available to one surgeon.

Anesthesia

When surgical services require anesthesia, anesthesia services rendered by a second physician are covered services. However, when the physician performs both the surgical service and the anesthesia service, the *allowable charge* for the anesthesia services will be 50% of what it would have been if a second physician had performed the anesthesia service.

Morbid obesity treatment

Your health plan covers treatment of morbid obesity through gastric bypass, or other methods recognized by the National Institutes of Health (NIH). According to the NIH guidelines, gastric bypass surgery is effective for the long-term reversal of morbid obesity for a patient who:

- weighs at least 100 pounds over or twice the ideal body weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables;
- has a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- has a body mass index of 40 kilograms per meter squared, without such comorbidity.

As used above, body mass index equals weight in kilograms divided by height in meters squared.

Reconstructive breast surgery and mastectomy

Mastectomy, or the surgical removal of all or part of the breast, is a covered service. Also covered are:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the *covered person*.

Reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to re-establish symmetry between two breasts is also covered.

Oral surgery

Your medical benefits cover oral surgery for:

- surgical removal of impacted teeth;
- maxillary or mandibular frenectomy when not related to a dental procedure;
- alveolectomy when related to tooth extraction;
- orthognathic surgery that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed *medically necessary* to attain functional capacity of the affected part;
- surgical services on the hard or soft tissue in the mouth when the main purpose is **not** to treat or help the teeth and their supporting structures; and
- the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

This is to clarify that oral surgery and certain non-routine dental services are covered under your Anthem medical benefits. Oral surgery includes surgical removal of impacted teeth and treatment of medically diagnosed cleft palate, or ectodermal dysplasia. A health service review is recommended prior to an oral surgery procedure.

Medical necessity review is required for non-routine oral surgery.

Organ and tissue transplants, transfusions

Your health plan covers some but not all organ and tissue transplants. Medical necessity review is required. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan. However, benefits for these services are limited only to those not available to the donor from any other source, including, but not limited to, other insurance coverage or any government program.

When only the donor is a covered person under the plan, only the organ donation procedure itself, including services rendered at the time of the organ donation procedure, are covered services. Any services provided prior to the organ donation procedures are not covered, whether inpatient or outpatient, even if they are provided in anticipation of the organ donation or as preparation for the organ donation.

Covered services for the identification of a suitable donor to a covered person for an allogeneic bone marrow transplant will include a computer search of established bone marrow registries and laboratory testing necessary to establish compatibility of potential donors. Donors may be from the patient's immediate family or have been identified through the computer search. These services must be ordered by a doctor qualified to provide allogeneic transplants.

Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are

experienced in *high dose* chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of *experimental/investigative* services.

Sterilizations and reversals of sterilization

Your *health plan* also covers the following surgical sterilization procedures, and reversals thereof:

- vasectomies; and
- tubal ligations.

Therapy



Your *health plan* covers the following therapies when the treatment is medically necessary for your condition and provided by a licensed therapist:

Cardiac rehabilitation therapy

Your *health plan* includes benefits for cardiac rehabilitation, which is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

Chemotherapy

Your *health plan* covers the treatment of disease by chemical or biological antineoplastic agents.

Occupational therapy

Your *health plan* covers occupational therapy following disease, injury, or loss of limb. Occupational therapy is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.

Physical therapy

Your *health plan* covers physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. Your coverage includes benefits for physical therapy to treat lymphedema.

Radiation therapy

Your *health plan* covers radiation therapy, including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.

Respiratory therapy

Your health plan covers respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

Speech therapy

Your health plan covers speech therapy, which is treatment for the correction of a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment. Speech therapy to treat developmental delay is not covered, except as required by Section 2.2-2818 of the Code of Virginia for early intervention services.



Helpful tip: It is suggested that you obtain a health services review prior to receiving occupational, physical or speech therapy to ensure the services are covered and *medically necessary*.

Vision correction after surgery or accident



Your medical benefits cover the cost of prescribed eyeglasses or contact lenses only when required as a result of surgery, or for the treatment of accidental injury. Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if:

- prescribed to replace the human lens lost due to surgery or injury;
- "pinhole" glasses are prescribed for use after surgery for a detached retina; or
- lenses are prescribed instead of surgery in the following situations:
 - contact lenses are used for the treatment of infantile glaucoma;
 - corneal or scleral lenses are prescribed in connection with keratoconus;
 - scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or
 - corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.

If you selected the vision, hearing and expanded dental option, see the **Optional benefits** section for a description of your routine vision benefits.

Wellness services



Well child care

Well child benefits include coverage for routine care, screenings, checkups, and immunizations for your child through age 6. These services are based on the recommendations of the American Academy of Pediatrics, and include the following:

- complete physical examinations, developmental assessment and guidance;
- immunizations such as diphtheria, tetanus, pertussis (DTP), polio, measles, mumps, rubella (MMR), hemophilus vaccine (HIB), hepatitis B, varicella virus (chicken pox) vaccine, pneumococcal conjugate vaccine, influenza, and other immunizations as may be prescribed by the Commissioner of Health; and
- certain laboratory and screening tests, including hearing and vision tests required for a preschool physical exam.

The American Academy of Pediatrics recommends the following schedule for well child care visits:

Birth	2 months	9 months	18 months	4 years
2- 4 days	4 months	12 months	2 years	5 years
2- 4 weeks	6 months	15 months	3 years	6 years



Helpful tip: These benefits are for well children. Treatment of an illness or *emergency* is covered according to the terms described for specific conditions or treatments.

Routine wellness



Your *health plan* provides routine wellness benefits. For covered members age 7 and older, benefits are provided for one check-up, routine laboratory and radiological services, and immunizations per plan year, as recommended by the American Medical Association (AMA) or the American College of Radiology (ACR). Contact Anthem member services at **800-552-2682** to determine which routine wellness services are covered.

Preventive care



Preventive care under your *health plan* includes (one each per plan year):

- a gynecological exam and Pap test including coverage for testing performed by any FDA-approved gynecologic cytology screening technologies;
- mammography screening for patients age 35 or older;
- prostate exam (digital rectal exam) and Prostate Specific Antigen test for enrollees ages 40 and older; and
- colorectal cancer screening, for patients age 40 or older, such as:
 - a fecal occult blood test;
 - flexible sigmoidoscopy;
 - colonoscopy; or
 - barium enema.

Sometimes during the course of a screening procedure (routine wellness or preventive care), abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your *provider* performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your *provider*. This may result in a possible difference in your *copayment* and/or *coinsurance*. Please see the Diagnostic test and Surgery sections on the **Summary of benefits**, and

earlier in this section, for a complete description of these benefits.



Helpful tip: Charges for routine laboratory, tests, shots and x- rays in conjunction with your routine wellness check- up *visit* apply toward the maximum for Routine Wellness Care described in the **Summary of benefits**.

What is not covered (Exclusions)

This alphabetical list of services and supplies that are excluded from coverage by *your health plan* will not be covered except as otherwise outlined in this booklet.

A

Your coverage does not include benefits for **acupuncture**.

B

Your coverage with ValueOptions, in addition to services shown as not covered throughout this section, does not include benefits for **behavioral health services** as follows:

- *inpatient* treatment or *inpatient stay* for conditions requiring only observation, diagnostic examinations, or diagnostic laboratory testing;
- *inpatient* treatment which might safely and adequately be rendered in a home, provider's office, or at any lesser level of institutional care;
- *inpatient* rehabilitation for the sole treatment of a chemical dependency diagnosis;
- services provided as a result of failure or refusal to obtain treatment or follow a plan of treatment prescribed or directed by a practitioner;
- court ordered examinations or care unless *medically necessary*;
- routine examinations or testing (may be covered under medical);
- illness resulting from or relating to commission of a felony;
- treatment of organic brain syndrome;
- treatment of anti-social personality, inadequate personality, sexual deviation or sexual dysfunction, social maladjustment without apparent psychiatric disorder, group delinquent reaction of childhood, mental retardation, Tourette's disorder, learning disabilities, and conduct and oppositional disorders;
- examination of an *inpatient* that is not related to the behavioral health diagnosis;
- marital counseling, education therapy, speech therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, and recreational therapy;
- psychoanalysis to complete degree or residency requirements;
- pastoral counseling;
- psychological testing for educational purposes;
- hypnosis for disorders not classified in the Diagnostic and Statistical Manual of Mental Disorders; or
- treatment of conditions not recognized in the Diagnostic and Statistical Manual of Mental Disorders such as adult child of alcoholic families, "ACOA", or co-dependency; conditions classified as "V-codes" in the Diagnostic and Statistical Manual of Mental Disorders; and conditions arising from developmental disorders (mental retardation, academic skills disorders, motor skills disorders, and organic brain disorders in which demonstrable and significant improvement from psychiatric treatment is unlikely).

Your coverage does not include benefits for **biofeedback therapy**.

C

Your coverage does not include benefits for:

- Over-the-counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, and ice bags; or
- **cosmetic surgery or procedures, including complications** that result from such surgeries and/or procedures. The severity of the complication is not a mitigating factor. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. A cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process, or to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

D

Your coverage does not include benefits for the following **dental** services. This list includes the majority of dental services not covered by Delta Dental and is not a comprehensive list of all non-covered services:

- services rendered after the date of termination of the covered person's coverage. There is one exception. Covered prosthetic services which are prepped or ordered before the termination date are covered if completed within 30 days following the termination date;
- brush biopsies of the oral cavity;
- gold foil restorations;
- athletic mouth guards;
- temporary dentures, crowns or duplicate dentures;
- oral, inhalation or intravenous (IV) sedation;
- bleaching of discolored teeth;
- dental pit/fissure sealants on other than first and second permanent molars;
- root canal therapy on other than permanent teeth;
- pulp capping (direct or indirect);
- upgrading of working dental appliances;
- precision attachments for dental appliances;
- tissue conditioning;
- separate charges for infection control procedures and procedures to comply with OSHA requirements;
- separate charges for routine irrigation or re-evaluation following periodontal therapy;
- analgesics (nitrous oxide);
- general anesthesia except in conjunction with oral surgery, surgical periodontia, or surgical endodontia and then only when the underlying dental service is a covered benefit;
- diagnostic photographs;
- periodontal splinting and occlusal adjustments for periodontal purposes;

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- occlusal analysis;
- controlled release of medicine to tooth crevicular tissues for periodontal purposes;
- tooth desensitizing treatments;
- care by more than one dentist when you transfer from one dentist to another during the course of treatment;
- care by more than one dentist for one dental procedure, or by someone other than a dentist or qualified dental hygienist working under the supervision of a dentist;
- surgical extractions of impacted teeth (this procedure may be covered under your medical benefits);
- preventive control programs, or oral hygiene instructions;
- complimentary services or dental services for which the participant would not be obligated to pay in the absence of the coverage under this plan or any similar coverage;
- dental services for lost, misplaced or stolen prosthetic devices including orthodontic retainers, space maintainers, bridges and dentures (among other devices);
- services that Delta Dental determines are for the purpose of cosmetic surgery or dentistry for cosmetic purposes;
- services that Delta Dental determines are for the purpose of correcting congenital malformations or replacing congenitally missing teeth;
- dental services for increasing vertical dimension, restoring occlusion, correcting developmental malformations, or for esthetic purposes;
- services billed under multiple dental service procedure codes which Delta Dental, in its sole discretion, determines should have been billed under a single, more comprehensive dental service procedure code. Delta Dental's payment is based on the allowance for the more comprehensive code, not on the allowances for the underlying component codes; and
- any services not listed as covered under **Dental services** in the **What is covered** section or in the **Optional benefits** section if you purchased the Expanded dental option, or services determined by Delta Dental, in its sole discretion, to be not necessary or customary for the diagnosis or treatment of the condition. Delta Dental will take into account generally accepted dental practice standards in the area in which the dental service is provided. In addition, a covered person must have a valid need for each covered benefit. A valid need is determined in accordance with generally accepted standards of dentistry.

E

Your coverage does not include benefits for **educational** or teacher services except as specified in this booklet.

Your medical coverage does not include benefits for *experimental/investigative* procedures, as well as services related to or complications from such procedures, except for clinical trial costs for cancer. The criteria for deciding whether a service is *experimental/investigative* or a clinical trial cost for cancer is described in **Exhibit A**. Your behavioral health coverage does not include benefits for *experimental/investigative* services or supplies as determined by ValueOptions in its sole discretion. The criteria for this determination is whether any supply or drug has received final approval to market by the U.S. Food and Drug Administration; whether there is sufficient information in the peer-reviewed medical and scientific literature for ValueOptions to judge safety and efficacy; whether available

scientific evidence shows a good effect on health outcomes outside of a research *setting*; and whether the service or supply is safe and effective outside a research *setting* as a current diagnostic or therapeutic option.

F

Your coverage does not include benefits for **family planning** services. These include:

- services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception, including any drugs administered in connection with these procedures;
- drugs used to treat infertility, even if they are used for an indication other than infertility; or
- services for abortions, except in the following circumstances and only if not otherwise contrary to law: when *medically necessary* to save the life of the mother; when the pregnancy occurs as a result of rape or incest which has been reported to a law enforcement or public health agency; or when the fetus is believed to have an incapacitating physical deformity or incapacitating mental deficiency which is certified by a provider.

Your coverage does not include benefits for palliative or cosmetic **foot care** including:

- flat foot conditions;
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;
- foot orthotics;
- subluxations of the foot;
- corns;
- bunions (except capsular or bone surgery);
- calluses;
- care of toenails;
- fallen arches;
- weak feet;
- chronic foot strain; or
- symptomatic complaints of the feet.

H

Your coverage does not include benefits for **hearing care** for a routine hearing loss that is not due to a specific illness or injury, hearing aids or exams for these devices, except as covered under **Well child care**. If you have purchased the vision, hearing and expanded dental option, additional hearing benefits are described in the **Optional benefits** section.

Your coverage does not include benefits for the following **home care services**:

- homemaker services;
- maintenance therapy;
- food and home-delivered meals; or
- custodial care and services.

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Your coverage does not include benefits for the following **hospital** services:

- guest meals, telephones, televisions, and any other convenience items received as part of your *inpatient stay*; or
- care by interns, residents, house physicians, or other *facility* employees that are billed separately from the *facility*.

M

Your coverage does not include benefits for **medical equipment, appliances and devices, and medical supplies** that have both a non-therapeutic and therapeutic use, such as:

- exercise equipment;
- air conditioners, dehumidifiers, humidifiers, and purifiers;
- hypoallergenic bed linens;
- whirlpool baths;
- handrails, ramps, elevators, and stair glides;
- telephones;
- adjustments made to a vehicle;
- foot orthotics;
- changes made to a home or place of business; or
- repair or replacement of equipment *you* lose or damage through neglect.

Your coverage does not include benefits for *medical equipment (durable)* that is not appropriate for use in the home.

Your coverage does not include benefits for services and supplies if they are deemed not **medically necessary** as determined by the appropriate *plan administrator* at their sole discretion. Nothing in this exclusion shall prevent *you* from appealing the *plan administrator's* decision that a service is not *medically necessary*.

However, if *you* receive *inpatient* or *outpatient* services that are denied as not *medically necessary*, or are denied for failure to obtain the required preauthorization, the following professional provider services that *you* receive during your *inpatient stay* or as part of your *outpatient* services will not be denied under this exclusion in spite of the medical necessity denial of the overall services:

For *inpatients*

1. services that are rendered by professional *providers* who do not control whether *you* are treated on an *inpatient* basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.
2. services rendered by your attending provider other than *inpatient* evaluation and management services provided to *you*. *Inpatient* evaluation and management services include routine *visits* by your attending provider for purposes such as reviewing patient status, test results, and patient medical records. *Inpatient* evaluation and management *visits* do not include surgical, diagnostic, or therapeutic services performed by your attending provider.

For *outpatients* - services of pathologists, radiologists and anesthesiologists rendering services in an (i) *outpatient* hospital *setting*, (ii) *emergency* room, or (iii) ambulatory surgery *setting*. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician.

N

Your coverage does not include benefits for **nutritional counseling** and related services, except when provided as part of diabetes education, or in conjunction with covered surgery to treat morbid obesity.

O

Your coverage does not include benefits for services and supplies related to **obesity** or services related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.

The exception to this exclusion is for morbid obesity as set forth in the “**Surgery**” paragraph of the “**What is covered**” section.

Your coverage does not include benefits for **organ or tissue transplants** including complications caused by them, except as outlined on page 31 of this book.

P

Your coverage does not include benefits for **paternity testing**.

Your outpatient **prescription drug** benefit does not include coverage for:

- over-the-counter drugs;
- any per unit, per month quantity over the plan’s limit;
- drugs used mainly for cosmetic purposes;
- drugs that are experimental, investigational, or not approved by the FDA;
- cost of medicine that exceeds the *allowable charge* for that prescription;
- drugs for weight loss, except in conjunction with covered treatment of morbid obesity;
- stop smoking aids;
- therapeutic devices or appliances;
- injectable *prescription drugs* that are supplied by a *provider* other than a pharmacy;
- charges to inject or administer drugs;
- drugs not dispensed by a licensed pharmacy;
- drugs not prescribed by a licensed *provider*;
- any refill dispensed after one year from the date of the original prescription order;
- medicine covered by workers’ compensation, Occupational Disease Law, state or government agencies;
- medicine furnished by any other drug or medical service;
- drugs used to treat infertility even if they are used for an indication other than infertility; or
- replacements for lost or stolen prescriptions.

Your coverage does not include benefits for **private duty nurses** in the *inpatient setting*.

R

Your coverage does not include benefits for rest cures, custodial, **residential**, halfway house or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether *you* receive active 24-hour skilled professional nursing care, daily physician *visits*, daily assessments, and structured therapeutic services.

Your coverage does not include benefits for care from institutions or *facilities* that are licensed solely as **residential treatment centers**, or other non-skilled, sub-acute *inpatient settings*.

S

Your coverage does not include benefits for **services or supplies** as follows:

- ordered by a doctor whose services are not covered under *your health plan*;
- care of any type given along with the services of an attending *provider* whose services are not covered;
- not listed as covered under *your health plan*;
- not prescribed, performed, or directed by a *provider* licensed to do so;
- received before the *effective date* of coverage or after a covered person's coverage ends;
- telephone consultations or consultations by other electronic means, charges for not keeping appointments, or charges for completing claim forms;
- for travel, whether or not recommended by a physician;
- given by a member of the covered person's immediate family;
- provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not *you* waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. *Your health plan* will pay for covered services when these program benefits have been exhausted;
- provided under a U. S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government;
- received from an employer mutual association, trust, or a labor union's dental or medical department; or
- for diseases contracted or injuries caused because of participation in war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

Your coverage does not include benefits for **services** for which a charge is not usually made. This includes services for which *you* would not have been charged if *you* did not have health care coverage.

Your coverage does not include benefits for:

- amounts above the *allowable charge* for a service;
- self-administered services or self-care;
- self-help training; or
- biofeedback, neurofeedback, and related diagnostic tests.

Your coverage does not include benefits for surgeries for **sexual dysfunction**. In addition, your coverage does not include benefits for services for **sex transformation**. This includes medical, behavioral health, and prescription drug services.

Your coverage does not include benefits for the following **skilled nursing facility stays**:

- treatment of psychiatric conditions and senile deterioration;
- a private room unless it is *medically necessary*; or
- *facility* services during a temporary leave of absence from the *facility*.

Your medical coverage does not include benefits for services related to **smoking cessation**, including stop smoking aids or services of stop smoking clinics.

T

Your coverage does not include benefits for the following **therapies**:

- physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services;
- speech therapy to treat developmental delay except as required by Section 2.2-2818 of the Code of Virginia for early intervention services;
- group speech therapy;
- group or individual exercise classes or personal training sessions; or
- recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

V

Your medical coverage does not include benefits for the following **vision** services:

- services for radial keratotomy and other surgical procedures to correct nearsightedness and/or farsightedness. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics;
- sunglasses of any type;
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer; or
- any other vision services not specifically listed as covered.

If you have purchased the vision, hearing and expanded dental option, additional vision benefits are described in the **Optional benefits** section.

W

Your coverage does not include benefits for services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if *you* waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the *covered person* reaches a settlement with his or her employer or the employer's insurer or self-insurance association because of the injury or disease.

Claims and payments

Your *health plan* considers the charge to be incurred on the date a service is provided. This is important because *you* must be actively enrolled on the date the service is provided. Also, the dates of service will affect your *deductible* (if any) and other limits described in the **Summary of benefits** and in this section.



Helpful tip: Any portion of your *deductible* that *you* met during the last quarter of the plan year (April, May, June) will be applied to your *deductible* for the following plan year.

Your out- of- pocket expense limit

Your *health plan* protects *you* from large out- of- pocket expenses by limiting the amount *you* spend out of your own pocket each plan year. Once the plan year limit on *your health plan* is reached, almost all other covered expenses are paid in full (100% of the *allowable charge*) for the rest of the plan year.

If you have not purchased the out- of- network option

What counts toward your out- of- pocket expense limit

- *deductible*, *copayments* and *coinsurance* for covered services from *providers* and *facilities* in your Anthem, BlueCard PPO, or ValueOptions networks.

What does not count toward your out- of- pocket expense limit

- expenses for services or supplies not covered by *your health plan*;
- amounts above the *allowable charge* (these amounts are not the patient's responsibility when services are rendered by a network *provider* or *facility*);
- amounts above the health plan limits;
- *copayments* and *coinsurance* for *outpatient prescription drugs*, routine and expanded dental services, and the optional routine vision and hearing benefits; and
- *deductible* amounts carried forward from the prior *plan year*.

If you have purchased the out- of- network option

What counts toward your out- of- pocket expense limit

- *deductible*, *copayments* and *coinsurance* for covered services from *providers* and *facilities* in your Anthem, BlueCard PPO, or ValueOptions networks, and *providers* and *facilities* **not** in the networks.

What does not count toward your out-of-pocket expense limit

- the plan's 25% payment reduction for covered services from *providers* and *facilities* not in your Anthem, BlueCard PPO, or ValueOptions networks;
- amounts above the *allowable charge* (these amounts are not the patient's responsibility when services are rendered by a participating *provider* or *facility*);
- amounts above the health plan limits;
- *copayments* and *coinsurance* for *outpatient prescription drugs*, routine and expanded dental services, and the optional routine vision and hearing benefits;
- expenses for services or supplies not covered by *your health plan*; and
- *deductible* amounts carried forward from the prior *plan year*.

How a claim is paid

Network and participating providers and facilities

If you go to a network or participating *provider* or *facility*, the *plan administrator* will pay the *provider* or *facility* directly.

If *coinsurance* or a *copayment* is applicable to covered services rendered by a network or participating *facility* or *provider*, or if any applicable *deductible* is not met, any such amounts may be collected at the time of service. Any applicable *coinsurance* is based on the *plan administrator's* negotiated payment arrangement with the *facility* or *provider*.

Non-participating providers and facilities

If the services of a non-participating *provider* or *facility* are covered in an *emergency*, *your health plan* may choose to pay *you* or anyone else responsible for paying the bill. *Your health plan* will pay only after it has received an itemized bill or proof of loss and all the medical information it needs to process the claim. It will not pay a non-participating *provider* more than it would have paid a participating *provider* for the same service.

When the *plan administrator's* payment for covered *out-of-network* services is made directly to *you*, *you* are responsible for sending payment to the *out-of-network provider*.

In all cases, the payment relieves the *plan administrator* and *your health plan* of any further liability for the service.

When you must file a medical claim with Anthem

Network *providers* file claims on your behalf. *You* may have to file a claim if *you* receive care from a *provider* or *facility* that does not participate in the network.

You will have to file a claim if you receive care billed by someone other than a doctor or hospital, or if the provider cannot file a claim for you. To file a claim follow these 3 steps:

1. Download a claim form at www.anthem.com/cova or call **800- 552- 2682** to order a claim form, or request one from your *benefits administrator*.
2. Please include the completed and signed claim form and any itemized bills for covered services. Each itemized bill must contain the following:
 - name and address of the person or organization providing services or supplies;
 - name of the patient receiving services or supplies;
 - date services or supplies were provided;
 - the charge for each type of service or supply;
 - a description of the services or supplies received; and
 - a description of the patient's condition (diagnosis).

In addition, private duty nursing bills must include the professional status of the nurse (for example, RN for registered nurse), the attending physician's written certification that the services were *medically necessary*, and the hours the nurse worked.

3. Send the completed claim form and any itemized bills for covered services to:

Anthem Blue Cross and Blue Shield
P. O. Box 27401
Richmond, VA 23279

File out- of- country medical claims through BlueCard Worldwide

Follow these simple steps if you receive medical services outside of the United States:

1. If the BlueCard Worldwide Service Center arranged your hospitalization, the *hospital* will file the claim for you, and you will need to pay the *hospital* for the out- of- pocket expenses you normally pay.
2. For *outpatient* and doctor care, or *inpatient* care not arranged through the BlueCard Worldwide Service Center, you will need to pay the health care *provider* and submit an international claim form with original bills to the Service Center.
3. International claim forms are available from the BlueCard Worldwide Service Center toll- free at **800- 810- 2583**, collect at **804- 673- 1177**, or online at www.bcbs.com/bluocardworldwide.

When you must file a dental claim with Delta Dental

Network *providers* file claims on your behalf. You may have to file a claim if you receive care from a *provider* who does not participate in the DeltaPremier network. To file a claim follow these steps:

Download a Delta Dental claim form at www.deltadentalva.com or ask your dentist for an ADA approved claim form at their office.

Be sure that each itemized bill contains the following:

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- name and address of the provider;
- name of the patient;
- date services were provided;
- the charge for each type of service provided;
- a description of each type of service provided; and
- the dental code for each type of service provided.

Send the completed and signed claim form and any itemized bill for covered services to:

Delta Dental of Virginia
4818 Starkey Road, S.W.
Roanoke, VA 24014

Delta Dental strives to process claim forms within 7-10 days. Delays may occur if claim forms are not filled out completely and accurately. If *you* do not receive reimbursement or correspondence regarding a claim within 30 days, please call Delta Dental member services at **888- 335- 8296**.

When you must file a prescription drug claim with Medco

You may need to file your own claim if:

- your prescription is filled by a non-participating pharmacy;
- *you* need to have a prescription filled before *you* receive your ID card; or
- *you* have a prescription that requires prior approval, but *you* need the prescription filled immediately.

Contact Medco if *you* need a Prescription Drug Reimbursement Form or if *you* have any questions about your drug program and related procedures.

To file a claim, follow these 3 steps:

1. Complete the Prescription Drug Reimbursement Form available online at **www.medco.com** or from Medco member service. If possible, ask the pharmacist to complete the pharmacy section of the form and sign it.
2. Pay for the prescription.
3. Mail your claim form to the address on the back of the form within 12 months of purchasing the prescription.

When you must file a behavioral health claim with ValueOptions

If *you* obtain preauthorization for services from a ValueOptions participating *provider*, claims will be filed on your behalf. However, if *you* have purchased the COVA Care Out-of-network option and *you* use a non-participating provider, or if *you* self-refer, *you* may have to file a claim for covered behavioral health services. The *provider* may also ask *you* to pay the bill at the time *you* receive covered services. If this happens, pay the *provider* and submit a claim form with a fully itemized bill

to ValueOptions for reimbursement processing. Call ValueOptions at **866- 725- 0602** to request that a claim form be mailed or faxed to *you*. Claim forms are also available under the “My Mental Health Benefits” tab on the Web at **www.achievesolutions.net/covacare**.

Be sure the itemized bill is on the *provider's* letterhead and that it includes the following information:

- name of the patient;
- identification number;
- diagnosis;
- each service provided;
- place of service;
- number and frequency of each service;
- date(s) of care; and
- charge for each item.

Mail your completed information to:

ValueOptions, Inc.

P. O. Box 1347

Latham, NY 12110-8847

Payment for covered services from a non-participating *provider* will be sent directly to *you*. After a properly completed claim form is received, it is typically processed within 15 days.

There may be instances when additional information is needed to make a final decision about payment. In these instances, we will send *you* a notice explaining the reason for the delay. A decision will be made within 30 days of receiving the additional information.

Timely filing of claims

No claim (proof of loss) will be paid if *your health plan* receives it more than 12 months after the date of service, except in the absence of legal capacity of the *covered person*. There is one exception. For *other covered services*, no claim will be paid if received more than 12 months after the end of the calendar year in which the *other covered services* were received.

When your claim is processed

Your health plan 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. The claim may be reopened by *you* or the *provider* furnishing the additional information. *You* or your *provider* must submit the additional information to *your health plan* within either 15 months of the date of service or 45 days from the date *you* were notified that the information is needed, whichever is later. Once your claim has been processed by *your health plan*, *you* will receive written notification of the coverage decision.

Recovery of overpayment

Your health plan has the right to recover any overpayment of benefits from persons or organizations that it has determined to have realized benefits from the overpayment:

- any person to, or for whom, such payments were made;
- any insurance company;
- a facility or provider; or
- any other organization.

You will be required to cooperate with *your health plan* to secure its right to recover the excess payments made on your behalf, on behalf of *covered persons* enrolled under *your health plan*, or persons determined to be ineligible.

When you are covered by more than one health plan

Coordination of benefits (COB)

Coordination of benefits (COB) rules apply when *you* or members of your family have additional health care coverage through other group health plans, including:

- group insurance plans, including other Blue Cross and Blue Shield plans or HMO plans;
- labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

You will receive and be required to complete each year an annual COB questionnaire. Claims payment will be withheld until the completed questionnaire is received.

Primary coverage and secondary coverage

When a *covered person* is also enrolled in another group health plan, one coverage will be primary and one will be secondary. The decision of which coverage will be primary or secondary is made using the order of benefit determination rules. Highlights of these rules are described below:

- If the other coverage does not have COB rules substantially similar to this health plan's, the other coverage will be primary.
- If a *covered person* is enrolled as the named insured under one coverage and as a dependent under another, generally the one that covers him or her as the named insured will be primary.
- If a *covered person* is the named insured under both coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the *covered person* is enrolled as a dependent child under both coverages (for example, when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the plan year will be primary.
- Special rules apply when a *covered person* is enrolled as a dependent child under two coverages and the child's parents are separated or divorced. Generally, the coverage of the parent or step-parent with custody will be primary. However, if there is a court order that requires one parent to provide for medical expenses for the child, that parent's coverage will be primary. If there is a court order that states that the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the plan year will be primary.
- If a covered active employee or employee's dependent is also covered by Medicare, the coverage provided by the employer is primary (unless Medicare eligibility is due to End Stage Renal Disease).
- If a covered retiree, survivor, LTD participant or their covered dependent is eligible for Medicare, the Medicare-eligible participant is no longer eligible for coverage under this plan (except during an End Stage Renal Disease coordination period).

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When *your health plan* is the primary coverage, it pays first. When *your health plan* is the secondary coverage, it pays second as follows:

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

Eligibility, enrollment and changes

Who is eligible for coverage

You are eligible for coverage if you are a part- or full-time, salaried, classified employee; or a regular, full-time or part-time salaried faculty. Your eligible dependents also may be covered. Retirees, LTD participants and survivors may also be eligible for coverage as described later in this section.

You may choose your type of membership as follows:

- Employee/retiree single – to cover yourself only
- Employee/retiree plus one – to cover yourself and one eligible dependent
- Family – to cover yourself and two or more eligible dependents

Members who cover ineligible persons may be removed from the program for a period of up to three years. In addition, the member will be responsible for claims paid in error and will be unable to reduce health benefits membership except within 31 days of the dependent's loss of eligibility or during open enrollment.

The following dependents are eligible for coverage under your *health plan*:

The employee's spouse

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

The employee's children

Under the health benefits program, the following eligible children may be covered to the end of the year in which they turn age 23 regardless of student status (age requirement is waived for adult incapacitated children), if the child lives at home or is away at school, is not married and receives over one-half of his or her support from the employee.

- Natural and Adopted Children: In the case of natural or adopted children, living at home may mean living with the other parent if the employee is divorced.
- Also, if the biological parents are divorced the support test is met if a natural or adopted child receives over one-half of their support from either parent or a combination of support from both parents. However, in order for the non-custodial parent to cover the child, the non-custodial parent must be entitled to claim the child as a dependent on his federal income tax return, or the custodial parent must sign a written declaration that he or she will not claim the child as a dependent on their federal income tax return.
- Stepchildren: Unmarried stepchildren living with the employee in a parent-child relationship. However, stepchildren may not be covered as a dependent unless their principal place of residence is with the employee, and the child is a member of the employee's household. A stepchild must receive over one-half of his or her support from the employee.

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- Incapacitated Children: Adult children who are incapacitated due to a physical or mental health condition, as long as the child was covered by the plan and the incapacitation existed prior to the termination of coverage due to the child attaining the limiting age. The employee must make written application, along with proof of incapacitation, prior to the child reaching the limiting age. Such extension of coverage must be approved by the plan and is subject to periodic review. Should the plan find that the child no longer meets the criteria for coverage as an incapacitated child, the child's coverage will be terminated at the end of the month following notification from the plan to the enrollee.
- Adult incapacitated children of new employees, may also be covered provided that:
 - The enrollment form is submitted within 31 days of hire;
 - The child has been covered continuously by group employer coverage since the disability first occurred; and
 - The disability commenced prior to the child attaining the limiting age of the plan.
 - The enrollment form must be accompanied by a letter from a physician explaining the nature of the incapacitation, date of onset and certifying that the dependent is not capable of self-support. This extension of coverage must be approved by the plan in which the employee is enrolled.
- Other Children: A child in which a court has ordered the employee to assume sole permanent custody. The principal place of residence must be with the employee, and the child must be a member of the employee's household.
- Additionally, if the employee or spouse shares custody with the minor child who is the parent of the "other child", then the other child may be covered. The other child, the parent of the other child, and the spouse who has custody must be living in the same household as the employee.
- When a child loses eligibility, coverage terminates at the end of the month in which the event that causes the loss of eligibility occurs.

Coverage for retirees and long term disability (LTD) participants

Retirees and LTD participants who enroll within 31 days of starting retirement or losing eligibility for coverage as an active employee may be eligible for coverage under this plan until they become eligible for Medicare (either due to age or disability). Dependent eligibility for the retiree group does not differ from that of active employees except as noted for non-annuitant survivors (see "When the member dies"). See your *benefits administrator* for more information about eligibility for coverage in the retiree group.

Who is not eligible for coverage

There are certain categories of persons who may not be covered as dependents under the program. These include:

- divorced spouses*
- parents
- grandparents
- aunts
- uncles
- dependent siblings**
- grandchildren**

- nieces**
- nephews**
- stepchildren unless both of these conditions are met:
 - 1) the stepchild lives with the member in a parent- child relationship, and
 - 2) the stepchild receives over one- half of his or her support from the employee
- dependent child after the end of the month in which the child marries
- children age 19 or older and not receiving over one- half of his or her support from the employee

* A court order to provide coverage for an ex-spouse does not make the ex-spouse eligible for coverage under this plan.

** The Department of Human Resource Management may determine when children who normally would not be eligible satisfy the criteria for “other children.”

Enrollment and changes

There are only certain times when *you* may enroll yourself and eligible dependents in a health benefits plan, or change your type of membership or plan.

When newly eligible

You may enroll within 31 days of the date of hire or becoming eligible. Your health coverage is effective the first of the month after the submission of your enrollment is received. If *you* are hired on the first working day of the month and the form is received that day, your coverage is effective the first of that month.

Retirement

Retirees eligible for coverage in the State Retiree Health Benefits Program but not eligible for Medicare may elect to continue coverage and membership level under this plan if they enroll in the retiree group within 31 days of their retirement date. Eligible retirees who did not participate in this plan as an active employee prior to retirement may enroll in single coverage at the time of retirement if they do so within 31 days of their retirement date.

Non- Medicare eligible retiree group participants may make membership and plan changes upon the occurrence of a qualifying mid-year event and at open enrollment. Retiree group members may reduce membership level at any time, and the *effective date* will be the first day of the month after the notification is received by their *benefits administrator*. However, retirees who cancel their own coverage may not return to the program.

Long term disability

Long Term Disability (LTD) participants eligible for coverage in the State Retiree Health Benefits Program but not eligible for Medicare may elect to continue coverage and membership level under this plan if they enroll in the retiree group within 31 days of the date that their coverage as an active employee ends.

Like retirees, non-Medicare eligible LTD participants may make membership and plan changes upon the occurrence of a qualifying mid-year event or at open enrollment, and they may reduce their membership level at any time. However, LTD participants who cancel their own coverage outside of open enrollment and without a qualifying mid-year event, or who are terminated for non-payment of premiums while enrolled in the retiree group, will not be reinstated at any level for the duration of the LTD period.

During open enrollment

Health benefits open enrollment occurs in the spring for employees and retirees who are not eligible for Medicare. The spring open enrollment is your opportunity to make changes in your health benefits plan and/or type of membership. The benefits and premiums associated with your open enrollment selections will be effective July 1 through June 30 of the following *plan year*.

Other changes outside of open enrollment

You may make membership and plan changes during the *plan year* that are based on qualifying mid-year events. *You* must submit your change within 31 days of the event. The change will be effective the first of the month after the date the submission of an election change is received. If notice is received the first day of the month, the change is effective that day. Other exceptions are birth, adoption, placement for adoption (changes take effect the first of the month in which the event occurs) and termination of ineligible members (changes are effective the last day of the month in which the member loses eligibility).

Qualifying mid-year events

The following events permit a change outside open enrollment. *You* may change a benefit election when a valid qualifying mid-year event occurs, but only if your change is made on account of, and corresponds with, a qualifying mid-year event that affects your own, your spouse's or your dependent's eligibility for coverage. *You* may change your plan or membership during the year if *you* apply to do so within 31 days of the event. If *you* have questions about these events, contact your *benefits administrator*.

Change in your employment status:

- begins/ends full-time employment
- begins/ends leave without pay or family medical leave
- changes from full-time to part-time or part-time to full-time
- begins retirement

Change in your marital status:

- marriage
- divorce
- death of a spouse

Change in your number of eligible family members

- birth or adoption (the Department of Human Resource Management must review all pre-adoptive placements to verify eligibility)
- death of a covered child
- covered child is no longer eligible for coverage under your plan (exceeds plan's age limit, marries, no longer receives over one-half of his or her support from the employee, etc.)
- judgment, decree or order to add a child
- judgment, decree or order to remove a child
- permanent custody of a child

Changes affecting your family member(s) employment

- spouse or covered child gains employer eligibility (including switching from part-time to full-time employment)
- spouse or eligible child loses employer eligibility (including switching from full-time to part-time employment)
- spouse begins/ends leave without pay

Other changes affecting your dependent(s)

- annual enrollment or significant change allowed under another employer's plan
- gains eligibility for Medicare or Medicaid
- loses eligibility for Medicare or Medicaid
- loses eligibility under another government sponsored plan

Changes due to special circumstances

- employee or dependent moves in or out of plan's service area
- HIPAA (Health Insurance Portability and Accountability Act) special enrollment due to loss of other health coverage

After coverage ends

Coverage ends on the last day of the month during which eligibility ceases. Unless otherwise agreed to in writing by the Commonwealth of Virginia, Department of Human Resource Management, the *covered person's* coverage ends on the last day of the month for which full payment is made. When a *covered person* ceases to be eligible or the required premiums are not paid, the *covered person's* coverage will end.

Examples of when a *covered person's* eligibility may cease include:

- when you leave your job with the employer, or change from full-time to part-time employment.
- when a dependent child becomes self-supporting or marries.
- when a dependent child reaches the end of the year in which the child turns 23.
- in the case of a handicapped dependent, when the child is no longer handicapped.
- in the case of your spouse, when you and your spouse divorce.

There are two exceptions. If you are an *inpatient* the day your coverage ends, your hospital coverage will continue until you are discharged to the extent that services were covered prior to the end of coverage. Also, *other covered services* such as rental of *medical equipment (durable)*, will be provided for a limited time for a condition for which you received covered services before your coverage ended. The time will be the shorter of when you become covered under any other group coverage, or the end of the plan year your coverage ends, or a period equal to the time you were enrolled under this plan.

When you become eligible for Medicare

You may remain enrolled under this health plan as long as you continue working. See your *benefits administrator* for more information. If you want to enroll under Medicare, you must make your own arrangements. Contact the nearest Social Security Office when you or a family member becomes eligible for Medicare (usually at age 65).

Participating retirees, LTD participants, survivors and their dependents who become eligible for Medicare, whether due to age or disability, and wish to continue participation in the State Retiree Health Benefits Program, must immediately enroll in one of the program's Medicare-coordinating plans. To ensure access to supplemental benefits, they must enroll in Medicare Parts A and B immediately upon eligibility. Failure to enroll in Parts A and B may result in coverage deficits since the program's Medicare-coordinating plans will not pay any part of a claim that would have been covered by Medicare had the participant been properly enrolled in Medicare. If it is determined that a retiree group participant is eligible for Medicare but has continued coverage in a non-Medicare plan, primary claim payments made in error may be retracted.

When the member dies

Covered family members retain coverage until the last day of the month immediately following the month the employee's death occurred. The employee's family members may elect Extended Coverage, or may also be eligible for an individual policy through Anthem.

Upon the death of a retiree or LTD participant, covered survivors are covered until the last day of the month in which the death occurs, and eligible survivors may obtain additional retiree group coverage as follows:

- Surviving family members for whom survivor retirement benefits have been provided may enroll in survivor coverage within 60 days of the retiree's/LTD participant's death, regardless of whether they had coverage prior to the retiree's/LTD participant's death (provided the retiree/LTD participant was still eligible for coverage at the time of death). Annuitant surviving spouses may continue coverage as long as the conditions outlined in the policies and procedures of the Department of Human Resource Management are met. Eligible surviving children may be covered through the end of the year in which they turn age 23 as long as they are unmarried and meet all other conditions for eligibility stated in the policies and procedures of the Department of Human Resource Management.
- Surviving family members who are enrolled in the program at the time of the retiree's/LTD participant's death may continue existing coverage in the retiree group by enrolling as survivors within 60 days of the retiree's/LTD participant's death. Non-annuitant surviving spouses may continue coverage until the end of the month in which they remarry, obtain alternate health plan coverage, or cease to meet any other applicable condition outlined in the policies and procedures of the Department of Human Resource Management. Eligible surviving children may be covered until they turn age 21 (or age 25 if a *full-time student*) as long as they are unmarried, do not obtain alternate health plan coverage and meet all other conditions for eligibility stated in the policies and procedures of the Department of Human Resource Management.
- Upon the death of a covered surviving spouse, dependents covered under the membership of that surviving spouse will be eligible only for Extended Coverage or conversion privileges.

Participating survivors who become eligible for Medicare must enroll in a Medicare-coordinating plan.

Survivors of state employees

If a state employee dies while in service, benefits may be available to survivors who either will immediately receive a retirement benefit from the Virginia Retirement System, or who are covered under the State Health Benefits Program at the time of the employee's death and wish to continue coverage. The deadline to enroll as a survivor is 60 days from the date of the employee's death. Current health coverage may continue for at least 30 days after the death of a state employee.

Contact the *benefits administrator* of the agency in which the state employee worked to enroll in coverage. For additional information, consult the "Survivor Benefits" Retiree Fact Sheet #10, which is available on the DHRM Web site at www.dhrm.virginia.gov. You may also request this information from your *benefits administrator*.

Survivors of retirees and LTD participants may also be eligible for coverage. See the section entitled “When the member dies” for more information.

Continuing coverage when eligibility ends

You and your dependents (including children under their own names) may be eligible for the following:

- Extended Coverage under the Public Health Service Act (see the General Notice of Extended Coverage Rights); or
- Individual coverage. *You* may contact Anthem Personal Health Care at **800-334-7676** to inquire about individual coverage. *You* must replace your coverage within 31 days of the day it ends in order to avoid a lapse in coverage.

General Notice of Extended Coverage Rights

This notice generally explains Extended Coverage, when it may become available to *you* and your family, and what *you* need to do to protect the right to receive it.

The right to Extended Coverage was created for private employers by federal law through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and these rights are reflected in the continuation coverage provisions of the Public Health Service Act which covers employees of state and local governments. Extended Coverage can become available to *you* when *you* would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the plan and under the law, *you* should contact your designated *benefits administrator*.

What is Extended Coverage?

Extended Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, Extended Coverage must be offered to each person who is a “qualified beneficiary.” *You*, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. These rights are also available to children covered through a Qualified Medical Child Support Order (QMCSO). Under the Plan, qualified beneficiaries who elect Extended Coverage must pay the full cost for Extended Coverage. Time limitations for making Extended Coverage premium payments will be included in the Election Notice provided at the time of the qualifying event.

If *you* are an employee, *you* will become a qualified beneficiary if *you* lose your coverage under the Plan because of either one of the following qualifying events:

- Your hours of employment are reduced. This would include periods of leave without pay (even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage) and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage.
- Your employment ends for any reason other than your gross misconduct.

If *you* are the spouse of an employee or retiree group participant, *you* will become a qualified beneficiary if *you* lose your coverage under the plan because of any one of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced (including periods of leave without pay, even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage, and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage);
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- *You* become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of any one of the following qualifying events:

- The parent/employee/retiree dies;
- The parent's/employee's hours of employment are reduced (including periods of leave without pay, even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage, and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage);
- The parent's/employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced, resulting in loss of dependent eligibility;
- The child stops being eligible for coverage as a dependent child under the plan.

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

When is Extended Coverage Available?

Your *benefits administrator* will automatically offer Extended Coverage to qualified beneficiaries upon the occurrence of the following qualifying events:

- Termination of employment;

- Reduction in hours of employment resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage, including leaves without pay;
- Death of the employee.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse or a dependent child's loss of eligibility for coverage as a dependent child), *you* or your representative must notify your *benefits administrator* within 60 days of the qualifying event (or within 60 days of the date coverage would be lost due to the qualifying event) by submitting written notification to include the following information:

- The type of qualifying event (e.g., divorce, loss of dependent child's eligibility-- including reason for the loss of eligibility);
- The name of the affected qualified beneficiary (e.g., spouse's and/or dependent child's name/s);
- The date of the qualifying event;
- Documentation to support the occurrence of the qualifying event (e.g., final divorce decree, dependent child's marriage certificate);
- The written signature of the notifying party;
- If the address of record is incorrect, an address for mailing the Election Notice.

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

How is Extended Coverage Provided?

Once the designated Commonwealth of Virginia *benefits administrator* becomes aware or is notified that the qualifying event has occurred, Extended Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect Extended Coverage. Covered employees may elect Extended Coverage on behalf of an eligible spouse, and parents may elect Extended Coverage on behalf of their eligible children.

Extended Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee/retiree, your divorce, or a dependent child's loss of eligibility as a dependent child, Extended Coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, Extended Coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before his coverage ends due to termination of employment, Extended Coverage for his covered spouse and/or children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date that coverage was lost due to termination of employment (36 months minus 8 months). Otherwise,

when the qualifying event is the end of employment or reduction of employee's hours of employment, Extended Coverage may last for only up to a total of 18 months. There are two ways in which this 18-month period can be extended.

1.) Disability extension of 18- month period of continuation coverage

You and anyone in your family covered under the Extended Coverage provisions of the Plan (due to termination of employment or reduction of hours) may be entitled to receive up to an additional 11 months of continuation coverage if it is determined by the Social Security Administration that any covered family member is disabled at some time during the first 60 days of continuation coverage, and the disability lasts at least until the end of the 18-month initial period of continuation coverage. The Office of Health Benefits Extended Coverage Administrator must receive notification of the disability determination within 60 days of either 1.) the date of the disability determination; 2.) the date of the qualifying event; 3.) the date on which coverage would be lost due to the qualifying event; or, 4.) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through this General Notice), AND within the first 18 months of Extended Coverage. Notification must be presented in writing and include the following information:

- The name of the disabled qualified beneficiary;
- The date of the determination;
- Documentation from the Social Security Administration to support the determination;
- The written signature of the notifying party (qualified beneficiary or representative);
- If the address of record is incorrect, a correct mailing address.

2.) Second qualifying event extension of 18- month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of Extended Coverage, the spouse and dependent children in your family can get up to 18 additional months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given (in the format and time frame specified below) to the Office of Health Benefits Extended Coverage Administrator. The extension may be available to the spouse and any dependent children receiving continuation coverage if the employee/former employee dies, the employee/former employee becomes divorced from the covered spouse, or the covered dependent child ceases to be eligible under the Plan, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Written notification must be given within 60 days of the date coverage would have been lost due to the second qualifying event and should include the following information:

- The type of second qualifying event (e.g., divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse and/or dependent child);
- The date of the second qualifying event;
- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support);
- The written signature of the notifying party;
- If the address of record is incorrect, a correct mailing address.

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Failure to furnish timely and complete notification of the second qualifying event or disability determination will result in loss of additional Extended Coverage eligibility. Notice will be considered furnished when mailed or, in the case of hand delivery, the date it is received by your *benefits administrator*.

Separate guidelines apply to continuation coverage under the provisions of the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA). If these provisions apply to *you*, see your *benefits administrator* for more information.

If you have questions:

Questions concerning your Plan or your Extended Coverage rights should be addressed to the contact listed under “**Plan contact information.**”

Keep your Benefits Administrator informed of address changes

In order to protect your family’s rights, *you* should keep your *benefits administrator* informed of any changes in the addresses of family members. *You* should also keep a copy, for your records, of any notices *you* send to your *benefits administrator* or the Office of Health Benefits Extended Coverage Administrator.

Plan contact information

For information about Extended Coverage, initial notification of qualifying events, and initial enrollment, contact your agency *benefits administrator*.

To make changes to Extended Coverage after initial enrollment, contact:

Office of Health Benefits Extended Coverage Administrator
101 N. 14th Street, 13th Floor
Richmond, VA 23219

Health Insurance Portability and Accountability Act (HIPAA)

Certificate of Group Health Plan Coverage

Date of this certificate: _____

Name of participant: _____

Name of health care plan: _____

Participant's identification number: _____

Membership level (Single, Employee + One, Family): _____

Name of individuals to whom this certificate applies: _____

Was the period of creditable coverage more than 18 months? (disregard periods of coverage before a 63-day break.) (Yes/No): _____

If less than 18 months, date coverage began: _____

Date coverage ended: _____

Date waiting period began: Not applicable

Person preparing this certificate and to whom questions should be addressed:

Name: _____

Address: _____

Telephone number: _____

Email address: _____

Agency: _____

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

Statement of HIPAA Portability Rights

This certificate is evidence of your coverage under the plan. *You* may need evidence of coverage to reduce a pre-existing condition exclusion period under another plan, to help *you* get special enrollment in another plan, or to get certain types of individual health coverage even if *you* have health problems. This certificate, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is furnished to everyone leaving the State Health Benefits Program or the State

Retiree Health Benefits Program (except for Medicare Supplement Plans). *You* may obtain additional certificates for *you* or your covered family members from your Agency *benefits administrator* (or the Virginia Retirement System for retirees) should *you* need them during the 24 months following your termination from the plan.

Pre- existing condition exclusions

Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if *you* are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, Extended Coverage (COBRA), coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If *you* do not receive a certificate for past coverage, talk with your new plan administrator.

You can add up any creditable coverage *you* have, including the coverage shown on this certificate. However, if at any time *you* went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage *you* had before the break.

- Therefore, once your coverage ends, *you* should try to obtain alternative coverage as soon as possible to avoid a 63-day break. *You* may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if *you* enroll in another plan.

Right to get special enrollment in another plan

Under HIPAA, if *you* lose your group health plan coverage, *you* may be able to get into another group health plan for which *you* are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if *you* request enrollment within 30 days. (Additionally, special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if *you* are eligible for coverage in another plan (such as a spouse's plan), *you* should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor

Under HIPAA, a group health plan may not keep *you* (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge *you* (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Rights to individual health coverage

Under HIPAA, if *you* are an “eligible individual,” *you* have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, *you* must meet the following requirements:

- *You* have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- *You* are not eligible for Extended Coverage (COBRA) or *you* have exhausted your Extended Coverage (COBRA) benefits; and
- *You* are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether *you* are laid off, fired, or quit your job.

- Therefore, if *you* are interested in obtaining individual coverage and *you* meet the other criteria to be an eligible individual, *you* should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

For more information

If *you* have questions, *you* may contact the person who prepared this certificate (contact information included). *You* may also contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at **866-444-3272** (for free HIPAA publications ask for publications concerning changes in health care laws) or the CMS publications hotline at **800-633-4227** (ask for “Protecting Your Health Insurance Coverage”). These publications and other useful information are also available on the Internet at **www.dol.gov/ebsa**, the U.S. Department of Labor’s interactive web pages – Health Elaws, or **www.cms.hhs.gov/hipaa**.

Request for Certificate of Group Health Plan Coverage

Use this form to request a Certificate of Group Health Plan Coverage from your *benefits administrator*. You may obtain additional certificates for *you* or your covered family members upon request while *you* are covered by the plan and during the 24 months following your termination from the plan.

Date of request: _____

Name of participant: _____

Address: _____

Telephone number: _____

Email address: _____

Name and relationship of any dependents for whom certificates are requested (and their address if different from above:

Medicare Part D Creditable Coverage Notice

If *you* are an active employee of the Commonwealth of Virginia who is covered under this plan, and *you* and/or any of your covered dependents are also eligible for Medicare, please read the following information carefully. It will confirm that your prescription drug coverage provided under the Commonwealth of Virginia Health Benefits Program is creditable.

Following is information about your current prescription drug coverage under *your health plan* and prescription drug coverage available for people with Medicare. It also explains the options that Medicare-eligible individuals have for Medicare prescription drug coverage and can help Medicare-eligible individuals decide whether or not they want to enroll in Medicare Part D coverage. At the end of this Notice is information about where Medicare-eligible individuals can get help to make decisions about prescription drug coverage. *You* should be aware that:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Commonwealth of Virginia Health Benefits Program has determined that the prescription drug coverage provided under *your health plan*, on average for all health plan participants, is expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered creditable coverage.

Because your existing coverage under the Commonwealth of Virginia Health Benefit Program is, on average, at least as good as standard Medicare prescription drug coverage, *you* can keep this coverage and not pay extra if *you* later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving coverage based on current active employment (for example, at the time of retirement) may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

In order to make the best health plan coverage decision for *you* and any covered dependents, *you* should compare *your health plan* coverage with the coverage and cost of the plans offering Medicare prescription drug coverage in your area (including which drugs are covered on the Medicare plans' formularies).

If *you* do decide to enroll in a Medicare prescription drug plan and drop *your health plan* coverage as an active employee (based on the policies and procedures of the Department of Human Resource Management and applicable law), be aware that *you* and your dependents will not be able to return to this coverage except with the occurrence of a consistent qualifying mid-year event or at open enrollment. The Commonwealth of Virginia Health Benefits Program does not offer a medical plan to active employees that excludes prescription drug coverage. Consequently, *you* must either maintain full coverage under the available plans (including prescription drug coverage) or terminate coverage completely. *You* do not have the option of terminating only the prescription drug benefit under your Commonwealth of Virginia plan.

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At the time an enrollee and/or covered dependent becomes eligible for Medicare, he/she/they may keep their state plan coverage based on active employment or may terminate coverage under the Commonwealth of Virginia Health Benefits Program based on that event if termination is completed within 31 days of eligibility for Medicare. However, once coverage has been terminated, neither the employee nor the dependent may re-enroll in the state program except upon the occurrence of a consistent qualifying mid-year event (for example, loss of eligibility for Medicare) or at open enrollment. An eligible dependent may not enroll unless the employee is enrolled. If an active employee or the covered dependent of an active employee has both coverage under the Commonwealth of Virginia Health Benefits Program and Medicare, except in limited circumstances, the state plan will pay primary to Medicare.

You should also know that if *you* drop or lose your coverage with the Commonwealth of Virginia Health Benefits Program and do not enroll in Medicare prescription drug coverage after the state coverage ends, *you* may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If *you* are eligible for Medicare and *you* go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% for every month that *you* did not have that coverage. For example, if *you* go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as *you* have Medicare prescription drug coverage. In addition, *you* may have to wait until the following November to enroll.

For more information, contact your agency's benefits administrator.

Note: *You* will receive a separate notice, in addition to this handbook section, annually prior to the Medicare Part D Annual Coordinated Election Period and at any time there is a change in the Commonwealth of Virginia Health Benefits Program's prescription drug coverage. *You* also may request a copy from your *benefits administrator*.

More detailed information about your options under Medicare prescription drug coverage is available in the "*Medicare & You*" handbook. If *you* have Medicare coverage, *you* will get a copy of the handbook in the mail every year from Medicare. *You* may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit **www.medicare.gov**, or
- Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for their telephone number) for personalized help, or
- Call **800- MEDICARE (800- 633- 4227)**. TTY users should call **877- 486- 2048**.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or *you* may call them at **800- 772- 1213 (TTY 800- 325- 0778)**.

Important information about your health plan

Changes in the health plan

The Commonwealth of Virginia may amend this health plan at any time. Any amendment to the health plan will change covered services to *covered persons* on the *effective date* of the change. This applies even though *you* may have an ongoing condition at the time of the change.

Complaint and appeal process

You have access to both a complaint process and an appeal process. Should *you* have a problem or question about *your health plan*, the appropriate *plan administrator's* member services department will assist you. Most problems and questions can be handled in this manner. For medical and the optional vision and hearing benefits, your *plan administrator* is Anthem. For behavioral health and EAP benefits, your *plan administrator* is ValueOptions. Delta Dental is the *plan administrator* for dental benefits. Medco is the *plan administrator* for your outpatient prescription drug benefits. *You* may also file a written complaint or appeal. Complaints typically involve issues such as dissatisfaction about *your health plan's* services, quality of care, the choice of and accessibility to *your health plan's providers* and network adequacy. Appeals typically involve a request to reverse a previous decision made by *your health plan*. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Complaint Process

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

Important: Written complaints or any questions concerning your medical, behavioral health, dental or prescription drug coverage may be filed to the following addresses:

Anthem Blue Cross and Blue Shield (for medical, optional vision and hearing)
Attention: Member Services
P.O. Box 27401
Richmond, VA 23279

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

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Medco Health Solutions, Inc. (for prescription drug)
Attn: General Manager
8111 Royal Ridge Parkway
Irving, TX 75036

ValueOptions, Inc. (for behavioral health)
P. O. Box 12438
Research Triangle Park, NC 27709-2438

Appeal Process

Your *health plan* is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider a coverage decision you find unacceptable. There are two types of appeals:

- *Plan administrator* appeals are requests to reconsider coverage decisions of pre-service or *post-service claims*. A separate expedited *emergency* appeals procedure is available to provide resolution within one business day of the receipt of a complaint or appeal concerning situations requiring immediate medical care. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain. All appeals to the *plan administrator* must be exhausted before an appeal can be made to the Department of Human Resource Management (DHRM).
- After *plan administrator* appeals are exhausted, you may request of DHRM an appeal process that includes an impartial clinical review by an independent, external reviewer of the final coverage decision made by the *plan administrator*. Additionally, other plan related issues may be appealed to DHRM as well. More information about this appeal may be found in the **Final DHRM Appeal Process** section.



Helpful tip: You must file your appeal within either 15 months of the date of service or 180 days from the date you were notified of the *adverse benefit determination*, whichever is later.

How to appeal a coverage decision

To appeal a coverage decision, please send a written request for an appeal to the appropriate *plan administrator's* address (see addresses in this section). Include an explanation of why you think the coverage decision was incorrect. (Alternatively, Anthem will accept a verbal request for appeal by calling a member services representative.) You may provide any comments, documents or information that you feel the *plan administrator* should consider when reviewing your appeal. Please include with the explanation:

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

Addresses:

Anthem Blue Cross and Blue Shield
Attn: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279

Medco Health Solutions, Inc.
Attn: Coverage Appeals
8111 Royal Ridge Parkway
Irving, TX 75063

Delta Dental of Virginia
Attn: Appeals
4818 Starkey Road, S.W.
Roanoke, VA 24018

ValueOptions, Inc.
P.O. Box 12438
Research Triangle Park, NC 27709-2438

How the plan administrator will handle your appeal

In reviewing your appeal, the *plan administrator* will take into account all the information *you* submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as one who typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

The *plan administrator* will resolve and respond in writing to your appeal within the following time frames:

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

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

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

Final DHRM Appeal Process

To further appeal the final coverage decision made by *your health plan* through its internal appeal process, *you* must submit to the director of the Commonwealth of Virginia, Department of Human Resource Management (DHRM), in writing within 60 days of *your health plan's* denial, the following:

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

You are responsible for providing DHRM with all information necessary to review the denial of your claim. The Department will ask *you* to submit any additional information *you* wish to have considered in this review, and will give *you* the opportunity to explain, in person or by telephone, why *you* think the claim should be paid. Claims denied due to such things as policy or eligibility issues will be reviewed by the director of DHRM. Claims denied because the treatment provided was considered not *medically necessary* will be referred to an independent medical review organization.

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

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

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

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

What's Not Appealable at DHRM

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

- specific coverage exclusions listed under “What is not covered” in the member handbook. However, denials of claims or coverage for services involving medical necessity (e.g. experimental or investigational procedures) can be appealed.
- matters in which the sole issue is disagreement with policies, rules, regulations, contract or law.
- claim amounts or service denials when the member’s cost is less than \$300.
- claim amounts above the allowable charge billed by a non-participating provider.

The decision of the *plan administrator* is final. If *you* are unsure whether a *plan administrator’s* decision can be appealed, call the Office of Health Benefits, **804- 371- 8458**.

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

Notice in writing

A notice sent to *you* by a *plan administrator* is considered “given” when delivered to the Department of Human Resource Management or your *benefits administrator*. If the Commonwealth of Virginia, or any one of the *plan administrators* must contact *you* directly, a notice sent to *you* is considered “given” when mailed to the enrolled member at the address shown in the Commonwealth of Virginia’s records. Be sure to notify the Department of Human Resource Management if your address changes.

Time limits on legal action

No legal action on a claim may be brought against the *plan administrators* or *your health plan* until after all appeal rights with respect to the claim have been exhausted. No legal action on a claim may be brought more than one year following the date that all appeal rights relating to the claim have been exhausted. This limit applies to matters relating to this health plan, to performance under this health plan, or to any statement made by an employee, officer, or director of Anthem concerning this health plan or the benefits available to a covered person.

Limitations of damages

In the event a covered person or his representative sues a *plan administrator*, or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any, exist under this health plan, the damages will be limited to the amount of the covered person’s claim for benefits. The damages will not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. Under no circumstances will this provision be construed to limit or preclude any extra contractual damages that may be available to *you* or your representative.

Continuing rights

On occasion, the Commonwealth of Virginia, or the *plan administrators* may not insist on your strict performance of all terms of *your health plan*. This does not mean they give up any future rights they have under *your health plan*.

Relationship to providers

The choice of a health care provider is solely the covered person's decision. *Providers* are not *plan administrator* employees or agents. They can contract with any appropriate provider or facility to provide services to you. Their inclusion or exclusion of a provider or a covered facility in any network is not an indication of the provider's or facility's quality or skill. They make no guarantees about the health of any *providers*. They do not furnish covered services but only make payment for them when received by *covered persons*.

They are not liable for any act or omission of any *provider*, nor are they responsible for a *provider's* failure or refusal to render covered services to a *covered person*.

Assignment of payment

A covered person may not assign the right to receive payment for covered services. Prior payments to anyone, whether or not there has been an assignment of payment, will not waive or restrict a *plan administrator's* right to make future payments to a covered person or any other person. This provision does not apply to dentists and oral surgeons.

Once covered services are rendered by a provider, the *plan administrator* will not honor requests not to pay the claims submitted by the provider. The *plan administrator* will have no liability to any person because it rejects the request.

Member Rights and Responsibilities

Making the most of your coverage

Successful partnerships take a strong commitment from all sides - each recognizing the rights and responsibilities of the other. Your health care is no different. It takes a strong partnership between *you*, your health care professionals, the Commonwealth of Virginia, and your *plan administrators* for coverage *you* can count on.

Below is a statement of rights and responsibilities for our partnership with *you*.

Your Rights:

You have the right to receive prompt treatment and service. When it comes to your health care, *you* should always be treated promptly, with courtesy and respect and receive the medical services *you* need from health care professionals. Likewise, when *you* have questions or need help with your plan benefits, *you* should always receive prompt and courteous service from *plan administrator* employees.

You have the right to know about all your treatment options and to participate in all discussions and decisions about your care. We encourage the health care professionals in our networks to discuss with *you* all treatment options regardless of cost or whether your benefits will cover the care. We encourage *you* to discuss each of these treatment options with your doctor and to participate in the decision about your course of care.

You have the right to privacy. Whether by health care professionals or by *plan administrator* employees, *you* should always be treated with dignity, and your right to privacy should always be respected. We abide by the Commonwealth of Virginia Privacy Protection Act and have a number of other procedures in place to ensure your privacy. Any medical information about *you* that we receive, including your medical records from health care professionals or hospitals, will be kept confidential and, except as permitted by law, will not be made available to anyone without your written permission. *You* can review any personal information collected about *you* by the *plan administrators* and corrections can be made at your request.

You have the right to health care coverage if you lose your coverage through your group plan. If *you* lose your health care coverage through your employer, *you* will still have options for health care coverage. Depending on factors such as your eligibility for other plans, your age and your state residency, *you* will be eligible for either another Blue Cross Blue Shield plan, a plan offered by another carrier or a government-sponsored program.

You have the right to voice complaints or file appeals. A member services representative can resolve most of your concerns if *you* are ever dissatisfied with the *plan administrators*, or the care *you* received from a participating health care professional. But, if *you* remain dissatisfied, *you* may file a complaint or appeal a decision. This booklet outlines the steps for *you* to follow.

You have the right to information. While *you* are enrolled as a member, we will periodically send *you* information on how to use the benefits and features of your plan. *You* may also request certain information about the *plan administrators*, or the health care professionals who contribute to your care by contacting the *plan administrators*.

You have the right to designate 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 authorization may be granted for a particular event or date of service after which time the authorization approval is revoked, or may be granted for any present or future claim for health care benefits *you* may have. Designations of authorized representative status are most appropriate when being granted to a health care provider or an attorney that may be representing *you* in connection with a claim. 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 claims matters. Explanation of Benefits statements will not be directed to your authorized representative, but will continue to be sent to *you* or the patient. To initiate the designation process, contact the appropriate *plan administrator*.

You have the right to make recommendations regarding the rights and responsibilities set forth here. Being a partner in your health care means remaining involved in and informed about the decisions that affect your health. We welcome all suggestions regarding what your rights and responsibilities as a member should be, as well as what our rights and responsibilities as your health plan should be. If *you* should have any questions, comments, or suggestions, please contact the *plan administrator's* member services department.

Responsibilities:

You have the responsibility to understand your health problems and to participate in developing mutually agreed upon treatment goals. It is important that *you* work together with your health care professionals and their treatment staffs. *You* can partner with them by following their advice and the care they recommend. Take the necessary steps to have your previous medical records, and any updates, transferred to your current doctor. *You* also have the responsibility to provide your doctors and the health plan with the information about your health and health habits that they may need in order to appropriately care for *you*. If *you* have questions or disagree with the treatment plan, discuss it with your provider. *You* should also be sure to understand the medications *you* are taking and whether *you* are scheduled for follow-up visits.

You have the responsibility to keep all diagnostic or treatment appointments as scheduled. Please consider the needs of others by being on time for appointments *you* schedule with health care professionals. And because giving patients the full attention they need does not always allow *providers* to stay on schedule, please be understanding if *you* have to wait before your provider can see *you*.

You have the responsibility to make your copayments (if your benefits include a copayment) at the time of your visit. Please be prepared to make your appropriate *copayment* when *you* receive your services. Applicable deductible and/or coinsurance amounts may also be collected.

You have the responsibility to pay monthly charges to maintain coverage (if your benefits require a monthly payment). If your monthly payment is late, the Commonwealth of Virginia, Department of Human Resource Management, has the right to suspend payment of your claims. The department will not be responsible for claims for any period for which full monthly charges have not been paid. If your monthly payment is not made within 31 days from the date due, the department may cancel your coverage. Once a full monthly payment is made, it cannot be refunded should your coverage be canceled after the first day of the month. Notice of cancellation of coverage does not relieve *you* from your obligation to pay the full monthly payment for any month of coverage already begun. If the entire monthly payment is not paid, coverage will be terminated and any partial amounts paid may not be refunded. Any claims paid for covered services during this time will be retracted and the member will be responsible for the cost of services.

You have the responsibility to notify your benefits administrator of any changes that may affect your membership records. When a change occurs in your employment, residence, or number of dependents, notify your *benefits administrator*. When a change in coverage available through another health insurance plan occurs (adding secondary coverage or discontinuing it, for example), it's important to notify the *plan administrator* because the change may affect your coverage.

You have the responsibility to take an active role in managing your health. Good health management means following the advice and instructions of your doctor and making the lifestyle changes your doctor recommends.

You have the responsibility to know what is considered emergency care. Be familiar with when to use the *emergency* room for care and when to seek care from your doctor. This booklet includes more information on when and how to use *emergency* room services.

HIPAA Privacy Practices

Disclosure of Protected Health Information (PHI) to the Employer

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

- (a) Plan - means the "State Health Benefits Programs."

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

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

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

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

- (a) not to use or further disclose PHI other than as permitted in Section (4) or as required by law;
- (b) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;
- (c) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;

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

(5) **The Plan** will disclose PHI only to the following employees or classes of employees:

- Director, Department of Human Resource Management
- Director of Finance, Department of Human Resource Management
- Staff Members, Office of Health Benefits

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

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

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

Definitions

Activities of daily living

means walking, eating, drinking, dressing, toileting, transferring (e.g. wheelchair to bed), and bathing.

Acute care

for behavioral health is inpatient care in which the patient is in a facility 24 hours a day under the care and direction of an attending physician.

Adverse benefit determination

is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by the health plan.

Allowable charge

means the amount on which deductible (if any), copayment, and coinsurance amounts for eligible services are calculated.

Benefits administrator

is the person appointed by your employer to assist you with your health plan. Your benefits administrator may also provide you information about your benefits. If there is a conflict between what your benefits administrator tells you and your health plan itself, your benefits will, to the extent permitted by law, be determined on the basis of the language in this booklet. Anthem may send notices intended for you to the benefits administrator. You may be provided with brochures, employee communications, or other material that describes the benefits available under your health plan. In the event of conflict between this type of information and your health plan, your benefits will be determined on the basis of the language in this booklet.

Coinsurance

is the percentage of the allowable charge you pay for some covered services.

Copayment

is the fixed dollar amount you pay for some covered services.

Covered persons

are you and enrolled eligible dependents.

Deductible

is a fixed dollar amount of covered services you pay in a plan year before your health plan will pay for certain remaining covered services during that plan year. The deductible amount is for a twelve month period and begins again each plan year. Deductible amounts incurred from April 1 through June 30 carry over to the new plan year.

Effective date

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

Emergency

is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity. This includes severe pain that without immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in:

- serious jeopardy to the mental or physical health of the individual;
- danger of serious impairment of the individual's body functions;
- serious dysfunction of any of the individual's bodily organs; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental/investigative

means any service or supply that is judged to be experimental or investigative at Anthem's sole discretion. Refer to **Exhibit A** for more information.

Extended Coverage (COBRA) beneficiary

is you or a covered dependent who elects to continue group coverage under Extended Coverage.

Facilities are:

- dialysis centers
- home health care agencies
- hospice providers
- hospitals
- skilled nursing facilities

First- tier drug

is a low cost drug, typically a generic drug.

High dose

means a dose of chemotherapy or radiation so high that it predictably requires stem cell rescue.

Home care services

are services rendered in the home setting. Home care includes services such as skilled nursing visits and physical, speech, and occupational therapy for patients confined to their homes. This also means home infusion services, which is therapy including such services as the intravenous and parenteral administration of medication to patients as well as enteral and parenteral nutrition. Home infusion therapy does not require that the patient is confined to his/her home.

Inpatient

means when you are a bed patient in the hospital.

Inpatient facilities

are settings where patients can spend the night, including hospitals, skilled nursing facilities, and partial day programs.

Levels of care

for behavioral health refers to the different types of treatment settings available to patients such as inpatient, partial, intensive outpatient, and outpatient care.

Maintenance medications

are those you take routinely to treat or control a chronic illness such as heart disease, high blood pressure, or diabetes.

Medical equipment (durable)

is used for a medical purpose, can withstand repeated use, and is appropriate for use in your home for daily living purposes.

Medically necessary

to be considered medically necessary, a service must:

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

Other covered services

are subject to the plan year deductible and include the following services:

- ambulance travel;
- dental accident services;
- diabetic supplies and equipment;
- home private duty nursing services;
- medical equipment, appliances, supplies and certain medications; and
- vision correction after surgery or accident.

Out-of-pocket expense limit

The amount of money that you pay out of your pocket for covered medical and behavioral health expenses (combined) during the plan year. Once the limit is reached, almost all other covered expenses are paid in full (100% of the allowable charge) for the rest of the plan year. The out-of-pocket expense limit is for a twelve month period and begins again each plan year.

Outpatient

is when you receive care in a hospital outpatient department, emergency room, professional provider's office, or your home.

Outpatient behavioral health services

are for the diagnosis and treatment of psychiatric conditions and include individual psychotherapy, group psychotherapy, and psychological testing.

Partial day service

for behavioral health is intensive treatment in a medically supervised setting with the opportunity for the patient to return home or to another residential setting at night.

Plan administrator

Your health plan benefits are administered by four plan administrators; Anthem Blue Cross and Blue Shield for medical, and the optional vision and hearing benefits; Delta Dental of Virginia for routine dental benefits, including the optional expanded dental benefits; Medco Health Solutions, Inc. for outpatient prescription drugs; and ValueOptions, Inc. for behavioral health and Employee Assistance Program (EAP) benefits.

Plan year

The period for which benefits are administered, which is July 1 through June 30.

Post- service claims

are all claims other than pre-service claims and urgent care claims. Post-service claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where you request authorization in advance.

Preauthorization

for behavioral health is the process of referring you to an appropriate provider and reviewing your treatment plan against medical necessity criteria. The process also includes referring you to an appropriate provider for your condition.

Prescription drugs

are medicines, including insulin, that require a prescription order from your doctor.

Pre- service claims

are claims for a service where the terms of the health plan require the member to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If you call to receive authorization for a service when authorization in advance is not required, that claim will be considered a post-service claim.

Primary care physician (PCP)

is a general or family practitioner, internist or pediatrician.

Providers (who may give care under your health plan):

- audiologists
- certified nurse midwives
- chiropractors
- chiropodists
- clinical social workers, psychologists, clinical nurse specialists in psychiatric behavioral health, professional counselors, marriage and family therapists
- dentists
- doctors of medicine (MD), including osteopaths and other specialists
- independent clinical reference laboratories
- occupational therapists
- opticians
- optometrists
- podiatrists

- registered physical therapists
- speech pathologists

Second- tier drug

is a moderate cost drug, typically a multi- source brand name drug. A multi- source brand name drug is a brand name drug which has a generic equivalent.

Setting

is the place where you receive treatment. It could be your home, your provider's office, a hospital outpatient department, a skilled nursing home, hospital inpatient room, or a partial day program.

Skilled nursing facility

is a facility licensed by the state in which it operates to provide medically skilled services to inpatients.

Specialty care providers

are any covered providers other than those defined as primary care physicians.

Stay

is the period from the admission to the date of discharge from a facility. All hospital stays less than 90 days apart are considered the same stay, and a new hospital inpatient copayment will not apply.

Third- tier drug

is a higher cost drug, typically a single source brand name drug. A single source brand name drug is a brand name drug which does not have a generic equivalent.

Visit

a period during which a covered person meets with a provider to receive covered services.

You

the enrolled member.

Your health plan

the COVA Care plan.

Exhibit A

Experimental/investigative criteria

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

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.
 - a) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
 - the following three standard reference compendia defined below:
 - 1) the U.S. Pharmacopoeia Dispensing Information
 - 2) the American Medical Association Drug Evaluations
 - 3) the American Hospital Formulary Service Drug Information
 - in substantially accepted peer- reviewed medical literature. Peer- reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer- reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or
 - b) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.
2. There must be enough information in the peer- reviewed medical and scientific literature to let us judge the safety and efficacy.
3. The available scientific evidence must show a good effect on health outcomes outside a research *setting*.
4. The service or supply must be as safe and effective outside a research *setting* as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered *experimental/investigative*.

Clinical trial costs

Clinical trial cost means patient costs incurred during participation in a clinical trial when such a trial is conducted to study the effectiveness of a particular treatment of cancer where all of the following circumstances exist:

- 1) The treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial;
- 2) Treatment provided by a clinical trial is approved by:
 - The National Cancer Institute (NCI);
 - An NCI cooperative group or an NCI center;
 - The U.S. Food and Drug Administration in the form of an investigational new drug application;
 - The Federal Department of Veterans Affairs; or
 - An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI;
- 3) With respect to the treatment provided by a clinical trial:
 - There is no clearly superior, non- investigational treatment alternative;
 - The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non- investigational alternative; and
 - The *covered person* and the physician or health care *provider* who provides the services to the *covered person* conclude that the *covered person's* participation in the clinical trial would be appropriate; and
- 4) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise.

“Patient cost” under this paragraph means the cost of a *medically necessary* health care service that is incurred as a result of the treatment being provided to the *covered person* for purposes of a clinical trial. “Patient cost” does not include (i) the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

Special Features and Programs

Your health plan covers a wide range of benefits to help *you* stay as healthy as possible. Having a healthy lifestyle and knowing how to make smart lifestyle choices can often improve health. For these reasons, *your health plan* provides you access to the following programs.

CommonHealth Wellness Program

The CommonHealth wellness program is offered to state employees through participating state agencies. The program is designed to make a positive difference in the health of the employee by integrating health awareness into the workplace. CommonHealth features a variety of medical screenings including cholesterol and blood pressure; fitness classes and challenges; health education programs and other activities. For more information, visit the CommonHealth Web site at www.commonhealthva.com.

24/7 NurseLine and AudioHealth Library

Illness or injury can happen, no matter what time of day. As an Anthem health plan member, *you* have access to a team of nurses, available to assist with your questions or concerns, 24 hours a day, seven days a week. These registered nurses can discuss symptoms you're experiencing, how to get the right care in the right setting and more and *you* can call as often as *you* like. Call **800-337-4770**.

For those who aren't comfortable discussing their health concerns with someone else or those just looking for more information on a health topic, there's the HealthLine Audiotape Library with more than 400 recorded health topics. Call **800-337-4770** to access this line. For the list of topics, go to anthem.com/cova and select AudioHealth Library under Special Programs.

Future Moms (formerly Baby Benefits)

You (or your covered dependent) are eligible to participate in the Future Moms program. This free program is designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery. A Future Moms consultant is assigned to women identified as having greater risk of premature delivery. The consultant (a nurse or health educator) works with the mother and her doctor during the pregnancy to determine what may be needed to help achieve a full-term delivery.

As soon as pregnancy is confirmed, sign up for the program by calling **800-828-5891**. *You* will receive:

- toll-free access to a registered nurse, any time day or night, in case *you* have questions or concerns along the way;
- a prenatal book to help *you* follow your pregnancy week by week, materials to help *you* handle the unexpected; and
- postpartum support and guidance in areas like breastfeeding and depression.

ConditionCare (formerly Better Prepared)

If *you* or a family member are living with asthma, diabetes, coronary artery disease (CAD), heart failure, chronic obstructive pulmonary disease (COPD), hypertension, hyperlipidemia, or obesity, *you* know the impact that it has on your life. This confidential disease management program will provide the tools and support needed to minimize your condition's effects, improve your health and help *you* feel better.

ConditionCare is a voluntary program and information is held in strict confidence. To register in this program, call **800-445-7922**. A dedicated nurse will be available to answer your questions, help *you* coordinate your benefits, and provide support to help *you* follow your doctor's plan of treatment.

When *you* call, please be sure to have your health insurance ID card and physician's name and address available.

In addition to members calling to enroll, the program receives names of members with certain chronic health conditions from medical and pharmacy claims, and case managers. *You* may be contacted by a ConditionCare enrollment specialist to find out if *you* or any of your eligible family members would like to participate in this program. With your permission, your health care information will be verified and will be shared with the ConditionCare staff and your physician. If your condition is under control or *you* are not interested in participating in the program, feel free to contact ConditionCare at **800-445-7922** to notify an enrollment specialist that *you* are not interested and do not wish to be contacted further.

Optional Benefits

Your health plan offers three optional benefits plans that can be purchased to supplement benefits included with the COVA Care Basic plan. You will be required to contribute toward the cost through additional payroll deductions in order to receive optional benefits. Each optional benefits plan is available separately, or you may elect to combine the Out-of-network option with either the expanded dental option or the vision, hearing and expanded dental option.

Out- of- network option

Under the COVA Care Basic plan, except in an emergency, you do not have coverage for the services of facilities and providers outside of the Anthem, BlueCard PPO, or ValueOptions networks. Selecting the Out-of-network option adds coverage for these facilities and providers.

The out-of-network benefit will always be the in-network benefit less a 25% reduction in the amount paid by your health plan. You will also be responsible for any deductible or copayment that applies.

For example, if you have the out-of-network option and are admitted to a non-network hospital, you will pay your inpatient facility copayment and Anthem will pay 75% of the allowable charge. You also pay any amount the non-network provider charges over the allowable charge.

In addition to adding coverage for facilities and providers outside your networks, the out-of-network option allows the accumulation of deductible, copayment and coinsurance amounts for these facilities and providers towards your out-of-pocket expense limits. However, the 25% reduction in the amount paid by your health plan will not count toward your out-of-pocket expense limits. Please see the **Claims and payments** section for a complete description of the out-of-pocket expense limit accumulations.

Expanded dental option

The COVA Care Basic plan automatically includes coverage for diagnostic and preventive, and primary dental services through Delta Dental. The expanded dental option through Delta Dental adds coverage for the following prosthetic, complex restorative, and orthodontic services:

Prosthetic and complex restorative services

If preventive services fail to save a tooth, the expanded dental option adds benefits for prosthetic and complex restorative services. These benefits include:

- Inlays (limited to the benefit for a resin restoration unless part of partial or bridge abutment);
- Onlays (limited to the benefit for a metallic restoration);
- crowns, crown repair, and post and core build-ups for crowns;
- labial veneers involving the incisal edge of anterior teeth, porcelain laminate (Laboratory processed);
- dental implants;
- dentures (full and partial), and denture adjustments and relining; and

- fixed bridges and repair.

Delta Dental must approve expanded dental services for covered persons under age 16 in advance. Replacement of prosthetic appliances, dentures, crowns, crown buildups, post and core to support crowns, onlays and bridges are limited to once every five-year period. There is one exception: Replacement of a bridge will be provided prior to the end of the five-year period if one or more abutment teeth are extracted.

When the expanded dental option is selected, prosthetic and complex restorative services are covered at 50% coinsurance. The annual maximum that *your health plan* covers is increased from \$1,200 under the basic plan to \$1,500 per plan year.

Orthodontic services

The expanded dental option also provides coverage for orthodontic services. Benefits are available if the problem is a handicapping malocclusion. That means it prevents normal chewing or eating. Your coverage includes:

- orthodontic appliances (installing only, no replacement or repair);
- services needed to diagnose the problem, including x-rays, study models and diagnostic casts;
- tooth guidance and harmful habit appliances;
- interceptive treatment;
- surgical access of unerupted teeth when performed for orthodontic purposes; and
- orthodontic evaluations when no treatment is initiated.

Your health plan includes coverage at 50% coinsurance for orthodontic services and pays up to \$1,200 per lifetime for orthodontic benefits. Orthodontic benefits paid under any other self-funded Commonwealth of Virginia coverage will count against the \$1,200 lifetime limit.

Vision, hearing and expanded dental option

The vision, hearing and expanded dental option adds routine vision and hearing services through Anthem, and all the benefits of the expanded dental option through Delta Dental as described earlier in this section.

Vision services

The vision, hearing and expanded dental option adds coverage for certain vision care services to identify and correct refractive error. Benefits are provided up to a maximum payment established for each covered service. Vision services are available from optometrists, opticians and ophthalmologists. *You* should obtain your examination from a network *provider*; however, *you* may obtain frames and lenses or contact lenses from any licensed *provider*.

The following services are covered:

- an eye examination once every 24 months (*you* pay \$35 copayment);
- one set of frames every 24 months (\$75 benefit maximum);

- one pair of single (\$50 benefit maximum), bifocal (\$75 benefit maximum), or trifocal (\$100 benefit maximum) eyeglass lenses every 24 months; or contact lenses of any type and other related contact lens services (\$100 benefit maximum), instead of eyeglass lenses, every 24 months.

The 24-month count starts the month in which *you* receive your eye examination or purchase eyeglass frames or lenses.

Hearing services

The vision, hearing and expanded dental option adds coverage for certain hearing care services to identify and treat hearing care for a routine hearing loss that is not due to a specific illness or injury. Benefits are provided up to a maximum payment established for each covered service. The examination may be obtained from an audiologist or doctor of medicine.

The following services are covered:

- an examination once every 48 months (*you* pay \$35 copayment); and
- purchase of hearing aid(s) and other related hearing aid services such as selection, fitting and repair every 48 months (\$1,200 benefit maximum).

The 48-month count starts the month in which *you* receive your hearing examination or purchase your hearing aid(s) or hearing related services.

Expanded dental

The COVA Care basic plan includes coverage for routine diagnostic and preventive, and primary dental services through Delta Dental. The expanded dental option described earlier in this section adds benefits for prosthetic and complex restorative services and orthodontic services through Delta Dental.

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